April 6, 2026

NOTE: Medicare Advantage Organizations, Prescription Drug Plan Sponsors, and Other Interested Parties

Announcement of Calendar Year (CY) 2027 Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies

Medicare Advantage and Part D are of central importance to the goals of driving greater choice and accountability within the Medicare program. We at CMS deeply appreciate the partnership of all the interested stakeholders who have weighed in on the Advance Notice of Methodological Changes for CY 2027 MA Capitation Rates and Part C and Part D Payment Policies (CY 2027 Advance Notice) with their valuable feedback. Above all, CMS is committed to delivering results for its two key constituencies: Medicare beneficiaries and taxpayers. In 2026, Medicare Advantage enrollment has grown and benefit offerings are robust. The final policies in the Announcement of CY 2027 MA Capitation Rates and Part C and Part D Payment Policies (CY 2027 Rate Announcement) will support the program, while also advancing our vision of a sustainable and credible Medicare Advantage program in the long run. In particular, the targeted risk adjustment policies in the CY 2027 Rate Announcement will promote greater competition and more accurate payments. We will continue to consider future policy improvements to the risk adjustment system in alignment with these goals.

In accordance with section 1853(b)(1) of the Social Security Act ("the Act"), we are notifying you of the annual capitation rate for each Medicare Advantage (MA) payment area for CY 2027 and the risk and other factors to be used in adjusting such rates.

In response to our request for comments on the CY 2027 Advance Notice, published on January 26, 2026, CMS received submissions from professional organizations, MA and Part D sponsors, advocacy groups, physicians, pharmaceutical manufacturers, pharmacy benefit managers, pharmacies, and interested persons. The CY 2027 Rate Announcement describes and responds to all of the substantive comments received that are in scope for the purposes of the CY 2027 Rate Announcement.

After considering all comments received, we are finalizing policies in the CY 2027 Rate Announcement.

The capitation rate tables for CY 2027 and supporting data are posted on the CMS website at https://www.cms.gov/medicare/payment/medicare-advantage-rates-statistics/ratebooks-supporting-data. The statutory component of the regional benchmarks, qualifying counties, and each county's applicable percentage are also posted on this section of the CMS website.

Attachment I of the CY 2027 Rate Announcement shows the final estimates of the National Per Capita MA Growth Percentage for CY 2027 and the National Medicare Fee-for-Service (FFS)

Growth Percentage for CY 2027, used to calculate the CY 2027 capitation rates. As discussed in Attachment I, the final estimate of the National Per Capita MA Growth Percentage for combined aged and disabled beneficiaries is 4.40 percent, and the final estimate of the FFS Growth Percentage is 5.46 percent. Attachment II provides a set of tables that summarizes the key Medicare assumptions used in the calculation of the growth percentages.

Section 1853(b)(4) of the Act requires CMS to release county specific per capita FFS expenditure information on an annual basis, beginning with March 1, 2001. In accordance with this requirement, FFS data for CY 2024 were posted on the above website with the CY 2027 Advance Notice.

Attachment II details the key assumptions and financial information behind the growth percentages presented in Attachment I.

Attachment III presents responses to Part C payment-related comments on the CY 2027 Advance Notice.

Attachment IV presents responses to Part D payment-related comments on the CY 2027 Advance Notice.

Attachment V provides the final Part D benefit parameters and details how they are updated.

Attachment VI presents responses to comments on updates for MA and Part D Star Ratings.

Attachment VII contains economic information for significant provisions in the CY 2027 Rate Announcement.

Attachment VIII contains the risk adjustment factors for the RxHCC risk adjustment models.

Key Updates from the CY 2027 Advance Notice

Growth Percentages: Attachment I provides the final estimates of the National Per Capita MA Growth Percentage and the FFS Growth Percentage, upon which the capitation rates are based, and information on deductibles for Medical Savings Accounts. Each year for the Rate Announcement, CMS updates the growth rates to be based on the most current estimate of per capita costs, based on the available historical program experience and projected trend assumptions at that time. The growth rates change between proposed and final as CMS incorporates updated data and assumptions. This year, the change in growth rates from the CY 2027 Advance Notice to the CY 2027 Rate Announcement is due primarily to incorporation of additional data, whereby the non-ESRD FFS USPCCs for both Part A and Part B are based on program experience and incurred dates through fourth quarter 2025.

CMS-Hierarchical Condition Category (CMS-HCC) Risk Adjustment Models:

- Non-Program of All-inclusive Care for the Elderly (PACE) Organizations: For CY 2027, CMS will continue to use the 2024 CMS-HCC risk adjustment model to calculate risk scores.

- PACE Organizations: For CY 2027, CMS will calculate risk scores as a blend of 50 percent of the risk score calculated using the 2024 CMS-HCC risk adjustment model and 50 percent of the risk score calculated using the 2017 CMS-HCC risk adjustment model.

Frailty Adjustment:

- Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs): For CY 2027, CMS will continue to use the frailty factors associated with the 2024 CMS-HCC risk adjustment model to calculate frailty scores for FIDE SNPs. FIDE SNP frailty scores will be compared to the PACE minimum frailty score calculated in the same manner to determine whether FIDE SNPs have a similar average level of frailty as the PACE program.

- PACE Organizations: For CY 2027, CMS will calculate frailty scores using a blend of 50 percent of the frailty score calculated with the 2017 CMS-HCC risk adjustment model frailty factors and 50 percent of the frailty score calculated with the 2024 CMS-HCC risk adjustment model frailty factors. This is consistent with the blend CMS will use to calculate risk scores for PACE organizations.

CMS-HCC Risk Adjustment Model Normalization Factors: For CY 2027, for all CMS-HCC risk adjustment models, CMS calculated the normalization factors using a four-year simple linear regression methodology and average historical FFS risk scores from 2022 through 2025.

- 2024 CMS-HCC Model: 1.079

- 2017 CMS-HCC Model: 1.202

- 2023 ESRD Dialysis CMS-HCC Model: 1.072

- 2019 ESRD Dialysis CMS-HCC Model: 1.145

- 2023 ESRD Functioning Graft CMS-HCC Model: 1.119

- 2019 ESRD Functioning Graft CMS-HCC Model: 1.209

Sources of Diagnoses for Risk Scores Calculated with CMS-HCC and RxHCC Risk Adjustment Models: CMS is finalizing the proposal to exclude diagnoses from unlinked chart review records (CRRs), with an exception for beneficiaries who switch from one MA organization to another (e.g., moved from one MA organization in CY 2026 to another MA organization in CY 2027).

Policies Adopted as Described

As in past years, policies in the Advance Notice that are not modified or retracted in the Rate Announcement become effective for the upcoming payment year. Clarifications in this CY 2027 Rate Announcement supersede information in the CY 2027 Advance Notice and prior Rate Announcements.

Calculation of FFS Costs: As has been the case for the last ten years, the Secretary has directed the CMS OACT to adjust the FFS experience for beneficiaries enrolled in Puerto Rico to reflect the nationwide propensity of beneficiaries with zero claims.

MA Benchmark, Quality Bonus Payments, and Rebate: We will continue to implement the methodology, as described in the CY 2027 Advance Notice, used to derive the benchmark county rates, how the qualifying bonus counties are identified, and the applicability of the Star Ratings.

Location of Network Areas for Private Fee-for-Service (PFFS) Plans in Plan Year 2028: The list of network areas for plan year 2028 is available on the CMS website at https://www.cms.gov/medicare/health-drug-plans/private-fee-for-service-plans/network-requirements.

Direct Graduate Medical Education (DGME) Carve-out Applied to Average Geographic Adjustments (AGAs): As in past years, we will continue carving out FFS DGME amounts from the MA capitation rates as described in the CY 2027 Advance Notice.

Indirect Medical Education (IME) Phase Out Applied to AGAs: We will continue phasing out FFS IME amounts from the MA capitation rates as described in the CY 2027 Advance Notice.

Organ Acquisition Costs for Kidney Transplants: As in past years, we will continue carving out Kidney Acquisition Costs from the MA capitation rates.

MA ESRD Rates: We will continue to set MA ESRD rates on a state basis.

MA Employer Group Waiver Plans (EGWPs): We will continue to use the payment methodology as described in the CY 2027 Advance Notice, but with finalized bid-to-benchmark ratios for CY 2027 MA EGWP payment rates as indicated in the table below.

Applicable Percentage	Bid to Benchmark Ratio
0.95	78.7%
1	77.8%
1.075	77.8%
1.15	77.7%

End-Stage Renal Disease (ESRD) CMS-HCC Risk Adjustment Models:

- Non-PACE Organizations: For CY 2027, CMS will continue to use the 2023 ESRD CMS-HCC risk adjustment models to calculate risk scores for beneficiaries in dialysis, transplant, and functioning graft status.

- PACE Organizations: For CY 2027, CMS will calculate risk scores as a blend of 50 percent of the risk score calculated using the 2023 ESRD CMS-HCC risk adjustment models and 50 percent of the risk score calculated using the 2019 ESRD CMS-HCC risk adjustment models.

MA Coding Pattern Difference Adjustment: For CY 2027, CMS will apply the statutory minimum MA coding pattern difference adjustment of 5.90 percent.

Sources of Diagnoses for Risk Scores Calculated with CMS-HCC Risk Adjustment Models:

- Non-PACE Organizations: CMS will continue the policy first adopted for CY 2022 to calculate all risk scores for payment to MA organizations using only risk adjustment-eligible diagnoses from encounter data and FFS claims. For CY 2027, CMS is finalizing the proposal to exclude diagnoses identified as resulting from audio-only services using modifiers "93" or "FQ."

- PACE Organizations: CMS will calculate risk scores using 50 percent of the risk score calculated with diagnoses from encounter data and FFS claims using the CMS-HCC models used for organizations other than PACE with 50 percent of the risk score calculated with pooled diagnoses from risk adjustment processing system (RAPS) data, encounter data, and FFS claims using the CMS-HCC models that have been used to calculate risk scores for PACE organizations (i.e., the 2017 CMS-HCC model and the 2019 ESRD CMS-HCC models). CMS is finalizing the proposal to exclude diagnoses identified as resulting from audio-only services using modifiers "93" or "FQ." The exclusion of diagnoses from unlinked CRRs for risk score calculation does not apply to PACE organizations for CY 2027.

RxHCC Risk Adjustment Models: For CY 2027, CMS will implement updated versions of the RxHCC risk adjustment models that reflect changes made to the Part D benefit for CY 2027 as a result of the Inflation Reduction Act of 2022 (IRA), and continue to adjust gross drug costs to account for the maximum fair prices (MFPs) of the selected drugs for which an MFP is in effect for initial price applicability year (IPAY) 2026 as part of the Medicare Drug Price Negotiation Program.

- Non-PACE Organizations: CMS will implement the RxHCC model proposed in the CY 2027 Advance Notice that uses 2023 diagnoses and 2024 expenditure data and has separate continuing enrollee model segments for beneficiaries in Medicare Advantage

prescription drug (MA-PD) plans and stand-alone Medicare Part D prescription drug plans (PDPs).

- PACE Organizations: CMS will implement a blend of the RxHCC model being finalized for non-PACE organizations (i.e., 2023/2024 calibration) and the RxHCC model calibrated on 2018 diagnoses and 2019 expenditure data (i.e., 2018/2019 calibration) by calculating risk scores as a blend of 50 percent of the risk score calculated using the 2023/2024 calibration, using MA-PD relative factors, and 50 percent of the risk score calculated using the 2018/2019 calibration.

RxHCC Risk Adjustment Model Normalization Factors: For CY 2027, for the RxHCC models, CMS will continue to implement separate normalization factors for MA-PD plans and PDPs. For the model calibrated on 2023/2024 data, we are finalizing the normalization factors calculated using the multiple linear regression methodology and average historical risk scores from 2020 through 2024 with a flag that identifies whether an average Part D risk score is based on dates of service before or after the onset of the COVID-19 pandemic. For the RxHCC model we are using solely for PACE organizations, we will continue to use the historical linear slope methodology and average risk scores from 2016-2020.

- 2027 RxHCC model (2023/2024 calibration):
    - MA-PD plans: 1.109
    - PDPs: 1.005
- 2027 RxHCC model (2018/2019 calibration) for PACE organizations only: 1.237

Sources of Diagnoses for Risk Scores Calculated with the RxHCC Risk Adjustment Models:

- Non-PACE Organizations: CMS will continue the policy first adopted for CY 2022 to calculate all risk scores for payment to Part D sponsors using only risk adjustment-eligible diagnoses from encounter data and FFS claims. CMS is finalizing the proposal to exclude diagnoses identified as resulting from audio-only services using modifiers "93" or "FQ."
- PACE Organizations: CMS will calculate risk scores using 50 percent of the risk score calculated with diagnoses from encounter data and FFS claims using the MA-PD relative factors of the RxHCC model used for organizations other than PACE (i.e., 2023/2024 calibration) with 50 percent of the risk score calculated with pooled diagnoses from RAPS, encounter data, and FFS claims using the RxHCC model calibrated on 2018 diagnoses and 2019 expenditure data (i.e., 2018/2019 calibration). CMS is finalizing the proposal to exclude diagnoses identified as resulting from audio-only services using modifiers "93" or "FQ." The exclusion of diagnoses from unlinked CRRs for risk score calculation does not apply to PACE organizations for CY 2027.

Annual Adjustments to Medicare Part D Benefit Parameters in CY 2027: As described in the CY 2027 Advance Notice, we will update the defined standard benefit deductible amount and the annual out-of-pocket threshold by multiplying the CY 2026 amounts by the CY 2027 Annual Percentage Increase and rounding as specified by the statute.

Part D Calendar Year EGWP Prospective Reinsurance Amount: As discussed in the CY 2027 Advance Notice, we will continue to use the updated methodology finalized in the Final CY 2025 Part D Redesign Program Instructions to calculate the prospective reinsurance payments to all Part D Calendar Year EGWPs.

Part D Risk Sharing: As discussed in the CY 2027 Advance Notice, we will apply no changes to the current threshold risk percentages for CY 2027.

Retiree Drug Subsidy Amounts: As discussed in the CY 2027 Advance Notice, we will use the same methodology as in prior years to update the cost threshold and cost limit for qualified retiree prescription drug plans.

/ s /
Chris Klomp
Director of Medicare & Deputy Administrator, CMS, and Senior Counselor to the Secretary, HHS

I, Jennifer Wuggazer Lazio, am a Member of the American Academy of Actuaries. I meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained in this Rate Announcement. My opinion is limited to the following sections of this Rate Announcement: The growth percentages and United States per capita cost estimates provided and discussed in Attachments I, II and III; the qualifying county determination, calculations of Fee-for-Service cost, direct graduate medical education carve-out, kidney acquisition cost carve-out, IME phase out, MA benchmarks, EGWP rates, and ESRD rates discussed in Attachment III; the Medicare Part D Benefit Parameters: Annual Adjustments for Defined Standard Benefit in 2027 described in Attachments IV and V; and the economic information contained in Attachment VII.

/ s /
Jennifer Wuggazer Lazio, F.S.A., M.A.A.A.
Director
Parts C & D Actuarial Group
Office of the Actuary

Attachments

2027 RATE ANNOUNCEMENT

Attachment I. Final Estimates of the National Per Capita Growth Percentage and the National Medicare Fee-for-Service Growth Percentage for CY 2027

Table I-1 below shows the National Per Capita MA Growth Percentage (NPCMAGP) for CY 2027. An adjustment of -1.24 percent for the combined aged and disabled cohort is included in the NPCMAGP to account for corrections to prior years' estimates as required by section 1853(c)(6)(C). The combined aged and disabled change is used in the development of the ratebook.

Table I-1. Increase in the NPCMAGP for CY 2027

	Prior increases	Current increases			NPCMAGP for 2027 with § 1853(c)(6)(C) adjustment[1]
	2003 to 2026	2003 to 2026	2026 to 2027	2003 to 2027	
Aged + Disabled	140.826%	137.849%	5.706%	151.421%	4.40%

[1] Current increases for 2003-2027 divided by the prior increases for 2003-2026.

Table I-2 below provides the change in the FFS United States Per Capita Cost (USPCC), which was used in the development of the county benchmarks. The percentage change in the FFS USPCC is shown as the current projected FFS USPCC for CY 2027 divided by projected FFS USPCC for CY 2026 as estimated in the CY 2026 Rate Announcement released on April 7, 2025.

Table I-2. FFS USPCC Growth Percentage for CY 2027

	Aged + Disabled	*Dialysis–only ESRD*
Current projected 2027 FFS USPCC	$1,297.74	$11,094.43
Prior projected 2026 FFS USPCC	$1,230.52	$10,372.92
Percent change	5.46%	6.96%

Table I-3 below shows the monthly actuarial value of the Medicare deductible and coinsurance for CYs 2026 and 2027. In addition, for CY 2027, the actuarial value of deductibles and coinsurance is being shown for non-ESRD only, since MA plan bids for CY 2027 exclude costs for ESRD enrollees. These data were furnished by the Office of the Actuary.

Table I-3. Monthly Actuarial Value of Medicare Deductible and Coinsurance for CYs 2026 and 2027

	2026	2027	Change	2027 non-ESRD
Part A Benefits	$41.82	$45.23	8.15%	$43.60
Part B Benefits[1]	191.17	205.54	7.52%	197.66
Total Medicare	232.99	250.77	7.63%	241.26

[1] Includes the amounts for outpatient psychiatric charges.

Medical Savings Account (MSA) Plans. The maximum deductible for MSA plans for CY 2027 is $18,900.

Attachment II. Key Assumptions and Financial Information

The USPCCs are the basis for the National Per Capita MA Growth Percentage. Below is a table that compares last year's estimates of USPCCs with current estimates for 2003 to 2028. In addition, this table shows the current projections of the USPCCs through 2029. We are also providing a set of tables that summarize the key Medicare assumptions used in the calculation of the USPCCs. Most of the tables include information for the years 2003 through 2029.

Most of the tables in this attachment present combined aged and disabled non-ESRD data. The ESRD information presented is for the combined aged-ESRD, disabled-ESRD, and ESRD only.

All of the information provided in this attachment applies to the Medicare Part A and Part B programs. Caution should be employed in the use of this information. It is based upon nationwide averages, and local conditions can differ substantially from conditions nationwide.

None of the data presented here pertain to the Medicare Part D prescription drug benefit.

Table II-1. Comparison of Current & Previous Estimates of the Total USPCC – non-ESRD

	Part A		Part B		Part A + Part B		
Calendar year	Current estimate	Last year's estimate	Current estimate	Last year's estimate	Current estimate	Last year's estimate	Ratio
2003	$296.18	$296.18	$247.66	$247.66	$543.84	$543.84	1.000
2004	314.08	314.08	271.06	271.06	585.14	585.14	1.000
2005	334.83	334.83	292.86	292.86	627.69	627.69	1.000
2006	345.30	345.30	313.70	313.70	659.00	659.00	1.000
2007	355.44	355.44	330.68	330.68	686.12	686.12	1.000
2008	371.90	371.90	351.04	351.04	722.94	722.94	1.000
2009	383.91	383.91	367.49	367.49	751.40	751.40	1.000
2010	383.93	383.93	376.34	376.34	760.27	760.27	1.000
2011	387.73	387.73	385.30	385.30	773.03	773.03	1.000
2012	377.37	377.37	391.96	391.96	769.33	769.33	1.000
2013	380.20	380.20	398.89	398.89	779.09	779.09	1.000
2014	370.20	370.20	418.46	418.46	788.66	788.66	1.000
2015	374.02	374.02	435.22	435.20	809.24	809.22	1.000
2016	377.55	377.55	444.84	444.84	822.39	822.39	1.000
2017	382.59	383.01	460.38	460.66	842.97	843.67	0.999
2018	387.79	388.22	493.59	494.19	881.38	882.41	0.999
2019	401.38	401.80	525.85	526.48	927.23	928.28	0.999
2020	403.93	403.94	524.78	524.95	928.71	928.89	1.000
2021	409.46	409.54	573.35	573.62	982.81	983.16	1.000
2022	434.10	434.61	606.80	607.19	1,040.90	1,041.80	0.999

	Part A		Part B		Part A + Part B		
Calendar year	Current estimate	Last year's estimate	Current estimate	Last year's estimate	Current estimate	Last year's estimate	Ratio
2023	454.78	456.39	663.06	663.87	1,117.84	1,120.26	0.998
2024	463.51	469.10	699.20	702.55	1,162.71	1,171.65	0.992
2025	479.03	484.86	740.17	739.82	1,219.20	1,224.68	0.996
2026	509.16	506.51	784.36	803.20	1,293.52	1,309.71	0.988
2027	543.92	530.86	823.41	857.27	1,367.33	1,388.13	0.985
2028	567.02	555.93	874.30	902.51	1,441.32	1,458.44	0.988
2029	592.75		927.95		1,520.70		

Table II-2. Comparison of Current & Previous Estimates of the FFS USPCC – non-ESRD

	Part A		Part B		Part A + Part B		
Calendar year	Current estimate	Last year's estimate	Current estimate	Last year's estimate	Current estimate	Last year's estimate	Ratio
2010	$371.20	$371.20	$374.30	$374.30	$745.50	$745.50	1.000
2011	371.15	371.15	383.17	383.17	754.32	754.32	1.000
2012	356.97	356.97	390.74	390.74	747.71	747.71	1.000
2013	363.99	363.99	394.75	394.75	758.74	758.74	1.000
2014	364.16	364.16	409.30	409.30	773.46	773.46	1.000
2015	369.52	369.53	428.33	428.33	797.85	797.86	1.000
2016	371.56	371.56	434.69	434.69	806.25	806.25	1.000
2017	373.30	373.61	450.48	450.48	823.78	824.09	1.000
2018	378.06	378.07	481.73	481.74	859.79	859.81	1.000
2019	385.47	385.42	508.60	508.59	894.07	894.01	1.000
2020	375.73	375.59	478.02	478.06	853.75	853.65	1.000
2021	390.06	390.06	559.16	559.39	949.22	949.45	1.000
2022	408.51	409.14	578.12	578.31	986.63	987.45	0.999
2023	419.62	422.14	625.54	626.15	1,045.16	1,048.29	0.997
2024	434.37	442.08	678.17	682.01	1,112.54	1,124.09	0.990
2025	456.50	457.96	737.81	721.97	1,194.31	1,179.93	1.012
2026	474.86	465.49	756.36	765.03	1,231.22	1,230.52	1.001
2027	497.37	487.18	800.37	815.88	1,297.74	1,303.06	0.996
2028	518.67	509.41	850.76	858.14	1,369.43	1,367.55	1.001
2029	541.85		902.85		1,444.70		

Table II-3. Comparison of Current & Previous Estimates of the ESRD Dialysis-only FFS USPCC

	Part A		Part B		Part A + Part B		
Calendar year	Current estimate	Last year's estimate	Current estimate	Last year's estimate	Current estimate	Last year's estimate	Ratio
2010	$2,952.75	$2,952.75	$3,881.39	$3,881.39	$6,834.14	$6,834.14	1.000
2011	2,862.38	2,862.38	3,908.01	3,908.01	6,770.39	6,770.39	1.000
2012	2,774.49	2,774.49	3,944.59	3,944.59	6,719.08	6,719.08	1.000
2013	2,794.19	2,794.19	4,088.66	4,088.66	6,882.85	6,882.85	1.000
2014	2,784.52	2,784.52	4,115.70	4,115.70	6,900.22	6,900.22	1.000
2015	2,775.84	2,775.84	4,060.87	4,060.87	6,836.71	6,836.71	1.000
2016	2,895.91	2,895.91	4,081.27	4,081.27	6,977.18	6,977.18	1.000
2017	2,883.27	2,883.27	4,102.66	4,102.66	6,985.93	6,985.93	1.000
2018	2,952.21	2,952.21	4,526.09	4,526.09	7,478.30	7,478.30	1.000
2019	3,040.74	3,040.74	4,614.18	4,614.18	7,654.92	7,654.92	1.000
2020	3,082.55	3,082.55	4,542.51	4,542.51	7,625.06	7,625.06	1.000
2021	3,295.54	3,295.54	4,786.27	4,786.27	8,081.81	8,081.81	1.000
2022	3,428.51	3,428.51	4,834.89	4,834.89	8,263.40	8,263.40	1.000
2023	3,675.60	3,675.90	5,028.96	5,030.00	8,704.56	8,705.90	1.000
2024	3,990.58	3,893.89	5,337.32	5,245.62	9,327.90	9,139.51	1.021
2025	4,180.75	4,156.63	5,934.03	5,656.96	10,114.78	9,813.59	1.031
2026	4,497.09	4,441.46	6,241.44	5,931.46	10,738.53	10,372.92	1.035
2027	4,730.00	4,720.20	6,364.43	6,214.25	11,094.43	10,934.45	1.015
2028	4,989.40	5,004.32	6,656.37	6,493.39	11,645.77	11,497.71	1.013
2029	5,256.96		6,982.38		12,239.34		

Table II-4. Basis for ESRD Dialysis-only FFS USPCC Trend

Calendar year	Part A			Part B			Part A & Part B		
	All ESRD cumulative FFS trend	Adjustment factor for dialysis-only	Adjusted dialysis-only cumulative trend	All ESRD cumulative FFS trend	Adjustment factor for dialysis-only	Adjusted dialysis-only cumulative trend	All ESRD cumulative FFS trend	Adjustment factor for dialysis-only	Adjusted dialysis-only cumulative trend
2025	1.04088	1.00651	1.04765	1.10748	1.00390	1.11180	1.07899	1.00498	1.08436
2026	1.11240	1.01306	1.12693	1.16033	1.00781	1.16940	1.13983	1.01000	1.15123
2027	1.16244	1.01966	1.18529	1.17860	1.01174	1.19244	1.17169	1.01510	1.18938
2028	1.21826	1.02629	1.25029	1.22788	1.01568	1.24714	1.22377	1.02020	1.24849
2029	1.27529	1.03298	1.31734	1.28302	1.01964	1.30822	1.27971	1.02533	1.31212

Table II-5. Summary of Key Projections

Part A[1]

Year	Calendar year CPI percent change	Fiscal year (FY) inpatient PPS update factor
2003	1.4%	3.0%
2004	2.1	3.4
2005	2.7	3.3
2006	4.1	3.7
2007	3.3	3.4
2008	2.3	2.7
2009	5.8	2.7
2010	0.0	1.9
2011	0.0	0.6
2012	3.6	0.1
2013	1.7	2.8
2014	1.5	0.9
2015	1.7	1.4
2016	0.0	0.9
2017	0.3	0.2
2018	2.0	1.8
2019	2.8	1.9
2020	1.6	3.1
2021	1.3	2.9
2022	5.9	2.5
2023	8.7	4.3
2024	3.2	3.1
2025	2.5	2.9
2026	2.8	2.6
2027	2.7	2.2
2028	2.4	2.5
2029	2.4	2.5

Part B[2]

Calendar year	Physician fee schedule		Outpatient hospital	ESRD dialysis update factor[5]
	Fees[3]	Residual[4]		
2003	1.4%	4.5%	4.4%	
2004	3.8	5.9	11.1	
2005	2.1	3.2	10.8	
2006	0.2	4.6	5.1	
2007	-1.4	3.5	8.2	
2008	-0.3	4.0	6.3	
2009	1.4	2.3	5.4	
2010	2.3	2.1	6.6	
2011	0.8	2.3	7.1	2.5%
2012	-1.2	0.8	7.2	2.1
2013	-0.1	0.2	7.2	2.3
2014	0.4	0.6	12.6	2.8
2015	-0.3	-0.3	7.4	0.0
2016	-0.4	-0.3	5.2	0.2
2017	0.1	1.1	7.4	0.6
2018	0.5	1.1	11.4	0.3
2019	1.2	2.8	5.2	1.3
2020	0.2	-11.6	-5.8	1.6
2021	4.8	12.9	19.7	1.6
2022	-1.1	2.8	4.6	1.9
2023	-0.5	4.3	8.4	3.0
2024	0.0	4.0	9.0	2.1
2025	-3.2	5.5	10.5	2.2
2026	3.0	3.2	9.4	2.2
2027	-2.4	3.4	9.1	1.4
2028	0.5	4.3	8.3	1.7
2029	0.4	2.0	8.8	1.8

[1] Percent change over prior year.

[2] Percent change in charges per aged Part B enrollee.

[3] Reflects the physician update and legislation affecting physician services—for example, the addition of new preventive services enacted in 1997, 2000, and 2010.

[4] Residual factors are factors other than price, including volume of services, intensity of services, and age/sex changes.

[5] The ESRD Prospective Payment System was implemented in 2011.

Table II-6. Medicare Enrollment Projections (In millions)

non-ESRD – Total Part A

Calendar year	Aged+Disabled	Hospice Adj.	Net Part A
2003	40.399	0.000	40.399
2004	41.132	0.000	41.132
2005	41.867	0.000	41.867
2006	42.683	0.000	42.683
2007	43.614	0.000	43.614
2008	44.739	0.000	44.739
2009	45.831	0.000	45.831
2010	46.923	0.000	46.923
2011	48.121	0.000	48.121
2012	50.098	0.000	50.098
2013	51.716	0.000	51.716
2014	53.309	0.000	53.309
2015	54.764	0.000	54.764
2016	56.232	0.000	56.232
2017	57.832	0.000	57.832
2018	59.153	0.000	59.153
2019	60.650	0.000	60.650
2020	62.002	0.000	62.002
2021	63.108	0.000	63.108
2022	64.290	0.000	64.290
2023	65.727	(0.194)	65.533
2024	67.179	(0.198)	66.981
2025	68.548	(0.199)	68.349
2026	69.789	(0.201)	69.588
2027	71.335	(0.204)	71.131
2028	73.004	(0.205)	72.798
2029	74.384	(0.206)	74.178

non-ESRD –Total Part B

Calendar year	Aged+Disabled	Hospice Adj.	Net Part B
2003	38.253	0.000	38.253
2004	38.780	0.000	38.780
2005	39.397	0.000	39.397
2006	39.991	0.000	39.991
2007	40.710	0.000	40.710
2008	41.578	0.000	41.578
2009	42.496	0.000	42.496
2010	43.454	0.000	43.454
2011	44.501	0.000	44.501
2012	46.048	0.000	46.048
2013	47.511	0.000	47.511
2014	48.957	0.000	48.957
2015	50.288	0.000	50.288
2016	51.614	0.000	51.614
2017	52.952	0.000	52.952
2018	54.172	0.000	54.172
2019	55.499	0.000	55.499
2020	56.796	0.000	56.796
2021	57.877	0.000	57.877
2022	58.990	0.000	58.990
2023	60.288	(0.188)	60.099
2024	61.584	(0.192)	61.393
2025	62.921	(0.193)	62.729
2026	64.271	(0.196)	64.075
2027	65.860	(0.200)	65.660
2028	67.558	(0.202)	67.356
2029	68.978	(0.203)	68.775

non-ESRD – FFS Part A

Calendar year	Aged+ Disabled	Hospice Adj.	Net Part A
2003	35.221	0.000	35.221
2004	35.878	0.000	35.878
2005	36.192	0.000	36.192
2006	35.511	0.000	35.511
2007	35.063	0.000	35.063
2008	34.853	0.000	34.853
2009	34.852	0.000	34.852
2010	35.358	0.000	35.358
2011	35.868	0.000	35.868
2012	36.653	0.000	36.653
2013	37.021	0.000	37.021
2014	37.221	0.000	37.221
2015	37.435	0.000	37.435
2016	38.007	0.000	38.007
2017	38.215	0.000	38.215
2018	38.035	0.000	38.035
2019	37.932	0.000	37.932
2020	37.172	0.000	37.172
2021	35.862	0.000	35.862
2022	34.784	0.000	34.784
2023	33.930	(0.194)	33.736
2024	33.447	(0.198)	33.249
2025	33.569	(0.199)	33.370
2026	33.963	(0.201)	33.762
2027	34.368	(0.204)	34.164
2028	34.659	(0.205)	34.453
2029	34.787	(0.206)	34.581

non-ESRD – FFS Part B

Calendar year	Aged+Disabled	Hospice Adj.	Net Part B
2003	32.972	0.000	32.972
2004	33.427	0.000	33.427
2005	33.626	0.000	33.626
2006	32.729	0.000	32.729
2007	32.079	0.000	32.079
2008	31.612	0.000	31.612
2009	31.444	0.000	31.444
2010	31.816	0.000	31.816
2011	32.176	0.000	32.176
2012	32.523	0.000	32.523
2013	32.738	0.000	32.738
2014	32.792	0.000	32.792
2015	32.883	0.000	32.883
2016	33.317	0.000	33.317
2017	33.243	0.000	33.243
2018	32.954	0.000	32.954
2019	32.682	0.000	32.682
2020	31.867	0.000	31.867
2021	30.533	0.000	30.533
2022	29.388	0.000	29.388
2023	28.398	(0.188)	28.209
2024	27.772	(0.192)	27.580
2025	27.868	(0.193)	27.675
2026	28.380	(0.196)	28.184
2027	28.874	(0.200)	28.674
2028	29.204	(0.202)	29.002
2029	29.370	(0.203)	29.168

ESRD

	ESRD - Total		ESRD - FFS	
Calendar year	Total Part A	Total Part B	Total Part A	Total Part B
2003	0.340	0.331	0.319	0.309
2004	0.353	0.342	0.332	0.321
2005	0.366	0.355	0.344	0.332
2006	0.382	0.370	0.353	0.340
2007	0.396	0.383	0.361	0.347
2008	0.411	0.397	0.367	0.353
2009	0.426	0.412	0.374	0.360
2010	0.442	0.428	0.388	0.373
2011	0.429	0.416	0.371	0.358
2012	0.441	0.429	0.379	0.366
2013	0.454	0.441	0.385	0.372
2014	0.469	0.456	0.390	0.377
2015	0.482	0.468	0.393	0.379
2016	0.496	0.481	0.400	0.384
2017	0.511	0.494	0.403	0.386
2018	0.525	0.507	0.405	0.387
2019	0.538	0.520	0.407	0.388
2020	0.542	0.524	0.398	0.379
2021	0.535	0.516	0.333	0.313
2022	0.532	0.511	0.296	0.275
2023	0.537	0.516	0.270	0.247
2024	0.545	0.522	0.255	0.231
2025	0.552	0.526	0.247	0.221
2026	0.561	0.537	0.240	0.211
2027	0.576	0.550	0.238	0.213
2028	0.593	0.568	0.243	0.218
2029	0.606	0.580	0.244	0.218

Table II-7. Part A Projections for non-ESRD (Aged+Disabled)*

Calendar year	Inpatient hospital	SNF	Home health agency	Managed care
2003	$248.02	$35.43	$11.88	$297.71
2004	259.34	39.50	12.79	326.65
2005	271.67	43.43	13.58	370.30
2006	276.94	47.59	14.15	375.51
2007	280.65	52.27	14.90	384.99
2008	288.38	57.41	16.15	405.41
2009	290.56	60.45	16.86	433.45
2010	290.52	63.23	17.16	422.53
2011	286.21	69.05	15.34	435.95
2012	280.58	61.05	14.77	432.54
2013	286.38	62.22	14.82	420.62
2014	285.91	63.03	14.64	383.81
2015	289.92	63.88	15.21	383.38
2016	295.09	61.34	14.80	389.70
2017	298.33	60.06	14.59	400.35
2018	303.79	59.39	14.57	404.97
2019	312.06	58.76	14.38	427.66
2020	300.07	62.23	13.20	445.88
2021	314.83	61.21	13.62	434.95
2022	325.91	68.33	13.82	464.24
2023	338.56	66.26	14.34	492.04
2024	349.49	69.46	14.96	492.17
2025	365.37	75.45	15.23	500.47
2026	374.77	83.71	15.92	541.43
2027	389.26	90.10	17.52	586.86
2028	404.16	95.32	18.69	610.36
2029	420.59	100.82	19.91	637.10

*Average monthly reimbursement per enrollee on an incurred basis. Excludes cost plan expenditures included in National Claims History file. The denominator of the calculation for all fields except Managed Care is Part A FFS enrollment. The denominator of the calculation for Managed Care field is Part C enrollment.

Table II-8. Part B Projections for non-ESRD (Aged+Disabled)*

Calendar year	Physician fee schedule	Outpatient hospital	Durable Medical Equipment, Prosthetics, Orthotics & Supplies (DMEPOS)
2003	$118.58	$35.27	$19.04
2004	129.94	40.49	18.91
2005	136.44	46.64	19.22
2006	142.19	50.65	20.14
2007	144.71	55.72	20.69
2008	149.92	60.84	22.02
2009	156.10	66.18	20.68
2010	162.73	70.92	20.91
2011	167.93	74.91	20.24
2012	166.39	80.61	20.46
2013	165.52	87.00	18.41
2014	168.08	99.96	15.95
2015	170.33	108.74	16.86
2016	170.44	114.39	15.53
2017	173.71	122.79	14.85
2018	178.42	138.01	17.33
2019	186.31	147.49	18.21
2020	165.58	137.98	18.25
2021	201.85	165.18	18.99
2022	201.26	170.74	21.19
2023	206.42	184.96	23.17
2024	215.09	201.83	25.43
2025	217.70	225.22	26.90
2026	232.07	246.96	28.73
2027	234.05	269.91	30.45
2028	245.26	292.43	32.08
2029	251.23	318.95	33.82

Calendar year	Carrier lab	Physician administered drugs	Other carrier	Intermediary lab
2003	$7.13	$17.65	$14.23	$7.27
2004	7.59	18.87	15.35	7.78
2005	8.08	17.45	17.97	8.22
2006	8.72	18.88	17.89	8.60
2007	9.59	19.77	18.67	8.92
2008	10.36	20.22	19.97	9.40
2009	11.44	22.10	20.10	8.92
2010	11.82	22.35	20.34	9.13
2011	11.97	24.15	20.68	9.60
2012	13.18	24.70	21.85	9.99
2013	13.52	26.23	21.42	9.89
2014	14.63	27.94	21.59	6.90
2015	14.53	32.13	22.29	7.04
2016	13.03	35.04	22.32	7.26
2017	13.36	37.23	23.55	7.30
2018	14.70	41.69	24.13	7.25
2019	15.62	46.64	24.60	7.12
2020	16.48	48.30	24.64	7.61
2021	19.93	53.59	26.08	8.85
2022	19.03	59.70	31.37	8.73
2023	20.28	74.46	38.22	8.23
2024	22.30	95.70	35.76	8.47
2025	24.30	119.50	38.87	8.80
2026	26.93	89.25	41.74	9.07
2027	28.20	96.47	44.41	9.11
2028	30.36	100.97	46.71	9.32
2029	32.58	107.76	49.27	9.57

*Average monthly reimbursement per enrollee on an incurred basis. Excludes cost plan expenditures included in National Claims History file. The denominator of the calculation for all fields except Managed Care is Part A FFS enrollment. The denominator of the calculation for Managed Care field is Part C enrollment.

Calendar year	Other intermediary	Home health agency	Managed care
2003	$11.02	$13.22	$254.38
2004	11.56	15.12	284.58
2005	13.65	17.52	318.75
2006	14.47	20.66	353.34
2007	15.99	24.57	366.01
2008	17.34	27.67	383.90
2009	21.11	31.77	385.73
2010	21.98	32.24	380.01
2011	22.84	29.19	389.17
2012	24.20	28.09	393.60
2013	23.51	28.14	406.92
2014	24.95	28.13	435.77
2015	26.81	28.42	447.03
2016	27.65	28.02	462.24
2017	29.28	27.45	476.08
2018	31.26	27.99	511.00
2019	33.40	28.38	549.65
2020	30.78	27.67	583.65
2021	34.40	28.78	589.19
2022	35.65	28.84	635.30
2023	38.60	29.38	696.20
2024	41.77	30.02	716.23
2025	44.00	30.76	742.03
2026	47.90	31.89	806.29
2027	50.98	34.89	841.21
2028	54.48	37.11	892.03
2029	58.06	39.46	946.32

Table II-9. 2027 Projections by Service Category for non-ESRD (Aged+Disabled)*

Service type	Current estimate	Last year's estimate	Ratio
Part A			
Inpatient hospital	$389.26	$382.45	1.018
SNF	90.10	85.83	1.050
Home health agency	17.52	18.39	0.953
Managed care	586.86	568.43	1.032
Part B			
Physician fee schedule	234.05	229.41	1.020
Outpatient hospital	269.91	270.20	0.999
DMEPOS	30.45	33.08	0.920
Carrier lab	28.20	24.95	1.130
Physician Administered Drugs	96.47	117.04	0.824
Other carrier	44.41	44.40	1.000
Intermediary lab	9.11	9.49	0.960
Other intermediary	50.98	48.73	1.046
Home health agency	34.89	36.43	0.958
Managed care	841.21	886.54	0.949

*Average monthly reimbursement per enrollee on an incurred basis. Excludes cost plan expenditures included in National Claims History file. The denominator of the calculation for all fields except Managed Care is Part A FFS enrollment. The denominator of the calculation for Managed Care field is Part C enrollment.

Table II-10. Claims Processing Costs as a Fraction of Benefits

Calendar year	FFS Part A	FFS Part B	Total Part A	Total Part B
2003	0.001849	0.011194	0.001849	0.011194
2004	0.001676	0.010542	0.001676	0.010542
2005	0.001515	0.009540	0.001515	0.009540
2006	0.001245	0.007126	0.001245	0.007126
2007	0.000968	0.006067	0.000968	0.006067
2008	0.000944	0.006414	0.000944	0.006414
2009	0.000844	0.005455	0.000844	0.005455
2010	0.000773	0.005055	0.000773	0.005055
2011	0.000749	0.004396	0.000749	0.004396
2012	0.001008	0.003288	0.001008	0.003288
2013	0.000994	0.002846	0.000994	0.002846
2014	0.001003	0.002884	0.001003	0.002884
2015	0.000952	0.002730	0.000952	0.002730
2016	0.000852	0.002348	0.000852	0.002348
2017	0.000833	0.002111	0.000833	0.002111
2018	0.000836	0.001953	0.000836	0.001953
2019	0.000699	0.001644	0.000699	0.001644
2020	0.000625	0.001536	0.000625	0.001536
2021	0.001038	0.002708	0.000600	0.001399
2022	0.001094	0.002801	0.000582	0.001310
2023	0.001102	0.002916	0.000579	0.001330
2024	0.001059	0.002662	0.000566	0.001260
2025	0.000976	0.002399	0.000504	0.001056
2026	0.000976	0.002399	0.000504	0.001056
2027	0.000976	0.002399	0.000504	0.001056
2028	0.000976	0.002399	0.000504	0.001056
2029	0.000976	0.002399	0.000504	0.001056

Approximate Calculation of the USPCC, the National MA Growth Percentage for Combined (Aged+Disabled) Beneficiaries, and the FFS USPCC (Aged+Disabled)

The following procedure will approximate the actual calculation of the USPCCs from the underlying assumptions for the contract year for both Part A and Part B.

Part A: The Part A USPCC can be approximated by using the assumptions in the tables titled, "Part A Projections for non-ESRD (Aged+Disabled)" and "Claims Processing Costs as a Fraction of Benefits." Information in the "Part A Projections" table is presented on a calendar year per capita basis. First, add the per capita amounts over all types of providers (excluding hospice). Next, multiply this amount by 1 plus the loading factor for administrative expenses from the "Claims Processing Costs" table. Then, divide by 12 to put this amount on a monthly basis.

Part B: The Part B USPCC can be approximated by using the assumptions in the tables titled, "Part B Projections for non-ESRD (Aged+Disabled)" and "Claims Processing Costs as a Fraction of Benefits." Information in the "Part B Projections" table is presented on a calendar year per capita basis. First, add the per capita amounts over all types of providers. Next, multiply by 1 plus the loading factor for administrative expenses from the "Claims Processing Costs" table and then divide by 12 to put this amount on a monthly basis.

The National Per Capita MA Growth Percentage: The National Per Capita MA Growth Percentage for CY 2027 (before adjusting for prior years' over/under estimates) is calculated by adding the USPCCs for Part A and Part B for CY 2027 and then dividing by the sum of the current estimates of the USPCCs for Part A and Part B for CY 2026.

The FFS USPCC: The tables used to calculate the total USPCC can also be used to approximate the calculation of the FFS USPCC. The per capita data presented by type of provider in the projection tables for both Part A and Part B are based on total enrollment. To approximate the FFS USPCCs, first add the corresponding provider types under Part A and Part B separately. For the FFS calculations, do not include the managed care provider type. Next, rebase the sum of the per capita amounts for FFS enrollees, i.e., multiply the sum by total enrollees and divide by FFS enrollees. (The enrollment tables in this attachment now also include FFS enrollment). Then, multiply by 1 plus the loading factor for administrative expenses and divide by 12.

Attachment III. Responses to Public Comments on Part C Payment Policy

We received approximately 43,700 timely pieces of correspondence containing a variety of comments on the proposals in the CY 2027 Advance Notice. Summaries of the public comments within the scope of the CY 2027 Advance Notice and CY 2027 Rate Announcement and our responses to those public comments are set forth in the various sections of this document under the appropriate heading. We note that some of the public comments were outside of the scope of the CY 2027 Advance Notice and CY 2027 Rate Announcement and are not addressed. We also note that we do not respond specifically to comments pertaining to general sentiments regarding Medicare Advantage and Part D, but we thank commenters for their feedback on the programs.

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

Comment: A few commenters appreciated CMS's continued diligence in calculating growth rates that reflect underlying utilization, cost trends, and program dynamics. These commenters stated that maintaining a consistent, data-driven methodology for estimating spending growth helps ensure payment accuracy and program stability.

A commenter suggested that CMS engage stakeholders in developing trend assumptions and underlying data sources, for example, by providing technical guidance or supplemental materials to promote transparency and shared understanding of key drivers in MA payment updates.

Another commenter recommended more structured actuarial engagement in MA rate development to facilitate greater technical input and dialogue, citing other federal and state program processes. Another commenter encouraged CMS to garner stakeholder input during actuarial user group calls on the types of information to include in the Advance Notice to improve stakeholders' understanding of CMS's projection methodologies.

A couple of commenters appreciated CMS's publication of the components of the growth rates with the CY 2027 Advance Notice, which they believed enhanced transparency regarding assumptions; these commenters encouraged CMS to continue this practice.

Response: We appreciate commenters' support and suggestions regarding opportunities for future engagement.

Comment: A commenter supported the proposed changes described in the CY 2027 Advance Notice to the table structure and content within Attachment II of the Rate Announcement but urged CMS to continue publishing separate aged and disabled enrollment data in Table II-6 to support transparency and allow for assessment of data reasonableness.

Response: As explained on pages 18 and 19 of the CY 2027 Advance Notice, we proposed to combine the aged and disabled enrollment data in Table II-6 to ensure that enrollment figures are presented consistently with the USPCC and ratebook development, in which non-ESRD aged and disabled experience and projections are combined. The revisions to the tables are designed to

balance data transparency with enhanced usability for stakeholders. We are finalizing the table changes as proposed.

Comment: Several commenters requested that CMS mitigate the impact on MA rates resulting from the skin substitutes payment policy in the CY 2026 Physician Fee Schedule (PFS) Final Rule (CMS-1832-F) by phasing-in the change over several years. Commenters suggested that phasing-in the change may allow time for data to emerge regarding the impacts.

Another commenter suggested that CMS delay the reflection of the CY 2026 PFS payment changes for skin substitute products in MA rates until at least CY 2028 to allow for corresponding adjustments to county-level area factors. Further, the commenter believed it inappropriate to apply the impact nationally, given localized spending patterns for skin substitutes.

Another commenter expressed concern about the magnitude of the skin substitute payment policy's impact on growth rates, citing internal analyses of lower spending in MA on skin substitute products.

A couple of commenters were concerned about multiple policy adjustments (e.g., changes to skin substitute payments, 340B recoupment adjustments, scheduled physician payment updates) embedded in the growth rate that could create volatility and may not be easily attributable to underlying medical trends. One of these commenters suggested that CMS adopt a framework to limit volatility by avoiding implementing multiple high-impact policy changes in the same year (e.g., FFS payment policy changes), phasing in any large technical corrections over multiple years, and distinguishing underlying cost trend from discrete policy or technical adjustments.

A few commenters believed that CMS has the discretion to adjust growth rates to reflect anticipated congressional adjustments to the physician fee schedule, based on past congressional actions, and urged CMS to adjust growth rates accordingly.

Response: While we appreciate the feedback from commenters, we do not find the suggestions to phase-in, delay, or adjust finalized FFS payment rules to be consistent with the statute. Section 1853 of the Act requires that FFS per capita cost estimates be used in developing MA rates and sets the general approach to updating the USPCCs and growth rates. Additionally, the projections are consistent with current law at the time the CY 2027 Rate Announcement projections were prepared. On pages 29 and 30 of the CY 2023 Rate Announcement, we explained CMS's longstanding approach of using current law as the basis for projections based on the requirements of the statutory language at Section 1853 of the Act.

Comment: A large number of commenters encouraged CMS to incorporate the most recently available cost and utilization data (e.g., 2025 experience) into growth rate calculations and to ensure that CY 2027 MA benchmarks reflect higher utilization, cost trends, and inflation observed by commenters. A large number of commenters expressed concern that if the growth

rates did not reflect the industry's higher utilization and cost trends and the impacts of healthcare inflation, the rates would be insufficient to cover the cost of care for Medicare beneficiaries in CY 2027, potentially leading to margin compression (e.g., for providers operating in full-risk value-based care arrangements), impacts on staffing and financial sustainability and stability, higher beneficiary premiums and cost sharing, reduced plan and provider choices, and fewer supplemental benefits. Several commenters cited recent years where MA plans have exited the market, particularly smaller plans as well as those in rural areas, as a potential consequence of inadequate growth rates.

Many commenters characterized the growth rates as unrealistically low in contrast with the CY 2026 growth rates. A large number of commenters compared the FFS growth rates to the Medicare growth in the National Health Expenditure data, trends for Medicare Supplement (i.e., Medigap), trends for the Accountable Care Organization Realizing Equity, Access, and Community Health (ACO REACH) model, and other analyses. A few of these commenters acknowledged differences in methodology and populations between these analyses and growth rate calculations while other commenters found these to be relevant comparisons.

A large number of commenters indicated that the growth rates were not consistent with their internal estimates of higher growth in the MA program and suggested increasing the growth rates to reflect the economics, current cost environment, and realities of health coverage in MA. Several commenters expressed concern that the growth rate estimates do not adequately account for serving complex enrollees in MA, including dual eligible beneficiaries and those with chronic conditions that exhibit higher utilization rates, increased care coordination needs, and greater reliance on supplemental benefits. A commenter suggested that any new MA policies impacting areas such as utilization management and coverage for additional drug indications should be reflected in the growth rates.

A commenter expressed concern that the spending patterns in FFS differ from the spending patterns in MA due to program differences but acknowledged the statutorily mandated method for setting benchmarks and growth rates. Several commenters cited specific drivers of expected increases in utilization and costs, including inpatient and outpatient utilization, patient acuity, emergency department and post-acute services, behavioral health, Part B drugs, and specialty drug costs.

Many commenters expressed concern that the CY 2027 Advance Notice growth rates did not include complete experience for the second half of 2025, where they expect higher utilization, and the impact of data "lag" in USPCC estimates as seen in restatements. A couple of commenters recommended that CMS use consistent data experience periods annually (e.g., incurred and paid-through dates).

Several commenters characterized the projected FFS growth rates as inconsistent with historical FFS trends (e.g., since 2023), and normalized trend (adjusting for the impact of skin substitutes)

averaged over recent years (e.g., for 2023-2026). Specifically, commenters considered CMS's projected trends for Part B drugs, physician, outpatient, DMEPOS, Skilled Nursing Facility, and inpatient costs to be inconsistent with recent and expected patterns of Medicare spend, citing published analyses of trends. A few commenters were concerned that inpatient utilization projected trends for 2026 and 2027 were lower than recent historical data and may not be adequately accounting for higher 2027 projected uncompensated care payments resulting from the "One Big Beautiful Bill Act", which CMS refers to as "The Working Families Tax Cut" legislation (Pub. L. 119-21).

A few commenters expressed concern regarding trends in the CY 2027 Advance Notice associated with the 2025 and 2026 non-ESRD FFS USPCCs, particularly following the prior years' trends and when comparing changes since the CY 2026 Rate Announcement. One of these commenters believed greater credibility should be given to higher utilization trends seen during 2024-2025 when developing 2027 projections.

A few commenters requested that CMS adjust the growth rate estimates to be consistent with OACT's estimates in the 2025 Medicare Trustees Report that was released in June 2025.

Response: As noted previously, section 1853 of the Act requires that FFS per capita cost estimates be used in developing MA rates and sets the general approach to updating the USPCCs and growth rates. Additionally, the projections are consistent with current law at the time the CY 2027 Rate Announcement projections were prepared.

The USPCC modeling approach used by CMS reflects projected changes in the factors used to update Medicare FFS payment rates. The projected expenditures for some of the Medicare payment systems include expected inflation, such as the projected market basket changes for inpatient, Skilled Nursing Facility, home health agency, and outpatient hospital projections and consumer price index (CPI) updates for DMEPOS projections.

The growth percentages are based on CMS's best estimate of historical program experience and projected trends at the time those values are announced. We continue to consider it best practice to base the growth rates on the most recent data and assumptions available at the time those values are announced. Therefore, for each release of the growth rates, CMS updates historical enrollment and claims, as well as projection factors, based on the most recent data.

The baseline supporting the USPCCs and growth rates has been revised since the CY 2027 Advance Notice to incorporate additional program experience. The updated non-ESRD FFS USPCCs for both Part A and Part B are based on program experience and incurred dates through fourth quarter 2025. The CY 2027 Advance Notice non-ESRD FFS USPCCs were based on program experience through second quarter 2025 for Part A and through third quarter 2025 for Part B.

Additional updates since the CY 2027 Advance Notice include reflection of final 2026 FFS payment regulations, updates to economic forecasts, and revised projection factors.

As noted by a few of the commenters, other estimates of Medicare spending growth (e.g., National Health Expenditures projections, Medicare Supplement market trends, ACO REACH Model experience) are based on different data, populations, and assumptions than those used to develop the projected growth rates for CY 2027 MA rates.

Comment: Many commenters requested greater transparency into the underlying data, assumptions and methodologies used to calculate growth percentages, such as utilization and unit cost trends, how recent FFS payment policy changes were reflected, key driving factors of trend changes, and any sensitivity analyses of trend estimates to data changes. One of these commenters cited the Actuarial Standards of Practice regarding actuarial communications including explanations for material changes in assumptions.

A commenter requested that impacts (e.g., changes to payment for skin substitute products under the CY 2026 PFS Final Rule) be included in the Advance Notice document rather than a separate trend document and further requested a step-by-step description of projection methodology in the CY 2027 Rate Announcement.

Specific transparency requests included:

(1) Disclosure of the incurred and paid-through dates of the data supporting the USPCCs within the Advance Notice, Rate Announcement, and trends document, as well as any expected data updates between the Advance Notice and Rate Announcement. Additionally, an explanation of why the CY 2027 Advance Notice Part A experience was through June rather than September 2025.

(2) An explanation of lower Advance Notice trends (e.g., utilization assumptions) compared to other sources, specifically why the MA growth rate was lower than the FFS growth rate.

(3) Explanation of the change in the Part A CY 2026 FFS USPCC in the CY 2027 Advance Notice compared to the CY 2026 Rate Announcement: specifically, what components are included in the "Other" trend category and how these factors contributed to the change in the Part A USPCC.

(4) An explanation of the inpatient utilization trend projections for 2026 and 2027 that are lower than trends observed over the past three years, including additional details regarding the sources and analyses used to support the projected inpatient utilization and case-mix assumptions.

(5) Confirmation that inpatient unit cost trends for 2026 and 2027 reflect the impact of the FY 2026 Inpatient Prospective Payment System (IPPS) Final Rule's increases in Medicare disproportionate share hospital (DSH) and uncompensated care payments (UCP).

(6) Additional clarification regarding what is included in the unit cost component for each service category in the trend document, specifically: which component of inpatient trend includes changes in UCPs and outlier payments, which component of outpatient trend includes the 340B Remedy OPPS adjustment, what unit cost related changes are included in the 'Other' component of the physician trend, and how CMS generally determines whether specific payment adjustments are reflected in unit cost trends versus other components of trend.

(7) Details on factors driving higher trends in 2025 and the decline in 2026 for the "Other" component of the physician trend, including an explanation of the major assumptions and costs underlying this component.

(8) Explanation for differences in Part B drug trends and assumptions used for growth rates compared to trends derived from historical experience and data cited in the CY 2026 PFS final rule.

(9) Clarification on the 2026 and 2027 growth rate assumptions for the temporary increase to Medicare Physician Fee Schedule conversion factors for 2026 (scheduled to return to 0 percent for 2027) under the "The Working Families Tax Cut" legislation.

(10) Information on the impact of the changes to payment for skin substitute products on the Part B FFS USPCC for 2026 and 2027, details on quantifying skin substitutes versus all other physician administered drug costs for 2023-2027 (e.g., separate PMPMs and trends), utilization assumption used for skin substitute spending in 2026, and whether CMS's trend projections generally incorporate assumptions about provider behavioral responses (e.g., shifting utilization to alternative services) and which component of the trend would these effects be reflected in. Also requested were the data sources and assumptions (e.g., utilization projections and any geographic weighting) used to project FFS skin substitute spending, how the projected spending reduction was allocated between unit cost, utilization, and residual "other" components within the Part B physician-administered drug category.

(11) Clarification of how 340B recoupment adjustments are reflected in growth rates, such as: whether the Outpatient Hospital unit cost trend for 2026 and 2027 incorporates the finalized 0.5 percent 340B recoupment reduction, and any other factors contributing to a lower unit cost trend compared to recent years.

(12) Confirmation whether Significant, Anomalous, and Highly Suspect (SAHS) Billing Activity adjustments were reflected in the 2023 and 2024 FFS USPCCs in the CY 2027 Advance Notice and the CY 2026 Rate Announcement and their impacts. Also requested was confirmation of which USPCC years were adjusted for SAHS.

Response: We discussed in the CY 2027 Advance Notice the methodology, sources of data, assumptions, and trends underlying the MA capitation rates at a level of detail consistent with past practice.

In support of the MA ratebook growth rates, CMS has, as required under section 1853(b)(3) of the Act, included an explanation of the assumptions and changes in methodology used in the CY 2027 Rate Announcement; see the key economic assumptions underlying the USPCCs included in Attachment II of this CY 2027 Rate Announcement. Consistent with prior years, with this CY 2027 Rate Announcement, we have published additional information regarding trends for the prior five years and unit cost increases to the contract year at https://www.cms.gov/medicare/payment/medicare-advantage-rates-statistics/ffs-trends. This information includes additional details of drivers of historical and projected trends. For example, for IPPS experience, the exhibit includes experience and assumptions for unit costs, utilization, and case mix.

Additionally, the USPCC projections reflect payment levels based on the most recent Medicare final rules for FY 2026 or CY 2026.

Additional specific responses as follows:

(1) The non-ESRD FFS USPCCs in the CY 2027 Advance Notice were based on actual spending and incurred experience through second quarter 2025 for Part A and third quarter 2025 for Part B. The non-ESRD FFS USPCCs for both Part A and Part B in the CY 2027 Rate Announcement are based on program experience and incurred dates through fourth quarter 2025.

At the time the CY 2027 Advance Notice USPCCs were developed, the third quarter 2025 Part A incurred FFS claims data had minimal claims runout, and we did not have reliable factors to complete the data. As a result, the CY 2027 Advance Notice Part A FFS USPCCs were based on actual experience through the second quarter 2025. Please note that our projection of Part A FFS spending through third quarter of 2025 was very close to the actual when we analyzed the data with more claims runout.

(2) The CY 2027 Advance Notice growth rate for MA was lower than the Medicare FFS growth rate primarily due to a negative prior period adjustment, reflecting lower risk scores for 2024 and 2025 than were assumed in the CY 2026 Rate Announcement baseline.

(3) The “other” trend category captures spending components that are not included in the primary categories. For inpatient hospital services, this category includes DSH payments, UCPs, FFS medical education payments, and other non-claims-based expenditures.

The increase in the CY 2026 USPCC reflected in the 2027 Advance Notice baseline is primarily driven by the higher FY 2026 UCP, as promulgated in the FY 2026 Long Term Care Hospital Prospective Payment System Final Rule (CMS-1833-F).

(4) Inpatient utilization trends for 2023-2025 were elevated relative to historical levels. We attribute this increase to the post-pandemic rebound in service use. We assume that, over the 2026-2028 period, utilization growth will gradually decline from its elevated level to the long-term underlying trend of close to 0 percent.

(5) UCP and DSH are not included in the tabulation of the inpatient unit cost trends. See next response for more information.

(6) The components of the unit cost trend are included in the Medicare Unit Cost Exhibit available on the CMS website at: https://www.cms.gov/files/document/ffs-trends-2025-2027-january-2026.pdf. The narrative section of the exhibit in the first page of the document includes the statement, "These unit cost increases reflect increases (or decreases) in the applicable market basket or fee schedule, as implemented on the specified effective date; they do not include assumptions for utilization, case-mix, enrollment, or other payment changes."

The unit cost values for inpatient services do not include spending for UCPs or outlier payments. Expenditures for these items are instead reflected in the "other" trend category. Similarly, the outpatient hospital unit cost trend reflects changes driven by the market basket update and other legislated adjustments; it does not include the effects of the 340B remedy offset.

The "other" trend category for the Physician services reflects spending not captured in the other trend categories, including payment adjustments associated with CMS alternative payment models and related value-based initiatives, such as CMS Innovation Center models.

(7) The "other" trend category captures spending components that are not included in the primary categories. For the PFS, the other category implicitly includes a behavioral offset, Alternative Payment Model (APM) incentive payments, Health Professional Shortage Areas (HPSA) bonus payments, and other non-claims based payments.

A key driver of the difference in the "other" component is the behavioral offset of +1.7% in 2025 and 0.0% in 2026.

(8) The CY 2026 PFS final rule (CMS-1832-F) cites an increase in skin substitutes from $250.0 million in 2019 to $10.0 billion in 2024. This increase is consistent with the CY 2027 Advance Notice non-ESRD USPCC spending for physician-administered drugs, which includes skin substitute products, that similarly increased from $18.3 billion in 2019 to $31.7 billion in 2024.

(9) Section 71202 of the "One Big Beautiful Bill Act" (OBBBA) (Pub. L. 119-21), which CMS refers to as the "Working Families Tax Cut" (WFTC) legislation, implemented a 2.5 percent update to the conversion factor for 2026. This is on top of the 0.75 percent update for physicians in alternative payment models (APMs) and 0.25 percent for physicians not in APMs (full updates are roughly 3.27 percent and 2.76 percent). The unit cost trend of 2.96 percent is the weighted

average of the updates, and we assume that 40.1 percent of Physician Fee Schedule spending is in APMs.

Additionally, the impact of the Relative Value Units (RVU) impact is not reflected in the published unit cost trend but is accounted for in the conversion factor. The impact changes in RVUs is reflected in the "other" category of the 2021-2027 non-ESRD trend exhibit available on the CMS website at https://www.cms.gov/files/document/trends-supporting-2027-growth-rates.pdf.

The Fact Sheet to the CY 2026 PFS final rule addresses the impact of the RVU on physician payments. That is, under the CY 2026 Physician Fee Schedule Rate Setting and Conversion Factor section of the fact sheet, "[t]he changes to the Physician Fee Schedule conversion factors for CY 2026 include these updates as required by statute, a one-year increase of +2.50 percent for CY 2026 stipulated by statute, and an estimated +0.49 percent adjustment necessary to account for finalized changes in work RVUs for some services."

(10) The below tables reflect the CY 2027 Advance Notice and CY 2027 Rate Announcement PMPM cost and trend of physician-administered (PA) drugs allocated between skin substitutes and other services.

CY 2027 Advance Notice	**2023**	**2024**	**2025**	**2026**	**2027**
PMPM					
PA drugs total	$74.48	$95.89	$118.60	$85.17	$91.39
Skin substitutes	$9.65	$22.15	$39.50	$1.50	$1.41
Non-skin substitutes	$64.83	$73.74	$79.10	$83.67	$89.98
PMPM trend					
PA drugs total	n/a	28.8%	23.7%	-28.2%	7.3%
Skin substitutes	n/a	129.5%	78.3%	-96.2%	-6.0%
Non-skin substitutes	n/a	13.7%	7.3%	5.8%	7.5%

CY 2027 Rate Announcement	2023	2024	2025	2026	2027
PMPM					
PA drugs total	$74.46	$95.70	$119.50	$89.25	$96.47
Skin substitutes	$9.66	$22.26	$40.04	$1.53	$1.22
Non-skin substitutes	$64.80	$73.44	$79.46	$87.72	$95.25
PMPM trend					
PA drugs total	n/a	28.5%	24.9%	-25.3%	8.1%
Skin substitutes	n/a	130.4%	79.9%	-96.2%	-20.3%
Non-skin substitutes	n/a	13.3%	8.2%	10.4%	8.6%

Additionally, the majority of the reduction in the 2026 USPPC PA drug spending from the CY 2026 Rate Announcement ($108.73) to the CY 2027 Advance Notice ($85.17) is attributed to the skin substitute provisions of the CY 2026 PFS final rule (CMS-1832-F). Specifically, rather than treat skin substitutes as biologicals for the purposes of Medicare payment, under the CY 2026 PFS final rule, CMS will pay for skin substitutes under the PFS as incident-to supplies. This change is expected to reduce Medicare spending on these products by nearly 90% in CY 2026.

The CY 2027 Rate Announcement baseline incorporates an assumed behavioral response of a 30 percent reduction in skin substitute product utilization in 2026, reflecting the impact of the aforementioned provisions in the CY 2026 PFS final rule (CMS-1832-F).

Finally, the development of the USPCCs used the historical national data on skin substitutes to estimate the impacts of the skin substitute provisions in the CY 2026 PFS final rule (CMS-1832-F).

(11) The published outpatient unit cost trend for 2026 and 2027 excludes the effects of the 340B remedy offset. Additionally, the 2027 update is lower than the updates for 2023-2026 because the projected market basket update for 2027 is comparatively low, while the projected productivity offset is comparatively high.

(12) As described in the CY 2027 Advance Notice, the SAHS ratebook adjustments are based on the “Medicare Program: Mitigating the Impact of Significant, Anomalous, and Highly Suspect Billing Activity on Medicare Shared Savings Program Financial Calculations in Calendar Year 2023” final rule (89 FR 79152; CMS-1799-F) and the May 27, 2025 *Accountable Care Organization Spotlight* newsletter. The corresponding adjustment to the USPCCs is based on CMS reporting of suspended claims for Durable Medical Equipment, Prosthetics, Orthotics & Supplies (DMEPOS) services for experience years 2023 and 2024.

We are finalizing the exclusion of certain urinary catheter claims as proposed. Specifically, in this CY 2027 Rate Announcement, the experience underlying the 2023 non-ESRD USPCC

includes a -$3.6 billion adjustment to reflect the suspension of 2023 payments for certain DMEPOS suppliers. The USPCC adjustment for suspended 2024 claims is -$2.3 billion for certain DMEPOS suppliers. Over 95 percent of these USPCC adjustments are for urinary catheter claims with HCPCS A4352 and A4353 and ostomy pouch claims with HCPCS A5057. The remaining adjustments are for claims with HCPCS A6197, L1852, and L3916.

Page 51 of the CY 2026 Rate Announcement had provided the USPCC adjustments to reflect the suspended payment of certain DMEPOS claims.

In conclusion, we believe that the information in the CY 2027 Advance Notice and this CY 2027 Rate Announcement provides the necessary support for understanding USPCC levels and trends.

ESRD Dialysis-Only USPCC and Growth Rate

Comment: A commenter appreciated the technical complexities involved in developing the ESRD USPCCs, found the detailed information included in the CY 2027 Advance Notice helpful, and encouraged CMS to closely monitor the alignment between projected and realized cost trends and adopt methodological refinements to improve the timeliness, adequacy, and accuracy of rates. Another commenter expressed concern regarding volatility in ESRD growth rates.

Both commenters requested greater transparency regarding the methodology and assumptions used to develop the ESRD USPCCs, with one of the commenters requesting that cost and trend data for ESRD experience be published similarly to the trend document published for non-ESRD experience, with an explanatory narrative to translate this information to the USPCC projections.

Response: As discussed in past Rate Announcements,[1] we believe it is important to update the FFS per capita cost estimates using the most current FFS data available at the time those values are announced and apply repricing adjustments to reflect changes in FFS payment rules. Similar to prior Rate Announcements, the method for calculating the county-level non-ESRD rates and the state-level ESRD rates includes AGAs based on a five-year rolling average of historical claims experience, which mitigates fluctuations in the rates.

The published Medicare unit cost increases by service category (available at https://www.cms.gov/medicare/payment/medicare-advantage-rates-statistics/ffs-trends) apply to provider payments for both ESRD and non-ESRD beneficiaries, and the published information includes trends for the ESRD Prospective Payment System (ESRD PPS) base rate.

The ESRD dialysis USPCCs are derived from the total ESRD USPCC baseline but are adjusted for recent trend differences between the total ESRD and dialysis ESRD populations. Thus, the

[1] Prior Rate Announcements are available at: https://www.cms.gov/medicare/payment/medicare-advantage-rates-statistics/announcements-and-documents.

ESRD dialysis USPCCs are projected using a base year USPCC trended to 2027 using total ESRD growth with an "adjustment factor for dialysis only." The utilization and intensity assumptions supporting the ESRD trends are based on multiple years of historical experience. The applicable trends are found in the table in Attachment II, "Basis for ESRD Dialysis-only FFS USPCC Trend."

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

Comment: Several commenters urged CMS to use its administrative authority to lift the statutory cap on benchmarks. A couple of these commenters noted that the MA benchmarks are capped at what the benchmark would have been using the pre-Patient Protection and Affordable Care Act (ACA) (Pub. L. 111-148) formula, which results in some plans not receiving the full quality bonus if the benchmark exceeds the cap.

Response: As we have stated in response to similar comments in prior Rate Announcements,[2] while we appreciate the commenters' concerns, we have not identified discretion under section 1853(n)(4) of the Act to eliminate application of the pre-ACA rate cap. The applicable amount (i.e., "benchmark cap") is the rate established under section 1853(k)(1) of the Act.

Section C. Calculation of Fee-for-Service Costs

Comment: A couple of commenters supported CMS efforts to streamline the number of data files released with the ratebook and make the files easier to use and urged data sharing and transparency wherever possible regarding the calculation of FFS costs. Another commenter appreciated the release of county level FFS data with the Advance Notice, to analyze the impacts of rebasing, and further requested that CMS publish any additional data possible with each Advance Notice, such as risk score data by county, repricing data, adjustments for Innovation Models and Health Professional Shortage Areas (HPSA), and any historical restatement of prior years of FFS data.

A commenter requested that CMS continue to publish the FFSyyPR.xlsx file to support transparency of the ratebook development.

Response: We appreciate the support and feedback. With the Rate Announcement, CMS annually publishes files under the "FFS Data (YYYY)" link at https://www.cms.gov/medicare/payment/medicare-advantage-rates-statistics which provides stakeholders with county-level information regarding risk scores, geographic indices, repricing adjustments, models, HPSA physician bonuses, rural emergency hospital (REH) facility payments, and adjustments for SAHS claims. As explained on page 38 of the CY 2027 Advance Notice, we proposed to discontinue publication of the FFSyyPR.xlsx file due to the integration of

[2] Please refer to previous Rate Announcements for years 2016 through 2026 available at https://www.cms.gov/medicare/payment/medicare-advantage-rates-statistics/announcements-and-documents.

excluding A-only and B-only Puerto Rico experience into standard NCH record processing effective with 2023 experience; we are finalizing the file changes as proposed.

Comment: A commenter supported CMS's continued refinements and repricing adjustments to the FFS cost calculation and further suggested that CMS make an adjustment to the AGA methodology to account for downward pressure of the COVID-19 pandemic and natural disasters on FFS costs.

Response: As discussed in prior Rate Announcements, the method for calculating the county-level rates includes AGAs based on a five-year rolling average of historical claims experience, which mitigates fluctuations in the rates.

The CY 2020 Advance Notice (page 21) and Rate Announcement (pages 27 and 28) included discussion and analysis of trends in the FFS data and concluded that our methodology of using five years of FFS experience mitigates annual fluctuations and anomalies in the data that may occur for a variety of reasons. The CY 2023 Advance Notice (pages 24 and 25) also discussed CMS's analysis of the trends in the 2020 FFS data that were impacted by the COVID-19 pandemic and affirmed our prior conclusion that using five years of historical data mitigates fluctuations in the rates despite local or regional events, such as natural or weather-related disasters, and varying impacts from nationwide events, such as pandemics.

Comment: Several commenters expressed concern regarding the financial sustainability of smaller regional plans that have absorbed enrollment from large national carriers exiting markets. Several other commenters expressed concern regarding the payment rates in rural areas, including the impacts of rebasing and the benchmark cap that may constrain payments, and suggested payment adjustments reflective of the cost of care in rural areas for smaller regional plans.

Response: We appreciate the concerns raised by the commenters, and for providing their insights into the market effects of payment policies.

With the annual Advance Notice, we release the applicable percentages and FFS cost data by county used in the development of the MA rates. With the annual Rate Announcement, CMS releases additional files (e.g., repricing adjustments) to provide stakeholders with information that may be used to monitor changes and analyze the drivers of changes in FFS per capita costs for specific counties each year.

As noted in prior Advance Notices, the law requires that MA benchmarks be based on a county's average Medicare FFS per capita costs.

Each year for the upcoming Annual Enrollment Period, CMS releases information regarding plan choices in the MA program, including detailed Landscape files with plan information by county as well as state-by-state Fact Sheets which may be used to monitor plan offerings in specific geographic areas.

Comment: A couple of commenters expressed concern that CMS limits its adjustment of the AGAs for CMS alternative payment models/demonstrations to those listed in the Advance Notice and recommended that CMS reconsider its policy of excluding CMS Innovation Center model/demonstration payments that are not funded from the Trust Funds from the AGA adjustment. One of the commenters recommended CMS publish the amounts paid to FFS providers through the CMS Innovation Center but not included in the benchmark calculations in the Rate Announcement.

Response: As explained on page 35 of the CY 2027 Advance Notice, we considered adjusting the FFS claims experience for care management fees, per-beneficiary-per-month fees, and/or advance payment of shared savings paid using the CMS Innovation Center appropriation instead of the Medicare Part A or B Trust Funds for other models/demonstrations conducted in the 2020–2024 period. However, we intend to continue prior policy and will not take fees of this type into account in our adjustments to historical FFS experience when they were not funded under Medicare Part A or B Trust Funds.

As we discussed on page 20 of the CY 2018 Advance Notice, the fees paid from administrative accounts authorized by section 1115A of the Act are not from the Parts A and B Trust Funds, from which Medicare claims are disbursed, so we do not consider those payments to be part of FFS costs. Per section 1853(c)(1)(D)(i) and (n)(2)(F) of the Act, CMS uses the "adjusted average per capita cost for the year involved, determined under section 1876(a)(4) [of the Act]" as the base payment amount for setting MA rates. Section 1876(a)(4) indicates that FFS costs used for MA rates are based on the estimated amount that would be payable for services covered under Parts A and B, and types of expenses otherwise reimbursable under Parts A and B (including administrative costs incurred by organizations described in sections 1816 and 1842). As these costs described in section 1876(a)(4) of the Act are paid from the Trust Funds, excluding costs paid from another appropriation is appropriate to determine FFS costs. *See also* sections 1817 and 1841 of the Act. In addition, section 1853(f) of the Act indicates that payments to MA organizations shall be made from the Trust Funds "in such proportion as the Secretary determines reflects the relative weight that benefits under Part A and under Part B represents of the actuarial value of the total benefits under this title." Therefore, we will not make an adjustment to historical FFS claims to account for payments made from the funds appropriated under section 1115A(f).

Comment: A few commenters expressed concern regarding changes to the FFS hospital rural floor wage index calculations that impacted specific service areas, whereby MA rates may lag behind actual cost trends, and further suggested that CMS make area-specific adjustments based on prior year restatements of growth trends, including an adjustment to the benchmark cap. A few commenters expressed concern that Medicare wage index changes have had downstream implications on MA rates (e.g., benchmark cap, quartiles, quality bonuses), without corresponding benchmark adjustments to mitigate these impacts.

Response: CMS appreciates the concerns raised by commenters. As discussed in past Rate Announcements,[3] given that MA county rates are based on FFS costs, we believe it is important to update the FFS per capita cost estimates using the most current FFS data available at the time those values are announced and apply repricing adjustments to reflect changes in FFS payment rules. The CY 2027 USPCC projections reflect payment levels based on the most recent Medicare final rules for FY 2026 or CY 2026. Section 1853(b)(1) of the Act prescribes the timing of the release of the MA capitation rates for the contract year and the risk and other factors to be used in adjusting such rates.

As noted on page 27 of the CY 2027 Advance Notice, CMS released the 2024 FFS cost data by county used in the development of the CY 2027 ratebook. The data is published on the CMS website at https://www.cms.gov/medicare/payment/medicare-advantage-rates-statistics. With the Rate Announcement, CMS annually publishes a tool and corresponding glossary, *Medicare FFS County 20YY web.xlsm*, which provides stakeholders with means to replicate the FFS rate development and publishes information regarding county-level geographic indices and repricing adjustments. Using this information, stakeholders are able to analyze the drivers of changes in FFS per capita costs for specific counties from one ratebook to another.

Comment: A commenter supported the inclusion of Rural Emergency Hospital (REH) additional payments and the removal of SAHS billing activity in the development of FFS costs used to calculate MA rates. Another commenter expressed concern regarding county variability resulting from adjustments for urinary catheter claims, suggesting further analysis and mitigation of the impact by phasing in the adjustments over time.

A few commenters suggested that CMS not make adjustments to the MA rates based on FFS waste, fraud and abuse asserting that rates may not account for MA organizations' investments made to proactively identify waste, fraud and abuse. One of these commenters requested more information regarding how the adjustment for urinary catheter claims will affect MA rates.

Response: On pages 27 and 28 of the CY 2027 Advance Notice, we described the proposed adjustment to the FFS experience used in the development of FFS per capita costs for the ratebook to include REH additional facility payments; we are finalizing the adjustment as proposed.

On pages 29 and 30 of the CY 2027 Advance Notice, we described the ratebook adjustment corresponding to the final rule titled, "Medicare Program: Mitigating the Impact of Significant, Anomalous, and Highly Suspect Billing Activity on Medicare Shared Savings Program Financial Calculations in Calendar Year 2023" (CMS-1799-F) (89 FR 79152). With the CY 2027 Advance Notice, we released 2023 and 2024 county-level impacts for non-ESRD beneficiaries and state-level impacts for dialysis ESRD beneficiaries of removing significant, anomalous, and highly

[3] Please refer to previous Rate Announcements available at https://www.cms.gov/medicare/payment/medicare-advantage-rates-statistics/announcements-and-documents.

suspect billing activity. Regarding concerns about county variability, the method for calculating the county-level non-ESRD rates and the state-level ESRD rates includes AGAs based on a five-year rolling average of historical claims experience, which mitigates fluctuations in the rates.

We are finalizing the exclusion of certain urinary catheter claims as proposed. Specifically, in this CY 2027 Rate Announcement, the experience supporting the 2023 non-ESRD USPCC includes an adjustment of -$3.6 billion to reflect the suspension of payments for certain DMEPOS claims. Also, in the CY 2027 Rate Announcement, the experience supporting the 2024 non-ESRD USPCC includes an adjustment of -$2.3 billion to reflect the suspension of payments for certain DMEPOS claims.

We believe that the information released with the CY 2027 Advance Notice and this CY 2027 Rate Announcement provides the necessary support regarding how the adjustment for urinary catheter claims will affect MA rates.

Comment: Several commenters requested clarification regarding whether 2020-2024 skin substitute FFS claims will be repriced for development of the AGAs to account for changes by county for the skin substitutes payment policy in the CY 2026 PFS final rule (CMS-1832-F). A few of these commenters noted that the CY 2027 Advance Notice stated that historical county-level Part B drugs are not repriced and that the trend document supporting the projected USPCCs had included an impact for skin substitutes in the physician administered drug category and further urged CMS to apply county-level repricing adjustments to historical skin substitute claims for the development of the AGAs.

Several commenters expressed concerns about variability in local impacts of skin substitute changes. One of these commenters urged CMS to analyze and consider the geographic impacts of skin substitute repricing when combined with risk adjustment model interactions. A commenter requested implementation of a guardrail to limit county-level rate changes to ensure a minimum increase for all counties.

Response: As described on page 31 of the CY 2027 Advance Notice and on page 35 of the CY 2022 Rate Announcement and consistent with prior years, 2020-2024 Part B drug claims, including skin substitutes, will not be repriced as we have not developed the data and systems to support such repricing. Also consistent with prior years, CMS did not propose to reprice Part B drugs in the CY 2027 Advance Notice; rather, we explicitly stated that we do not reprice Part B drugs as part of our adjustments to the AGAs. The method for calculating the rates includes AGAs based on a five-year rolling average of historical claims experience, which mitigates annual fluctuations and anomalies in the data.

Comment: A large number of commenters urged CMS to use only MA-eligible beneficiaries (those with both Part A and Part B) in MA benchmark calculations, instead of including Part A-only and Part B-only beneficiaries. Commenters were concerned that including Part A-only beneficiaries distorts FFS cost calculations due to different spending patterns that vary

geographically. Several commenters referenced Medicare Payment Advisory Commission's (MedPAC) analysis and prior recommendation on this topic.

Commenters offered policy suggestions such as making the Puerto Rico benchmark adjustment nationwide to include only beneficiaries with both Part A and Part B. A commenter requested that Puerto Rico be held harmless if this adjustment were to be expanded nationally.

Several commenters indicated that from an actuarial perspective, the FFS cost base used to establish MA benchmarks should be limited to beneficiaries with both Part A and Part B to ensure actuarial alignment between the FFS population used to develop rates and the population eligible to enroll in MA. Furthermore, a commenter cited the underlying populations used for ratebook development and risk model calibration as support for this approach.

In addition, several commenters cited the plain language of the statute. A commenter requested that CMS provide a legal analysis of the statutory requirement for actuarial equivalence under section 1876(a)(4) of the Act. Another commenter believed that the spirit of the law did not intend for MA benchmarks to be based on a population that is not eligible for MA enrollment.

Response: We refer commenters to the detailed response, including legal analysis of provisions of section 1876(a)(4), that we provided on pages 22 through 24 of the CY 2020 Rate Announcement, regarding use of FFS data for costs of all Medicare beneficiaries, whereby CMS concluded that it finds the current ratebook methodology (our longstanding policy of considering costs of beneficiaries with Part A and/or Part B) to be consistent with section 1853(c)(1)(D) of the Act. We continue to believe that it is not necessary to change the methodology at this time, nor is it required as the statutory language clearly permits CMS to include Medicare beneficiaries who have Part A only or Part B only. While we recognize that calculating rates based on data that excludes beneficiaries entitled only to Part A would yield different results than calculating rates based on our current methodology, that fact alone does not determine which methodology should be employed.

Regarding suggestions from commenters for nationwide expansion of the adjustment for Puerto Rico, we have discussed in past Advance Notices and Rate Announcements that while most Medicare beneficiaries are automatically enrolled in Part B and must opt out to decline it, beneficiaries in Puerto Rico must take affirmative action to opt in to Part B coverage. As a result, we believe it is appropriate to adjust the FFS rate calculation for Puerto Rico used to determine MA rates so that it is based only on the Medicare costs for beneficiaries with both Part A and Part B. We will continue the adjustment to the FFS rate calculation for Puerto Rico used to determine CY 2027 MA rates to be based only on beneficiaries with both Part A and Part B, given that beneficiaries in Puerto Rico must take affirmative action to opt in to Part B coverage.

We appreciate the suggestions submitted by commenters. For CY 2027, we will continue to calculate FFS spending for the purpose of establishing MA benchmarks using FFS claims and utilization data for beneficiaries in Part A and/or Part B.

Puerto Rico

Comment: Many commenters supported continuing the adjustment of the calculation of benchmarks in Puerto Rico using only claims data for beneficiaries with both Part A and Part B, and the adjustment to the FFS experience for beneficiaries enrolled in Puerto Rico to reflect the nationwide propensity of beneficiaries with zero claims. Commenters stated that these adjustments remain necessary to help plans in Puerto Rico maintain benefits for the populations they serve, due to high rates of poverty and chronic disease and benefit gaps in Puerto Rico (e.g., statutory exclusions from the Medicare Savings Program and the Part D Low-Income Subsidy). Several commenters stated that these adjustments produce a more accurate projection of FFS costs per capita in Puerto Rico, citing the high MA penetration level and the high proportion of dually eligible beneficiaries.

Several commenters expressed concern regarding the credibility of FFS experience, given the relatively small population of FFS beneficiaries in Puerto Rico that does not resemble the MA population, and that the benchmarks may not fully account for their cost of care. One of these commenters referenced actuarial credibility principles regarding the FFS population in Puerto Rico and urged CMS to use statutory authority and/or the CMS Innovation Center's demonstration authority to revise the benchmark methodology in Puerto Rico to achieve parity with national or territorial comparators. Another commenter expressed concern that the annual changes in FFS wage index, including the changes to the low wage index policy, will contribute to declines in the MA rates for Puerto Rico and suggested policy options for the wage index in FFS to ensure sufficient funding to stabilize the healthcare workforce.

Several commenters expressed concern regarding the disparity in payment rates between Puerto Rico and the U.S. mainland and requested additional increases to the Puerto Rico rates. A few commenters characterized the MA rates in Puerto Rico as anomalous based on comparisons to the rates in other areas and the pre-ACA benchmarks.

Several commenters expressed concern that the level of MA rates in Puerto Rico contribute to instability of the MA market with deterioration of provider infrastructure, diminished MA plan competition, reduced capacity to sustain high-quality access to care, and increased movement of both healthcare providers and beneficiaries to the U.S. mainland. Commenters indicated that rates in Puerto Rico do not adequately reflect the costs of providing care in Puerto Rico, requesting that CMS make adjustments to MA rates in Puerto Rico to account for the local market dynamics and to achieve greater parity with rates on the mainland.

Suggestions from commenters were to use a proxy rate for Puerto Rico, establish a minimum floor benchmark (e.g., at USVI rates), and establish a minimum floor AGA of 0.7 (with one of these commenters suggesting that such an adjustment be non-budget neutral).

A couple of commenters recommended an adjustment be made to MA benchmarks in Puerto Rico to reflect the disproportionate representation of dually eligible beneficiaries. Another

commenter recommended a floor adjustment to ensure that the rates in Puerto Rico increase at least at the same rate as the national average increase.

Commenters made other suggestions, including considering the Part B premium buy-downs in Dual Eligible Special Needs Plans (D-SNPs) to be part of A/B bids (rather than as part of MA rebates) for Puerto Rico plans, adopting alternative methods for applying the quartile adjustment to reduce disparities caused by tying the adjustment to FFS spending at the county level, and issuing guidance regarding the allocation of funds to the Part A and Part B portion of bids.

A commenter suggested that CMS consider creating a technical working group involving MA plans in Puerto Rico and other key stakeholders that can develop longer term solutions that will help ensure accessible, high-quality and affordable care for seniors in Puerto Rico.

Response: CMS thanks the commenters for their thoughtful insights and comments. We appreciate the suggestions and recommendations submitted by commenters. However, we note that section 1853 of the Act prescribes the general approach that FFS per capita costs be used in developing MA rates and CMS has limited discretion to incorporate targeted adjustments or exceptions, such as applying floors for specific locales.

As noted in prior Advance Notices, the law requires that MA benchmarks be based on a county's average Medicare FFS per capita costs, and there is no evidence that FFS costs in Puerto Rico are higher than the costs observed in the FFS claims data and, thus, no basis for overhauling Puerto Rico's MA benchmarks. Section 1853(c)(1)(D) requires an estimate of the per capita costs for services covered under Parts A and B for individuals who are not enrolled in an MA plan. We believe that using data pertaining to actual Medicare FFS costs in Puerto Rico is the best approach to developing the estimate of FFS per capita costs for the contract year, and we have not seen evidence to suggest that Medicare FFS costs in another jurisdiction are a reliable proxy. As we stated in the CYs 2017 and 2018 Rate Announcements and based on the number of FFS beneficiaries used in development of the ratebook FFS rate, we have determined that the FFS data in Puerto Rico is sufficient for establishing accurate MA benchmarks. As noted in the CY 2027 Advance Notice, the credibility adjustment is used for counties that have certain levels of FFS beneficiaries.

For the past ten years, the Secretary has directed OACT to adjust the FFS experience for beneficiaries in Puerto Rico to reflect the nationwide propensity of beneficiaries with zero claims. For the CY 2027 ratebook development, the Secretary has directed OACT to adjust the FFS experience for beneficiaries in Puerto Rico to reflect the nationwide propensity of beneficiaries with zero claims. For purposes of making this adjustment, consistent with the Secretary's instructions, OACT evaluated experience exclusively for beneficiaries that are enrolled in both Part A and Part B and also not eligible for VA coverage.

The updated study analyzed experience for calendar years 2020 through 2024, using the cohort of FFS beneficiaries enrolled mid-year (i.e., enrolled in both Part A and Part B as of the mid-year

dates used for the study) to approximate the average enrollment for the year. On average, 13.9 percent of Puerto Rico FFS beneficiaries with both Part A and Part B were found to have no Medicare claim reimbursements per year. This compares to a nationwide, non-territory proportion of 6.1 percent of FFS beneficiaries without Medicare spending. These results were applied to the Puerto Rico FFS experience by adjusting the weighting of the enrollment and risk scores for the zero-claim cohort to reflect the nationwide proportion of zero-claim beneficiaries. The resulting impact was an average increase in the standardized FFS costs in Puerto Rico of 4.4 percent for 2020 through 2024. Accordingly, a 4.4 percent adjustment was applied to the pre-standardized Puerto Rico FFS rates supporting the CY 2027 ratebook development.

We explained on page 51 of the CY 2025 Rate Announcement that Section 1854 of the Act specifies the costs that may be included in the A/B bid and that CMS does not have discretion under section 1854(a)(6)(A) to treat the payment of the Part B premium as a benefit under Part A or Part B.

Section D. Direct Graduate Medical Education

Maryland Total Cost of Care (TCOC) Model

Comment: Several commenters expressed concerns with the methodologies for determining the Maryland TCOC Model DGME, IME, and KAC carve-outs, stating that continuing to use the adjustment methodology for DGME and IME, as finalized in the CY 2025 Rate Announcement, and the adjustment methodology for KAC, as finalized in the CY 2026 Rate Announcement, will create added challenges for Maryland MA organizations already facing what commenters assert to be a "suboptimal MA market."

A few commenters discussed the uniquely challenging financial environment for MA organizations in Maryland due to the interactions between the Maryland TCOC Model and the MA benchmark methodology. These commenters stated that the DGME, IME and KAC carve-out methodologies have further reduced MA benchmarks in Maryland counties, with pronounced impacts in Baltimore City and Baltimore County, and could potentially affect plan participation in Maryland. A commenter noted that a separate carve-out for KAC is disruptive to the current integrated framework and creates challenges for smaller, regional plans from a cost attribution standpoint.

Several commenters recommended CMS reconsider its DGME, IME and KAC carve-out methodologies for 2027; a commenter recommended that CMS end the DGME and KAC carve-outs to limit disruption to the Maryland MA market and avoid disproportionately negative impacts to Maryland MA organizations and their beneficiaries.

Response: We appreciate the concerns raised by the commenters. CMS will continue to use the methodology finalized in the CY 2025 Rate Announcement for the DGME and IME carve-outs and the methodology finalized in the CY 2026 Rate Announcement for the KAC carve-out, as

proposed in the CY 2027 Advance Notice. This data source and methodology for calculating the MA rates in Maryland more accurately reflects FFS per capita costs for the payment year that are the basis for MA rates, as required by the statute. Even with the use of these methodologies, MA rates in Maryland continue to be among the highest in the country compared to the average MA rates of other states.

Section E. Organ Acquisition Costs for Kidney Transplants

Maryland TCOC Model

See Comment and Response in the section titled, "Direct Graduate Medical Education."

Section F. IME Phase Out

Maryland TCOC Model

See Comment and Response in the section titled, "Direct Graduate Medical Education."

Section G. MA ESRD Rates

Comment: Several commenters expressed concerns that ESRD rates are not sufficient to cover the cost of care for beneficiaries with ESRD. The commenters requested that CMS continue regular evaluations of ESRD rates to improve the adequacy and accuracy of MA ESRD benchmarks and payment. A commenter requested that CMS share more information about its analysis of ESRD payments and costs. A commenter highlighted the potential consequences of inadequate rates for ESRD, including impacts to all MA beneficiaries through increased premiums and cost-sharing, reduced benefits, and fewer plan options.

Response: We appreciate the comments regarding MA ESRD payment adequacy given the increased enrollment into MA plans by beneficiaries with ESRD. CMS continues to analyze these issues and consider whether, consistent with the statutory requirements for setting ESRD rates in section 1853(a)(1)(H) of the Act, any refinements to the methodology may be warranted in future years to ensure appropriate ESRD payment rates.

Comment: Several commenters expressed concern that the state-based rate-setting methodology results in rates that are inadequate to cover costs in certain markets. These commenters stated that state-based rate setting masks within-state variations in ESRD costs and noted that expenditures for ESRD care in metropolitan areas can deviate from the state average, indicating the need for a more localized approach in setting payment rates. Commenters suggested CMS should continue to consider the use of smaller geographic areas as the basis for calculating MA ESRD benchmarks, and a few commenters stated CMS should provide more underlying data associated with the analysis of core-based statistical areas as an alternative to state-based payments. Commenters acknowledged that certain areas, such as rural and medically

underserved areas, could receive lower rates under a new methodology and suggested CMS consider adjustments to these areas to ensure continued access to services.

Response: We appreciate the comments regarding ESRD rate setting and refers commenters to the analyses of sub-state ESRD rates provided in the CY 2023 and CY 2024 Advance Notices. In the CY 2024 Advance Notice, CMS provided details of our analysis of potential changes in ESRD rates by Core-Based Statistical Areas (CBSA), showing that CBSAs representing the 40 percent of enrollment with the 68 highest area deprivation index (ADI) measures were expected to receive CY 2022 ESRD rates that were an average of 2.13 percent lower under the CBSA-level approach. CMS continues to believe our longstanding rate-setting approach for ESRD is fair and reasonable, and CMS agrees with commenters that any significant changes to the current methodology should be fully examined prior to implementation. CMS will continue taking into consideration commenters' concerns and recommendations.

Comment: A few commenters stated concerns that the Maximum Out-Of-Pocket (MOOP) limit is a factor contributing to underpayment for beneficiaries with ESRD. Commenters suggested that CMS update the MA benchmark to incorporate the difference between FFS Medicare out-of-pocket costs and the MA MOOP to support accurate payments for beneficiaries with ESRD.

Response: While we appreciate commenters' suggestions, CMS does not find the suggestions to revise the ESRD rate-setting methodology to be consistent with our interpretation of section 1853 of the Act. As explained in the CY 2012 Advance Notice and CY 2012 Rate Announcement, CMS interprets the statutory changes made by the ACA to MA payment to indicate that all MA payment rates, including the separate rates of payment for ESRD enrollees, should closely align with FFS Medicare costs. As provided in section 1853(a)(1)(H) of the Act, CMS establishes separate rates of payment to MA organizations for ESRD beneficiaries enrolled in MA plans. See also 42 C.F.R. §§ 422.254 and 422.304 through 422.308. The rates used for enrollees in dialysis or transplant status are based on statewide average FFS Medicare costs for ESRD beneficiaries in dialysis status. For enrollees with functioning graft status, the MA county benchmark rates are the payment rates. The rates for those in dialysis, transplant, and functioning graft status are also adjusted using a risk adjustment methodology that is specific to the health care costs for beneficiaries with ESRD in such statuses. We understand the concern about potential underpayment of ESRD costs leading to increases in costs for all MA enrollees, including those without ESRD; however, the data CMS uses to calculate the CY 2027 MOOP limits includes out-of-pocket expenses from beneficiaries with and without diagnoses of ESRD because the MOOP limits will apply to enrollees with and without diagnoses of ESRD in CY 2027. This practice avoids discriminating against beneficiaries with diagnoses of ESRD (or any group of beneficiaries with a particular high-cost condition or health status) that would result if there were higher premiums, cost sharing, or MOOP amounts applicable only to those individuals with a certain chronic condition. Additional detail on how CMS finalized MOOP limits calculations, including the data used and the percentiles of FFS Medicare data projections that should be used in those calculations is available in the final rule titled, "Medicare Program;

Maximum Out-of-Pocket (MOOP) Limits and Service Category Cost Sharing Standards" (CMS-4190-FC4) (87 FR 22290) published April 14, 2022.

Comment: A few commenters recommended CMS make changes to the Bid Pricing Tool (BPT) to reclassify the ESRD subsidy to be a Medicare-covered service rather than an A/B Mandatory Supplemental benefit. The commenters suggested that in the short term, CMS should make the ESRD and non-ESRD service categories consistent and merge the ESRD and MA BPT format, and in the long-term, CMS should eliminate the ESRD BPT filing altogether as CMS receives the same information through encounter and MLR data.

Response: We appreciate the suggestions submitted by the commenters related to the BPT. Section 1853(a)(1)(H) of the Act requires the Secretary to establish "separate rates of payment" with respect to beneficiaries with ESRD enrolled in MA plans and does not require that a competitive bidding methodology be used for CMS capitation payments for ESRD enrollees. In setting such separate rates, CMS has established an approach for paying MA organizations for enrollees with ESRD that directly use the rates, rather than bids. As such, the ESRD rates are intended to be the payment rate for Medicare-covered services for enrollees with ESRD, and the ESRD subsidy cannot be paid under the rates used in the bids to determine payment for non-ESRD beneficiaries. Therefore, the ESRD subsidy that is permitted in plan bids for non-ESRD beneficiaries will remain as a mandatory supplemental benefit. MA plans do not bid on ESRD beneficiaries. At this time, CMS does not find it necessary to require that MA plans submit a separate A/B bid for beneficiaries with ESRD. Regarding the commenters' request that CMS eliminate the ESRD BPT filing requirement, please refer to the CY 2026 MA bid pricing tool instructions for more information as well as the final CY 2027 MA bid pricing tool instructions which will be released in spring 2026.

Section H. MA EGWPs

Comment: A few commenters expressed their support for EGWPs as an important healthcare option for Medicare beneficiaries and employers. One commenter expressed support for the continuation of the current EGWP payment methodology for CY 2027, and a few commenters expressed appreciation for the inclusion of the preliminary bid-to-benchmark ratios for EGWPs in the CY 2027 Advance Notice to facilitate more accurate benefit and premium information for employers and beneficiaries. A commenter further expressed support for CMS's waiver of EGWP bidding requirements and requested that CMS confirm EGWP bidding requirements in the Rate Announcement to support stability and allow EGWPs to price accurately.

Response: We appreciate the support. As noted in the section "Policies Adopted as Described," we will continue to use the payment methodology as described in the CY 2027 Advance Notice for EGWPs, but with finalized bid-to-benchmark ratios for CY 2027 MA EGWP payment rates.

Comment: A commenter requested that CMS provide updated bid-to-benchmark ratios based on February enrollment data in advance of the Rate Announcement release to reduce operational

pressures on MA plans with short windows for the negotiation with employers and finalization of bids.

Response: We appreciate this recommendation. In response to feedback from the industry, CMS began publishing preliminary bid-to-benchmark ratios for EGWPs based on January enrollment data with the CY 2023 Advance Notice. Due to timing and operational constraints, CMS is unable to provide bid-to-benchmark ratios based on February enrollment data in advance of the release of the Rate Announcement.

Comment: Some commenters recommended CMS exclude negative margin plans from the calculation of estimated bid-to-benchmark ratios for EGWPs to avoid undermining the availability of supplemental benefits and limiting EGWPs' ability to expand.

Response: As we have stated in past Rate Announcements,[4] CMS does not believe that there is a reasonable rationale to exclude these plans from the calculation of the bid-to-benchmark ratios because the ratios are intended to be representative of the market. Negative margin plans are included in the non-EGWP market as well, so the bids of such plans are included when the bid-to-benchmark ratios are developed. CMS does adjust for factors which would otherwise result in significant differences between the EGWP and non-EGWP market. More specifically, while the majority of plans in the EGWP market are PPO plans, the non-EGWP market is predominantly HMO plans. EGWP individual market bid-to-benchmark ratios are calculated separately for HMO and PPO plan types by quartile. Unlike the HMO/PPO difference between EGWPs and non-EGWPs, there is no data to suggest that a similar difference exists between EGWPs and non-EGWPs regarding negative margin plans upon which CMS can judge the reasonableness of adjusting the bid-to-benchmark ratios to account for negative margin plans.

Comment: A commenter expressed support for the continuation of the policy permitting EGWPs to buy down Part B premiums.

Response: We appreciate the support.

Comment: A commenter suggested adjusting current rate setting to capture differences in the use of HMO and PPO plans between the EGWP and non-EGWP markets. The commenter stated that it would be more accurate for CMS to segment the benchmark calculation by HMO and PPO products and adjust the bid-to-benchmark ratio for the differing products accordingly.

Response: We appreciate this suggestion; however, CMS is continuing to apply current methodology for paying EGWPs in CY 2027. Consistent with how CMS has developed EGWP payments since 2019, the CY 2027 EGWP payment methodology takes into account the prevalence of HMO and PPO enrollment in the EGWP market by calculating CY 2027 individual market bid-to-benchmark ratios separately for HMO and PPO plan types by quartile. CMS then takes into account the prevalence of HMO and PPO enrollment in the EGWP market to combine

[4] Please see the CY 2026 Rate Announcement (https://www.cms.gov/files/document/2026-announcement.pdf), CY 2025 Rate Announcement (https://www.cms.gov/files/document/2025-announcement.pdf), CY 2024 Rate Announcement (https://www.cms.gov/files/document/2024-announcement-pdf.pdf), and CY 2023 Rate Announcement (https://www.cms.gov/files/document/2023-announcement.pdf).

the ratios by quartile. This methodology is more consistent with the county rates for individual market plans, which are also not calculated separately for HMO and PPO plan types.

Comment: A commenter encouraged facilitating greater access to EGWPs in rural markets. The commenter noted that implementing additional flexibilities around telehealth for provider network requirements could address factors that inhibit the formation of direct contract networks and enable more EGWPs to be offered in rural markets.

Response: We note this comment is unrelated to our proposals in the CY 2027 Advance Notice. We interpret this comment to be an issue related to service areas and network adequacy considerations, rather than EGWP payment policy. Therefore, this comment is outside the scope of this document. Of note, to enable employers/unions to offer coordinated care plans to all their Medicare-eligible members wherever they reside, CMS has waived certain service area requirements for EGWPs; CMS encourages readers to review Chapter 9 of the Medicare Managed Care Manual for more information on EGWP waivers.

Comment: A commenter recommended that CMS allow professional or trade associations to pool membership to enroll beneficiaries in EGWPs, suggesting that CMS work with membership organizations such as the U.S. Chamber of Commerce to facilitate this approach.

Response: We appreciate the comment but note that issues related to eligibility for EGWPs, including whether professional or trade associations may sponsor or pool membership for EGWP coverage, are outside the scope of this document.

Section I. CMS-HCC Risk Adjustment Model

Comment: Some commenters supported the proposed 2027 CMS-HCC risk adjustment model. Specific examples of support from some commenters included:

- Updating the model with more recent underlying data, specifically 2023 diagnoses and 2024 expenditure data from FFS, will improve actuarial accuracy and better reflect current utilization, expenditure, coding, and diagnostic patterns.
- Separating certain chronic kidney disease HCCs improves clinical precision and payment accuracy for beneficiaries with varying stages of kidney disease.
- Excluding diagnoses derived from audio-only encounters strengthens documentation integrity and better aligns payment with clinical encounter standards.

Response: We thank the commenters for their support. We agree and also understand the balance of updating the risk adjustment model using more recent underlying data with providing more time for stakeholders to adjust to the 2024 CMS-HCC model. Therefore, for CY 2027, CMS will continue to calculate Part C non-ESRD risk scores using the 2024 CMS-HCC model while we evaluate risk adjustment model refinements for the future.

Comment: Several commenters supported updating the CMS-HCC model in principle but raised concerns about implementation timing or payment volatility. Many commenters recommended that CMS delay implementation of the proposed 2027 CMS-HCC risk adjustment model recalibration and the proposed diagnostic source exclusions until CY 2028 or phase in the changes over multiple years. Commenters stated that immediate implementation would create payment volatility, destabilize smaller or regional plans, and potentially lead to benefit reductions or premium increases for enrollees. While some commenters agreed that using more recent data improved actuarial accuracy, these commenters recommended that CMS address what they referred to as technical concerns, particularly related to skin substitute spending, before finalizing the model.

Response: CMS appreciates the concerns raised by the commenters related to the timing of the implementation of the updated 2027 CMS-HCC risk adjustment model. We continue to believe it is important to update the CMS-HCC risk adjustment model regularly and will consider updates for future years. Payment accuracy declines the longer a model ages and is used to predict expenditures for more recent enrollees in MA plans. Therefore, delaying implementation of a risk adjustment model that is based on more recent underlying data prolongs the use of a risk adjustment model that, though still accurate according to CMS's measures (i.e., having a predictive ratio between 0.90 and 1.10), is waning in its ability to predict current costs. The longer CMS waits to update the risk adjustment model, the more impactful it will be on the year-over-year bottom line impacts for MA organizations. Although the proposed 2027 CMS-HCC risk adjustment model would have accurately reflected more recent relative costs, treatment and utilization patterns, and coding practices that are likely to persist in future years, we acknowledge commenters' concerns about stability in the MA market. Consequently, for CY 2027, CMS will continue to use the 2024 CMS-HCC risk adjustment model that was fully implemented for CY 2026, in lieu of the updated risk adjustment model that was proposed in the CY 2027 Advance Notice, in order to allow the MA market more time to adjust to the completed phase in of the 2024 CMS-HCC risk adjustment model.

Comment: Some commenters asked for more technical transparency. They encouraged CMS to release additional technical documentation, predictive ratios, and white papers, and to provide greater opportunity for stakeholder engagement prior to finalization. Multiple commenters requested that CMS provide at least 60 days' notice for changes to the risk adjustment model, and another commenter recommended that major risk adjustment model changes be finalized two years before implementation.

Response: Like in previous years when similar changes were proposed, CMS believes that the period provided for comments on the CY 2027 Advance Notice is sufficient. Per section 1853(b)(2) of the Act, the Advance Notice of proposed changes to the methodology and assumptions used to determine annual MA capitation rates and the risk and other factors used in adjusting MA capitation rates under section 1853(a)(1)(C) is required to have a minimum 30-day

comment period. The CY 2027 Advance Notice was released on January 26, 2026, and comments were accepted through February 25, 2026, satisfying the statutory minimum. The only exception to this statutory minimum was a separate statutory requirement for a 60-day comment period, as first described in Part I of the CY 2019 Advance Notice, that applied only to proposals to implement certain changes to the CMS-HCC model based on section 1853(a)(1)(I) of the Act, in accordance with requirements in the 21st Century Cures Act (Pub. L. 114-255). That requirement applied to the specific model changes proposed pursuant to section 1853(a)(1)(I) and does not apply to the recalibration proposed for CY 2027. In setting these timelines, CMS seeks to achieve multiple goals, including providing the statutorily-required amount of time for public comment while also releasing the Advance Notice using more current data to calibrate the model and ensuring that the Rate Announcement is published by the statutory deadline.

We acknowledge the commenters' request for additional transparency and engagement in the model development process. CMS will continue to consider future opportunities to provide additional resources and engage with stakeholders as we evaluate updates to the CMS-HCC risk adjustment model. As noted above, CMS provided the public with sufficient information to review the proposals in the CY 2027 Advance Notice, and the statutorily-required comment period was satisfied.

Comment: Many commenters opposed the proposed 2027 CMS-HCC risk adjustment model. Commenters had a number of questions about and concerns with the proposed CMS-HCC risk adjustment model including:

- Some commenters raised concerns that the 2027 CMS-HCC model CMS proposed was reducing the relative factors for demographics common chronic conditions such as Diabetes, Heart Disease, Chronic Obstructive Pulmonary Disease (COPD), Substance Use Disorders, Congestive Heart Failure (CHF), Chronic Kidney Disease (CKD) Stages 3–5, Obesity and Related Metabolic Conditions, Major Depression and Other Serious Psychiatric Disorders, Vascular Disease, as well as the associated count variables and interactions.
- Many commenters were concerned that by including the costs for skin substitutes in the model without an adjustment for elevated skin substitute spending the 2027 CMS-HCC model CMS proposed arbitrarily inflated payments for some conditions, while reducing payments for several chronic illnesses and age demographics that have no interaction with this spending. Commenters believe that relative factors for conditions not directly related to skin substitute spending would be higher if the 2027 CMS-HCC model CMS proposed had adjusted for the excess skin substitute spending and requested that CMS analyze the model with an adjustment for skin substitute spending.
- Some commenters were concerned that the accuracy of the proposed CMS-HCC risk adjustment model could not be evaluated without additional data, including the overall fit statistics (R2, predictive ratios) and for specific groups of beneficiaries.

Response: A data year update to the risk adjustment model means CMS is recalibrating the CMS-HCC model with more recent diagnoses and expenditures data. CMS will continue to use the 2024 CMS-HCC model, so there will be no data year updates for CY 2027. However, we conducted extensive analysis of the potential impacts of the updated model on risk scores and HCC coefficients. There is no change in the variables included in the model, such as the demographics, HCCs, HCC counts, or interactions, but there can be changes to the relative factors associated with each variable relative to a prior model due to differences in diagnostic coding patterns, utilization, and cost in the Original Medicare program since the model was last updated. CMS does not alter the level of the coefficients other than when certain constraints are applied for technical reasons (e.g., the model produced negative relative factors that are then constrained to zero per the long-standing risk adjustment principles).[5]

High-cost items and services increase variation in the model's sample and can impact the relative factors for specific variables associated with the high-cost spending (e.g., observed skin substitute spending in 2024 increased the relative factor for skin conditions in the proposed model by around 42.9 percent compared to the 2024 CMS-HCC model and for other conditions like Morbid Obesity reduced the negative impact). However, the fact that high-cost items and services were included in the proposed model does not prevent the model from accurately predicting costs overall, for large subgroups, just as the 2024 CMS-HCC model does.

The impact of the proposed model cannot solely be assessed by analyzing changes in relative factors for individual conditions since the risk score is the sum of relative factors assigned to a beneficiary and determines the expected relative cost. The standard measures of predictive accuracy (e.g., predictive ratios and R^2) are similar between the 2024 CMS-HCC risk adjustment model and the proposed 2027 CMS-HCC risk adjustment model and are not wholly indicative of how accurately the model would reflect relative costs in the payment year or the effect of making an adjustment for skin substitute prices. Each year, as we develop a new risk adjustment model, CMS assesses the changes in relative factors as well as the impact on overall payment compared to the current model.

CMS tested the effect of including observed skin substitute spending in the proposed model by recalibrating the proposed model after reducing prices for skin substitutes by 90 percent. This adjustment is consistent with the policy in the 2026 PFS final rule (CMS-1832-F) and suggestions from commenters. Through this analysis, we found that raw MA risk scores would have been 0.1 percent lower than the proposed 2027 CMS-HCC model if CMS had reduced skin substitute prices when calibrating the 2027 CMS-HCC model. We further found that the causes underlying decreasing relative factors for some conditions in the proposed 2027 CMS-HCC model relative to the 2024 CMS-HCC model are multiple and complex. There were significant changes in Original Medicare between 2019 (the payment year for the 2024 CMS-HCC model) and 2024 (the payment year for the 2027 CMS-HCC model) as the COVID-19 pandemic

[5] Risk adjustment principles can be found in the 2024 Report to Congress: Risk Adjustment in Medicare Advantage.

increased mortality and changed utilization patterns among Medicare enrollees while the healthcare delivery system adopted new technology and responded to changing incentives amid growth in value-based care models. As a result of all of these factors, we observed increased coding intensity in the Original Medicare data between 2019 and 2024, which is the primary driver of the differences we see between the 2024 CMS-HCC model and the proposed 2027 CMS-HCC model.

In addition, our analysis showed that skin substitute spending is associated with a broad range of conditions, and many beneficiaries using skin substitutes have multiple chronic conditions. For some conditions with decreasing relative factors compared to the 2024 CMS-HCC model, reducing skin substitute prices in the proposed 2027 CMS-HCC model further reduces the relative factor across segments (e.g., morbid obesity). For other conditions that are prevalent in MA (diabetes, heart disease, substance use disorders, Chronic Kidney Disease (CKD), major depression and other psychiatric disorders, Chronic Obstructive Pulmonary Disease (COPD) and other lung disorders), the weighted average relative factor is similar or increases after reducing skin substitute prices, but the adjusted model relative factor is still lower than the 2024 CMS-HCC model relative factor. In general, the direction of the relative factor change compared to the 2024 CMS-HCC model is the same with or without an adjustment for skin substitute prices, but the magnitude of the change differs. Relative factors for skin conditions and other conditions correlated with skin substitute spending (vascular disease and infections) are still higher than the 2024 CMS-HCC model but the change is less positive. Finally, the minimal effect in the modeling of adjusting skin substitute prices aligns with our expectations, because the number of Original Medicare beneficiaries (about 56,000 individuals) with extremely high skin substitute spending is a very small percentage of the overall Original Medicare population; while in absolute terms spending for this category of services was high, it represents a small percentage of total Original Medicare outlays.

Table III-1 CMS-HCC Model Relative Factor Changes With and Without an Adjustment to Reduce the Prices of Skin Substitutes

Condition Group (Body System)	2024 MA Enrollment	2027 CMS-HCC Model Impact on Relative Factors	2027 CMS-HCC Model Impact on Relative Factors After Recalibrating with Adjustment for Skin Substitute Prices
Diabetes	9,798,377	0.0%	0.0%
Heart Disease	9,676,304	-1.1%	-1.1%

Condition Group (Body System)	2024 MA Enrollment	2027 CMS-HCC Model Impact on Relative Factors	2027 CMS-HCC Model Impact on Relative Factors After Recalibrating with Adjustment for Skin Substitute Prices
Lung	5,677,459	-14.3%	-12.5%
Kidney	4,926,803	-14.3%	-10.7%
Metabolic	4,314,283	-8.0%	-16.0%
Neoplasm	3,637,420	2.5%	5.1%
Psychiatric	3,442,824	-6.7%	-3.3%
Substance Use	2,158,497	-8.3%	-8.3%
Musculoskeletal	2,001,004	-10.3%	-10.3%
Neurological	1,924,193	13.0%	13.0%
Cognitive	1,678,259	6.3%	6.3%
Cerebrovascular	1,591,912	0.0%	0.0%
Arrest	1,267,688	17.6%	17.6%
Eye	1,202,325	6.7%	6.7%
Vascular	1,136,945	18.8%	12.5%
Infectious Disease	935,896	30.8%	23.1%

Condition Group (Body System)	2024 MA Enrollment	2027 CMS-HCC Model Impact on Relative Factors	2027 CMS-HCC Model Impact on Relative Factors After Recalibrating with Adjustment for Skin Substitute Prices
Skin	872,447	42.9%	9.5%
Gastrointestinal	846,005	-10.0%	-10.0%
Injury	768,432	0.0%	10.0%
Liver	739,970	0.0%	0.0%
Spinal	462,290	12.5%	0.0%
Blood	423,663	8.3%	8.3%
Openings	280,590	16.7%	16.7%
Amputation	112,831	0.0%	0.0%
Transplant	41,068	0.0%	0.0%

Note: The change in relative factors is weighted by MA enrollment in each segment of the CMS-HCC model

The change in relative factors alone is not predictive of the change in risk scores as a whole as stated above. Beneficiaries often have multiple conditions, and the model also accounts for demographic factors such as age, sex and dual status, interactions between conditions, and the count of number of HCCs attributed to the beneficiary that must be considered when assessing the overall impact on risk scores.

Table III-2 MA Risk Score Changes by Condition Group With and Without an Adjustment to Reduce the Prices of Skin Substitutes

Condition Group (Body System)	2024 MA Enrollment	2027 CMS-HCC model Impact on MA Risk Scores	2027 CMS-HCC model Impact on MA Risk Scores After Recalibrating with Adjustment for Skin Substitute Prices
Diabetes	9,798,377	-4.3%	-4.9%
Heart Disease	9,676,304	-5.0%	-5.6%
Lung	5,677,459	-5.7%	-6.0%
Kidney	4,926,803	-6.0%	-6.3%
Metabolic	4,314,283	-5.5%	-6.8%
Neoplasm	3,637,420	-2.1%	-1.7%
Psychiatric	3,442,824	-4.6%	-5.0%
Substance Use	2,158,497	-5.5%	-6.1%
Musculoskeletal	2,001,004	-3.2%	-5.3%
Neurological	1,924,193	-0.3%	-1.0%
Cognitive	1,678,259	-1.7%	-2.6%
Cerebrovascular	1,591,912	-2.7%	-3.6%
Arrest	1,267,688	-2.5%	-3.4%

Condition Group (Body System)	2024 MA Enrollment	2027 CMS-HCC model Impact on MA Risk Scores	2027 CMS-HCC model Impact on MA Risk Scores After Recalibrating with Adjustment for Skin Substitute Prices
Eye	1,202,325	-2.6%	-2.7%
Vascular	1,136,945	1.5%	-1.8%
Infectious Disease	935,896	2.2%	-0.5%
Skin	872,447	8.1%	-1.3%
Gastrointestinal	846,005	-3.0%	-3.6%
Injury	768,432	-1.0%	-1.9%
Liver	739,970	-3.0%	-3.0%
Spinal	462,290	4.5%	-1.1%
Blood	423,663	1.1%	0.9%
Openings	280,590	5.2%	1.0%
Amputation	112,831	-1.2%	-4.8%
Transplant	41,068	8.6%	9.5%

Comment: Several commenters noted that CMS accounted for the changes to the Part B skin substitute policies in the CY 2026 Physician Fee Schedule in the benchmark calculation but did not make the corresponding adjustments for skin substitute costs in the risk adjustment model. Commenters characterized this difference as a methodological misalignment. Some commenters further argued that the model, as proposed, was fundamentally flawed because it uses 2024 skin substitute pricing when skin substitute pricing will be reduced by 90 percent in 2026, and that

CMS should either exclude or reprice skin substitute claims prior to finalizing the model so that the coefficient for specific conditions reflects the value relative to OM cost in 2027. A couple of commenters suggested that by not making an adjustment for the skin substitute policy change in FFS the proposed model could violate the actuarial equivalence requirement in Section 1853(a)(1)(c)(i) of the Social Security Act. These commenters expressed their belief that risk scores must reflect the FFS spending used to set county benchmarks, and the calibration of the risk model and the benchmark-setting methodology must be aligned to ensure that benchmark payments and risk models accurately reflect the expected cost of providing health benefits. They asked CMS to demonstrate how the proposed model meets the actuarial equivalence requirement.

Response: While CMS is not finalizing the updated model for CY 2027, the proposed 2027 CMS-HCC model is methodologically sound and satisfies statutory requirements for actuarial equivalence. Section 1853(a)(1)(c)(i) of the Social Security Act instructs CMS to adjust the payments made to MA organizations "for such risk factors as age, disability status, gender, institutional status, and such other factors as the Secretary determines to be appropriate, including adjustment for health status . . . so as to ensure actuarial equivalence." It also authorizes CMS to "add to, modify, or substitute for such adjustment factors [i.e., age, disability status, gender, etc.] if such changes will improve the determination of actuarial equivalence."

The proposed 2027 CMS-HCC model satisfies the statutory requirement of actuarial equivalence because, within the limitations of such a model, it accurately predicts variations in total average cost. The statute does not require that every single change made from the previous CMS-HCC model improves its predictive accuracy. CMS retains the discretion and authority to design the risk adjustment models so as to achieve actuarial equivalence, just as earlier payment models were designed to do. Those earlier payment models do not limit the scope of the Secretary's authority today or in the future.

Furthermore, the CMS-HCC model does not set the aggregate level of funding for the MA program. The level of funding for MA is set by the USPCC and related benchmarks, which are determined separately, and which reflect the payment policy changes applicable to skin substitutes. Because the rates exclude the elevated skin substitute spending and the risk adjustment model accurately distributes risk around the average, payments will continue to accurately reflect FFS costs in aggregate across large population groups typical of insurer risk pools. This was also true in prior years when the USPCC and related benchmarks were higher because observed skin substitute spending was included, and the risk adjustment model applied in payment was based on older data with much lower skin substitute spending.

Comment: Many commenters opposed the proposed 2027 CMS-HCC model recalibration, expressing concern that updating the model with more recent data underpredicts risk for beneficiaries with multiple chronic conditions and disproportionately affects dual-eligible beneficiaries, institutional populations, rural beneficiaries, and other high-acuity populations.

Several commenters argued that the combined effect of recalibration and normalization will compress payments for complex beneficiaries and could destabilize smaller, regional, and specialized plans, including Special Needs Plans (SNPs).

Response: We appreciate the commenters' concerns regarding the impact of the proposed recalibration on specific populations and plan types. CMS updates the CMS-HCC risk adjustment model periodically to ensure that it reflects current utilization patterns, treatment costs, and coding practices in FFS. The proposed 2027 CMS-HCC model uses 2023 diagnoses and 2024 expenditure data, which represents the most recent data available for model calibration. As discussed in the CY 2027 Advance Notice, whenever CMS applies different years of data to update the Part C model, the coefficients in the model will decrease for some HCCs and increase for other HCCs due to changes in utilization, treatment patterns, and coding. This is an expected and inherent feature of model recalibration and is not unique to the CY 2027 update.

The CMS-HCC model is a national model that captures average variation in costs between population subgroups. The goal of risk-adjusted payments is to pay accurately using the appropriate relative risk across subgroups of beneficiaries. As with every update of the risk adjustment model, the impact on each plan will vary depending on the demographic and health characteristics of their enrollees. Plans whose enrollees have a higher concentration of conditions associated with HCCs for which coefficients have decreased relative to the prior model will experience a larger impact from recalibration. This is the expected result of updating the model to reflect more recent FFS experience and does not indicate that the model is inaccurate or that affected populations are being underpaid relative to their actual costs.

Comment: Several commenters had recommendations to calibrate the model using different data or methodologies. Commenters recommended the exclusion or restriction of diagnoses derived from in-home health risk assessments and proposals for structural reforms to the risk adjustment model such as multi-year lookbacks, concurrent or hybrid methodologies, encounter-based calibration, or alternative data sources.

Response: We appreciate the extensive and thoughtful comments and feedback we received, and we will consider these recommendations in the development of future risk adjustment model proposals.

Comment: Several commenters expressed concern that the projected CY 2027 MA risk score trend included in the 2027 Advance Notice Fact Sheet may understate current cost and utilization dynamics. Commenters suggested that more recent data should be incorporated to ensure the pace of evolution in cost and utilization is fully reflected in the projection. A commenter noted that the presentation of the MA risk score trend in the Advance Notice Fact Sheet does not fully capture its interaction with other revenue factors, and that the MA revenue picture would be incomplete without accounting for those dynamics.

Response: The MA risk score trend is the average increase in MA risk scores per year over the most recent three-year period available, not accounting for normalization and the MA coding pattern adjustment, which are included separately in the Fact Sheet. We do not make adjustments to the trend for utilization or underlying medical costs. While there may be other factors influencing MA plan revenue the MA risk score trend is included in the Fact Sheet because it has direct bearing on MA payments and the MA revenue picture would be incomplete without it. We also note the trend is an industry average and individual plans' experience will vary.

CMS-HCC Risk Adjustment Model for PACE Organizations

Comment: Commenters who provided feedback supported the proposed methodology of applying the 50 percent blend of the risk score calculated using the 2017 CMS-HCC model — incorporating diagnoses derived from the Risk Adjustment Processing System (RAPS), encounter data, and FFS claims — and 50 percent of the risk score calculated using the proposed 2027 CMS-HCC model, incorporating diagnoses derived from encounter data and FFS claims exclusively. A commenter expressed appreciation for CMS's proposal to accelerate the blending timeline in CY 2027 relative to the schedule previously outlined in the CY 2026 Rate Announcement, characterizing this adjustment as reflective of CMS's responsiveness to stakeholder feedback, further noting that some PACE organizations had been preparing for this transition and at this point believe the proposed earlier shift to a 50-50 blended rate in CY 2027 should be manageable. Several commenters specifically encouraged CMS to continue providing clear and timely operational guidance, maintaining current and accessible submission resources, and offering regular opportunities for technical dialogue, so that PACE organizations may confidently adapt to evolving programmatic expectations.

Response: CMS appreciates the support expressed by commenters and thanks them for their thoughtful engagement on this topic. Because CMS is finalizing the policy to continue using the 2024 CMS-HCC risk adjustment model for CY 2027, CMS will blend 50 percent of the risk score calculated using the 2024 CMS-HCC risk adjustment model with 50 percent of the risk score calculated using the 2017 CMS-HCC risk adjustment model.

CMS appreciates the work PACE organizations have done during this transition period and is committed to providing robust technical assistance to facilitate smooth and successful implementation. To that end, CMS will continue to offer support through multiple channels, including Technical Assistance Calls, Computer Based Trainings (CBTs) and PACE-specific support on the designated PACE technical website.[6] CMS remains committed to transparency and ongoing stakeholder engagement and encourages PACE organizations to utilize the above resources as they adapt to the evolving programmatic expectations associated with the CY 2027 risk adjustment methodology.

[6] CSSC Operations website at https://www.csscoperations.com/internet/csscw3.nsf/DID/AO68XEU906.

Comment: A few commenters recommended that CMS undertake a formal assessment of the CMS-HCC risk adjustment model with respect to its accuracy in predicting costs for the PACE population. Specifically, these commenters raised the question of whether the current V28 HCCs systematically underpredict costs for the PACE population, which they characterize as a high-need and high-cost population. In the event that such underprediction is confirmed, the commenters recommended that CMS consider adopting approaches or features analogous to those applied in other payment models designed for high-need, high-cost populations. The commenters expressed particular support for the concurrent risk adjustment approach on the grounds that it would facilitate faster adjustment and more timely reimbursement, and would more effectively account for acute, high-cost events that are not amenable to prospective prediction. Additionally, the commenters recommended that CMS utilize a PACE-like population as the basis for comparison when evaluating the model's predictive accuracy for the PACE population. A separate commenter encouraged CMS to consider increased weighting for chronic conditions within the model in order to more fully capture the compounding impact of multiple chronic conditions on cost — a characteristic the commenter identified as defining of the PACE population and as a key contributor to cost variation that may not be adequately reflected through demographic factors alone. This commenter further recommended that future model development incorporate adjustments to the normalization factor to ensure that increases in HCC coefficients more comprehensively capture the incremental costs associated with beneficiaries presenting with multiple chronic conditions.

Response: CMS appreciates the feedback regarding the CMS-HCC risk adjustment model's accuracy for the PACE population, acknowledging concerns about its predictive performance and chronic condition weighting. For PACE, CMS will use 50 percent of the 2017 CMS-HCC risk adjustment model blended with 50 percent of the 2024 CMS-HCC model. CMS acknowledges concerns from commenters about the accuracy of the model for the PACE population. Using distinct data or HCCs to calibrate separate models for PACE and MA may result in differences in predicted risk for individual beneficiaries. However, we note that to the extent that the variation in the cost of conditions in the model for the PACE population differs from MA, the population and these costs are not predicted by the demographic factors or other features in the model, they are reflected in the frailty factors.

Section J. ESRD CMS-HCC Risk Adjustment Models

Non-PACE Organizations: CMS did not receive comments on the ESRD CMS-HCC risk adjustment models for non-PACE organizations for CY 2027. CMS will continue to use the 2023 ESRD CMS-HCC risk adjustment models to calculate risk scores for beneficiaries in dialysis, transplant, and functioning graft status.

PACE Organizations: CMS did not receive comments on the ESRD CMS-HCC risk adjustment models for PACE organizations for CY 2027. CMS will calculate blended risk scores for PACE participants in dialysis, transplant, and functioning graft status with 50 percent of the risk score

calculated using the 2023 ESRD CMS-HCC risk adjustment models and 50 percent of the risk score calculated using the 2019 ESRD CMS-HCC risk adjustment models.

Section K. Frailty Adjustment for FIDE SNPs and PACE Organizations

Frailty for Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs)

Comment: Commenters raised some concerns regarding Health Outcomes Survey (HOS) response rates stating their belief that low HOS response rates may artificially depress frailty adjustment scores for FIDE SNPs specifically. A commenter called for CMS to undertake an examination of how to improve survey response rates and ensure representative responses across MA organizations, expressing concern that response rates for both Consumer Assessment of Healthcare Providers and Systems (CAHPS) and HOS surveys may be approaching levels that result in metrics no longer representative of frailty across a population. Another commenter recommended that CMS collaborate with stakeholders on alternative approaches to measure frailty among FIDE SNPs and PACE plans, suggesting that alternative frailty indices or approaches be modeled and that CMS consider allowing FIDE SNPs to survey only those members who are at a nursing home level of care.

Response: CMS acknowledges the concerns regarding survey response rates. We note that the HOS has had considerable validation of its ability to accurately capture functional limitations and other health related characteristics. While we understand that surveys can have operational challenges in administration, as noted in prior Rate Announcements (e.g., 2019), we believe that the HOS and HOS-modified (HOS-M) continue to be sufficient for a frailty adjustment to payment at the plan level because activities of daily living (ADL) data are collected to calculate frailty scores in the same manner that they are collected and used to calculate frailty factors for model calibration (i.e., limitations in activities of daily living collected from self-reported surveys). In addition, data are collected consistently across respondents, such that frailty scores are calculated using data collected in the same manner across plans, thereby allowing survey results to be compared across plans and relative to PACE (a requirement for determining whether FIDE SNPs receive a frailty adjustment in payment) and thus resulting in frailty payment adjustments that are comparable. Regarding the request for CMS to consider allowing FIDE SNPs to survey only members at a nursing home level of care, CMS is authorized by statute to apply frailty to the payments to FIDE SNPs that have a similar average level of frailty as organizations in the PACE program. Measuring the frailty of only specific members of a FIDE SNP would be inconsistent with CMS authority to make a frailty adjustment to FIDE SNP payments specified in Section 1853(a)(1)(B)(iv) of the Social Security Act. The statute permits that CMS may make frailty payment adjustment to FIDE SNPs that have similar average levels of frailty as the PACE program. Basing a FIDE SNP's comparison to PACE on the subset of FIDE SNP enrollees needing nursing home care would result in a frailty score that does not represent the level of frailty for all members enrolled in the FIDE SNP as the statute directs.

Comment: A commenter requested clarification on why the frailty factors for full Medicaid beneficiaries with zero or one to two ADLs are lower than the frailty factors for non-Medicaid and partial Medicaid beneficiaries with the same level of ADLs. The commenter recommended that CMS revise these factors and apply a floor on frailty factors to account for the most severe conditions.

Response: CMS makes frailty adjustments to predict the Medicare expenditures of community populations with functional impairments that are unexplained by the diagnoses in the CMS-HCC risk adjustment model. If the CMS-HCC risk adjustment model (regardless of model version) overpredicts or is better at predicting expenditures for a certain group of beneficiaries, it may result in a negative or lower frailty factor. A floor on the frailty factors is not needed. If the factors are negative or lower than the factors for a previous version of the CMS-HCC risk adjustment model it is because the demographics, HCCs, count variables, and interaction terms in the CMS-HCC risk adjustment model over predict or better predict the cost for the population. CMS notes that the observation of full Medicaid beneficiaries with zero or one to two ADLs having a lower frailty factor than their counterparts in the partial or non-dual segment is consistent with frailty factors for past CMS-HCC risk adjustment models including the 2017 and 2020 CMS-HCC risk adjustment models.

Because frailty factors are unique to each version of the CMS-HCC risk adjustment model, in alignment with the finalized policy to continue using the 2024 CMS-HCC risk adjustment model for CY 2027, CMS will also continue to use the frailty factors associated with the 2024 CMS-HCC risk adjustment model to calculate frailty scores for CY 2027.[7]

Frailty for PACE Organizations

Comment: Commenters that explicitly addressed the blend of frailty factors supported the proposed blend of 50 percent of the frailty factors associated with the 2017 CMS-HCC risk adjustment model and 50 percent of the frailty factors associated with the 2027 CMS-HCC risk adjustment model.

Response: CMS appreciates the support. To calculate frailty scores for CY 2027 for PACE organizations, CMS is finalizing the proposed blend of frailty factors associated with the risk adjustment models being finalized for PACE organizations for CY 2027 (i.e., the 2017 CMS-HCC risk adjustment model at 50 percent and the 2024 CMS-HCC risk adjustment model at 50 percent).

Comment: While commenters supported the blend of the frailty factors corresponding with the CMS-HCC risk adjustment model blend, they expressed concern that the frailty factors associated with the updated CMS-HCC model, and ultimately frailty scores, will not fully

[7] See the CY 2024 Rate Announcement, Section L for the frailty factors associated with the 2024 CMS-HCC risk adjustment model.

account for the costs of PACE participants. These commenters also reported concerns regarding HOS-M survey administration and response rates. Commenters noted that response rates to the HOS-M continue to be low among many PACE organizations, and that response rates among participants with complex medical conditions, including dementia and Alzheimer's, are lower than for participants without these conditions, further compromising the frailty factor's ability to accurately reflect costs of participants. The commenters highlighted their concerns that the HOS-M survey does not adequately capture the challenges people with cognitive impairment face in completing surveys, as current protocols only allow PACE staff to help in limited situations when participants specifically request assistance, which is less likely to occur among those with cognitive limitations. Additionally, some commenters believe that participants do not accurately indicate their limitations in ADLs. Multiple commenters strongly urged CMS to modify the CY 2026 HOS-M survey administration protocol to allow PACE organizations to designate a member of the interdisciplinary team to proactively offer completion assistance to participants living with complex medical conditions, which they believe would increase the likelihood that participants' needs are adequately represented in survey results. A commenter specifically raised concerns about the proposed 2027 CMS-HCC risk adjustment model frailty factors for lower ADL tiers, noting that while they support the frailty factors associated with three to six ADLs, the frailty factors for individuals with two or fewer ADL limitations lower frailty scores. This commenter expressed concern that some of the frailest and most complex patients fall within the lower ADL limitation groups and strongly suggested that CMS maintain frailty factors associated with the 2017 CMS-HCC risk adjustment model for two or fewer ADLs.

Response: CMS acknowledges the concerns related to the response rates for the HOS-M for PACE participants, particularly among participants with dementia. We collect survey data in a consistent manner for all PACE organizations, as this helps to ensure equitable frailty results for payment. In addition, ADL data are collected to calculate frailty scores in the same manner that these data are collected and used to calculate frailty factors for model calibration (i.e., limitations in activities of daily living collected from self-reported surveys). Permitting variation in how the survey is administered for participants with specific conditions, or in specific circumstances, may disproportionately affect frailty scores for certain organizations, depending on what proportion of an organization's participants have that condition and which organizations provide the assistance. There will continue to be proxy allowances in the survey administration protocol. For the HOS-M survey, a proxy response is at the discretion of the PACE participant, and PACE staff may inform the family member or caregiver of their right to request a proxy if participants with dementia need assistance completing the survey.

If the CMS-HCC risk adjustment model (regardless of model version) overpredicts or is better at predicting expenditures for a certain group of beneficiaries, it may result in a negative or lower frailty factor. CMS notes that the observation of full Medicaid beneficiaries with zero or one to two ADLs having a lower frailty factor than their counterparts in the partial or non-dual segment is consistent with frailty factors for past CMS-HCC risk adjustment models including the 2017

and 2020 CMS-HCC risk adjustment models and that, compared to the 2017 CMS-HCC risk adjustment model, the proposed 2027 CMS-HCC risk adjustment model results in higher frailty factors for beneficiaries with zero to two ADLs among both dual and non-dual eligible beneficiaries.

For CY 2027, CMS will calculate risk scores using a blend of the 2017 CMS-HCC risk adjustment model at 50 percent and the 2024 CMS-HCC risk adjustment model at 50 percent. Consequently, CMS will also use a corresponding blend of 50 percent of the frailty factors associated with the 2024 CMS-HCC risk adjustment model[8] and 50 percent of the frailty factors associated with the 2017 CMS-HCC risk adjustment model.[9]

Section L. MA Coding Pattern Difference Adjustment

Comment: Several commenters supported CMS's proposed 5.9 percent MA coding pattern adjustment factor for CY 2027.

Response: CMS appreciates the support of the commenters. CMS is finalizing the proposed MA coding pattern adjustment factor of 5.9 percent for CY 2027.

Comment: A few commenters opposed CMS's proposed 5.9 percent MA coding pattern adjustment factor for CY 2027 and provided alternative recommendations to the statutory minimum adjustment factor of 5.9 percent, as summarized below:

Higher Adjustment Factor:
A few commenters recommended a higher adjustment factor than the statutory minimum. These commenters expressed concern that the statutory minimum does not account for the full impact of coding pattern differences between MA and FFS. Several commenters further referenced MedPAC analyses demonstrating that MA plans continue to receive substantial overpayments attributable to coding intensity differentials. A few commenters who recommended a higher adjustment factor expressed concern that the current application of the minimum adjustment coding pattern adjustment affects all plans equally, despite the coding intensity variation across MA plans and suggested that the adjustment should be tailored to specific plan behavior.

Specific Methodological Recommendations:

- Targeted Approaches: Several commenters requested that CMS consider an approach that addresses variation in coding by targeting plans with higher coding intensity.
    - **General comments supporting targeted approaches.** A few commenters expressed concerns about the variation in coding patterns throughout the MA industry, noting that applying a uniform MA coding pattern adjustment factor does not account for

[8] See the CY 2024 Rate Announcement, Section L for the frailty factors associated with the 2024 CMS-HCC risk adjustment model.

[9] See the CY 2017 Rate Announcement, Section J for the frailty factors associated with the 2017 CMS-HCC risk adjustment model.

plan-level differences and may lead to inequitable outcomes. A few commenters advocated for targeted approaches, that focus on plans that tend to code more intensely. This was based on their concern that certain MA organizations code much more aggressively than others. They argued that the current approach leads to material gains for large insurers and material losses for smaller insurers.

- **Segmented/tiered approach.** Several commenters suggested that CMS consider a segmented or tiered approach to estimating the MA coding pattern adjustment factor that recognizes different levels of coding patterns among organizations such that the lowest factor is applied to lower coding organizations while the highest factor is applied to higher coding organizations. The commenters believe that a tiered approach could deter excessive coding and ensure the MA coding pattern adjustment accounts for differences in coding patterns without negatively affecting plans that adhere to proper coding guidelines, which would improve equity across plans and level the competitive playing field.

A commenter expressed support for what they referred to as CMS's multi-pronged approach to reducing coding intensity that targets the highest-coding MA plans and acknowledged the fact that the V28 model has reduced some MA coding intensity but noted that substantial differences in coding trends across plans persist.

Response: We appreciate commenters' feedback. Section 1853(a)(1)(C)(ii) of the Act establishes a minimum MA coding pattern adjustment, which was originally adopted beginning with 2014 payment. The current statutory minimum coding pattern adjustment is 5.9 percent. In accordance with statute, CMS analyzes coding pattern differences and determines what the coding pattern adjustment factor should be on an annual basis. Based on our analysis, we have found that for CY 2027, the minimum adjustment applied uniformly is sufficient to reflect differences in coding patterns between MA plans and providers under FFS Parts A and B. Therefore, we are finalizing our proposed MA coding pattern adjustment factor for CY 2027.

We appreciate the comprehensive and thoughtful comments and feedback we received on this proposal. Ensuring that the coding pattern adjustment policy appropriately addresses differences in coding patterns between the FFS program and MA is essential, and we will continue to monitor coding trends across MA organizations in the future.

Comment: A commenter encouraged CMS to continue engaging with stakeholders on its insights and analyses on issues where there is not industry consensus, such as coding pattern differences, including the methodology used for CMS's annual analysis of MA coding pattern differences.

Response: CMS appreciates this feedback and remains committed to ongoing stakeholder engagement on coding pattern differences and related risk adjustment policies. We will continue to consider additional ways in which we can engage with stakeholders as we evaluate the MA

coding pattern adjustment and other risk adjustment policies. We value the input and perspectives of all stakeholders in this process.

Comment: Several commenters suggested ways in which coding intensity can be addressed. A commenter suggested prioritizing Risk Adjustment Data Validation (RADV) audits for plans whose coding practices significantly diverge from established industry or regional benchmarks. Another commenter suggested that excluding unlinked chart review records (CRRs) may reduce MA coding intensity but mentioned that plans could mitigate the impact by recapturing excluded diagnoses by converting unlinked CRRs into linked CRRs, thereby limiting the proposal's effectiveness and potentially offsetting its intended impact. A few commenters urged CMS to exclude the demographic component of the risk score from the coding pattern adjustment, stating that the adjustments should apply only to diagnosis-based components to better target differences in coding rather than demographic trends.

Response: We appreciate the suggestion and are regularly evaluating ways to improve the accuracy of the data we receive and the payments that we make. The coding pattern adjustment is applied to account for the impact on MA risk scores of the differential coding patterns between MA and FFS, whereas the primary goal of the RADV audits is to address improper payments to MA organizations. The coding pattern difference adjustment does not absolve MA organizations of the longstanding obligation to ensure compliance with risk adjustment requirements.

CMS also appreciates stakeholder thoughts regarding the link between MA coding and unlinked CRRs and the application of the MA coding pattern adjustment factor. We acknowledge the impact of excluding diagnoses from unlinked CRRs may differ across MA organizations. However, the unlinked CRR policy is not intended to achieve a specific impact on MA risk scores or differences in coding patterns between FFS and MA. The finalized policy to exclude diagnoses from unlinked CRRs from risk adjustment, with an exception for beneficiaries switching between MA organizations from one year to the next, is meant to promote data and program integrity. CMS's risk adjustment rules require that risk adjustment diagnoses be from a face-to-face visit with a qualified healthcare provider (QHP). By requiring MA organizations to link diagnoses submitted on CRRs to an encounter to be eligible for risk adjustment, CMS will have precise information on how diagnoses are associated with services provided to MA enrollees and be able to ensure that the diagnoses included for risk adjustment align with program requirements.

Regarding the exclusion of the demographic component from the coding pattern adjustment, we recognize that the CMS-HCC risk adjustment model includes both demographic and diagnosis-based (HCC) components, and the combined role these components play in predicting beneficiary costs. CMS applies the factor as required by statute. Per section 1853(a)(1)(C)(ii)(IV) of the Act, CMS is required to apply a coding adjustment to risk scores to reflect differences in diagnostic coding patterns between MA and FFS.

Comment: A few commenters cited recent research indicating that coding differences between MA and FFS have narrowed significantly under the 2024 CMS-HCC risk adjustment model. They expressed concern that additional reductions to MA risk scores could result in underfunding MA plans relative to FFS costs and may result in an overcorrection.

Response: CMS appreciates these comments and the references to recent research on coding pattern differences. CMS will continue to monitor emerging research and data as it develops future proposals.

Section M. Normalization Factors for the CMS-HCC Risk Adjustment Models

Comment: Several commenters supported the Part C normalization methodology as proposed.

Response: CMS appreciates the support.

Comment: Several commenters requested greater transparency into the normalization factor, including the distinct impact of the normalization factor on payment, additional normalization methodologies that CMS considered, and that CMS clarify whether skin substitutes or CMS Value Based Insurance Design (VBID) demonstration influenced the normalization factor.

Response: When CMS updates a CMS-HCC risk adjustment model for a year, it may make a variety of updates. The CMS-HCC model proposed for CY 2027 was updated to include more recent underlying FFS diagnosis and expenditure data, which allows the model coefficients to reflect more recent costs and coding trends that improved the accuracy of the model, and an updated denominator year, which brought the year in which the 1.0 FFS risk score is set to a more recent year.

The denominator update has a direct impact on the normalization factor, which serves the purpose of keeping the average FFS risk score at 1.0 in each payment year. For any given model, risk scores tend to increase over time due to changes in population and coding practice and therefore, when a risk adjustment model predicts expenditures in years other than the denominator year, the average FFS risk score may no longer be 1.0, as it was in the denominator year. Consequently, for each payment year, CMS calculates a normalization factor for each model to project the average FFS risk score from the denominator year to the payment year. We apply this normalization factor to all risk scores from that model to account for underlying trends in FFS coding and population from the denominator year to the payment year to keep the average FFS risk score at the same average (1.0).

Updating the denominator year to a more recent year brings the 1.0 year closer to the payment year so there are fewer years of trend to account for through normalization, resulting in a normalization factor that is typically lower than the normalization factor used with a risk adjustment model with an older denominator year. Because the normalization factor is lower, the impact of normalization is positive, offsetting the downward impact of the CMS-HCC model

proposed for CY 2027. If the normalization factor impact is broken out from the combined risk adjustment model revision and normalization impact, the remaining impact is that of the model on risk scores without consideration for underlying trend (i.e., the raw model impact). The raw model impact does not measure actual payment impacts because a good proportion of the difference in risk scores between models is due to differences in trend. As a result, a model update is intertwined with the normalization factor, and for this reason CMS included the combined impact in the Fact Sheet. If the raw impact of the proposed risk adjustment model and the impact of the model's updated normalization factor proposed for CY 2027 are broken out from one another, the impact of the raw risk adjustment model revisions is -4.16%, and normalization is +0.84%. Again, we note that the raw risk adjustment model impact taken alone is not a payment impact because it is conflated with underlying differences in trend between the two models.

The normalization payment impact is not directly affected by the inclusion or exclusion of skin substitutes from the CMS-HCC model because risk scores used to calculate a model's normalization factor for a year are calculated with the same set of CMS-HCC model relative factors. For example, each risk score used to calculate the 2027 CMS-HCC model normalization factor was calculated using the 2027 CMS-HCC model. The trend can differ between CMS-HCC models as the model coefficients differ and predict different levels of risk for the same population. Regarding concerns about the influence of the VBID demonstration on the normalization factor, VBID does not impact the normalization trend because that model only applies to MA, and normalization is based on the trend in FFS risk scores.

Comment: A number of commenters also suggested alternative methods. These commenters think the proposed five-year multiple linear regression approach results in a normalization factor that is too high because it relies on 2021 through 2025 data that commenters believe over emphasizes the recovery in risk scores from the COVID-19 pandemic and that CMS should instead exclude risk scores from 2021 and/or 2022. Other commenters suggested generally that CMS should include more years before 2021 in the trend or otherwise account for the commenters' belief that the pre-pandemic trend will better represent FFS risk growth from 2025 to 2027 than the post-pandemic trend.

Response: Because the most recent five years in the risk score trends are in the "post-COVID-19" period for CY 2027, there was no longer an adjustment for the pre- and post-pandemic experience and, as noted in the CY 2027 Advance Notice, the value of the coefficient for the COVID-19 flag in a multiple linear regression is zero. Consequently, there is no difference in the normalization factor calculated with a multiple linear regression methodology that includes a COVID-19 flag (all with a value of 1) compared to a simple linear regression methodology that does not include a COVID-19 flag. Since the COVID-19 flag no longer has an impact on the normalization factor calculation, CMS removed the flag for simplicity.

CMS acknowledges that the inclusion of the 2021 risk score in the FFS trend used to calculate the normalization factors without an adjustment leads to a higher normalization factor than if we relied on the most recent three (2023 through 2025) or four years (2022 through 2025). FFS risk scores under the 2024 CMS-HCC model increased 2.5 percent from 2021 to 2022 and increased 1.8 percent per year on average from 2022 through 2025. Most recently, FFS risk scores increased 2 percent from 2024 to 2025. The normalization factor for the 2024 CMS-HCC model under the proposed five-year multiple linear regression normalization calculation methodology (1.083)[10] assumes FFS risk scores will grow by 1.8 percent per year from 2025 to 2027, a rate below the growth for the most recent period. We do not see evidence that FFS risk score growth is returning to pre-pandemic trends of around 1 percent per year by 2027 and do not think this assumption is reasonable given the data available. However, a normalization factor calculated with a simple linear regression method and data from the most recent three years (1.080) or most recent four years (1.079) does produce a reasonable estimate of growth from 2025 to 2027 of 1.7 percent and 1.6 percent respectively. We acknowledge there is uncertainty with any prediction and believe it is reasonable to assume FFS risk score growth could slow from the most recent period. Given this, in response to suggestions from commenters, we are adopting a simple linear regression methodology to calculate the normalization factors for all CMS-HCC models using the most recent four years of data (2022 – 2025) for CY 2027. We anticipate returning to the most recent five years of data available for CY 2028. The average FFS risk scores, as previously published in the CY 2027 Advance Notice, are provided in Table III-3 and the regression coefficients and final normalization factors for CY 2027 are provided in Table III-4.

Table III-3. Average FFS Risk Scores for the CMS-HCC Models

Year	2024 CMS-HCC Model	2017 CMS-HCC model	2023 ESRD Dialysis CMS-HCC Model	2019 ESRD Dialysis CMS-HCC Model	2023 ESRD Functioning Graft CMS-HCC Model	2019 ESRD Functioning Graft CMS-HCC Model
2021	0.968	1.053	0.997	1.047	0.975	1.054
2022	0.992	1.084	1.006	1.060	1.006	1.086
2023	1.009	1.108	1.022	1.080	1.029	1.110
2024	1.025	1.131	1.032	1.095	1.051	1.135
2025	1.045	1.155	1.046	1.111	1.074	1.160

[10] We note that the normalization factor for the 2024 CMS-HCC model calculated using five years of average FFS risk scores is 1.083 under a multiple linear regression approach where all values for the COVID-19 flag are 1 and under a simple linear regression approach that excludes the COVID-19 flag from the calculation.

Table III-4. CMS-HCC Model Normalization Factors and Regression Coefficients for CY 2027

Coefficient	2024 CMS-HCC Model	2017 CMS-HCC model	2023 ESRD Dialysis CMS-HCC Model	2019 ESRD Dialysis CMS-HCC Model	2023 ESRD Functioning Graft CMS-HCC Model	2019 ESRD Functioning Graft CMS-HCC Model
Intercept (β_0)	-34.3935	-46.6351	-25.2790	-32.9083	-44.6911	-48.8577
Average Change in FFS Risk Scores (β_1)	0.0175	0.0236	0.0130	0.0168	0.0226	0.0247
Normalization Factor	**1.079**	**1.202**	**1.072**	**1.145**	**1.119**	**1.209**

Comment: Some commenters requested that CMS exclude the demographic component of the risk score when developing the normalization factor and that CMS should apply the normalization factor only to the diagnosis portion of the MA risk score because the demographic portion of the risk score is not influenced by trends in health status or documentation.

Response: The CMS-HCC model normalization factor is a technical adjustment applied to risk scores to keep the average MA risk score relative to an average 1.0 risk score in FFS. The risk score is made up of a demographic component and a diagnosis component and both are used to predict the overall risk relative to the average in FFS. The average FFS risk score for the proposed model is 1.0 in 2024, the year used to set the denominator for creation of the relative factors. However, the average FFS risk score can change over time due to underlying trends in FFS health status, demographic characteristics, and coding practices. Accordingly, the technical normalization adjustment must be developed with and applied to the entire risk score to fully account for the FFS risk score changes between the denominator year and payment year and maintain the average FFS risk score at a 1.0 in the payment year (2027).

Section N. Sources of Diagnoses for Risk Score Calculation

Non-PACE Organizations

Comment: Some commenters supported excluding diagnoses from audio-only services in alignment with the long-standing face-to-face requirement, citing their belief that the synchronization is appropriate. Commenters expressed the view that diagnoses used for risk-adjusted payment should reflect encounters that meet the longstanding face-to-face requirement and that the proposed exclusion would strengthen consistency between model calibration and

data submission practices. Commenters acknowledged that diagnoses from telehealth visits are eligible for risk adjustment when those visits meet all criteria for risk adjustment eligibility and noted their belief that they have always interpreted this to prohibit diagnoses from audio-only services.

Response: CMS is finalizing the proposal to exclude diagnoses from audio-only encounters. While the proposal was to exclude diagnoses from the 2027 CMS-HCC model calibration and risk score calculation, and CMS is not finalizing the proposed 2027 CMS-HCC model calibration, we will still exclude diagnoses from audio only services from risk score calculation using the 2024 CMS-HCC model. The isolated average impact of excluding diagnoses from audio only services is 0.00% under both the proposed 2027 CMS-HCC model and the 2024 CMS-HCC model. This exclusion is operationalizing previously issued CMS guidance and ensures that the risk adjustment reflects documentation standards requiring diagnoses to be supported by clinically appropriate encounters and the longstanding CMS guidance that diagnoses must result from a face-to-face encounter to be eligible for risk adjustment.[11] CMS will only exclude diagnoses from audio only services if no other service reported on the encounter is eligible for risk adjustment when applying the filtering logic. In excluding diagnoses from audio-only encounters for risk score calculation, CMS is in no way prohibiting the use of audio services as a means of providing beneficiary care. For the purposes of risk adjustment, a diagnosis that results from a face-to-face visit, and meets all other criteria, will be considered for risk adjustment if it occurs at any point during the applicable data collection period.

Telehealth services can satisfy the face-to-face requirement when delivered through an interactive audio and video telecommunications system that enables real-time, two-way communication between the provider and patient. Audio-only services do not meet this requirement when an encounter record contains only service lines with audio-only modifiers, it indicates that no face-to-face interaction occurred, and therefore those diagnoses are not eligible for risk adjustment.

Comment: A few commenters opposed the proposal to exclude diagnoses derived from audio-only encounters, stating that audio-only services remain an important access modality, particularly in rural and underserved areas, and that exclusion could reduce equitable recognition of clinical complexity for beneficiaries who rely on audio-only services to access care. Several commenters similarly requested delay or phased implementation of the exclusion, citing operational readiness concerns and potential beneficiary impacts.

Response: As discussed in the CY 2027 Advance Notice, the exclusion of diagnoses derived from audio-only encounters is consistent with previously issued CMS guidance and aligns the

[11] See the May 4, 2022, HPMS memorandum: "Risk Adjustment Processing System (RAPS) and Encounter Data System (EDS) Submission – UPDATE" and Chapter 7 of the Medicare Managed Care Manual https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/mc86c07.pdf

risk adjustment model with documentation standards that require diagnoses to be supported by encounters that meet applicable clinical standards.

Consistent with longstanding policy, diagnoses must result from a face-to-face encounter to be considered for risk adjustment. Diagnoses resulting from telehealth services can meet the face-to-face requirement when services are provided using an interactive audio and video telecommunications system that permits real-time interactive communication. Records that include only lines with audio-only modifiers indicate that no services were provided in a face-to-face manner and, therefore, do not meet the face-to-face requirement for risk adjustment eligibility. The impact of the exclusion on plan risk scores is expected to be minimal since CMS guidance does not permit these diagnoses currently and because CMS will continue to include all diagnoses from encounters with another procedure code that meets CMS risk adjustment criteria. Excluding audio-only diagnoses starting in 2027 is a technical update to operationally align with the face-to-face policy by excluding diagnoses that are solely audio-based telehealth services.

We are finalizing the proposal for the technical operational adjustment to exclude diagnoses obtained from audio-only encounters using modifier "93" or "FQ" (where applicable) from risk score calculation when no other line on the encounter data record, chart review record, or FFS claim is risk adjustment eligible. In excluding diagnoses from audio-only encounters for risk score calculation, CMS is in no way prohibiting the use of audio services as a means of providing beneficiary care.

Comment: A minority of commenters supported CMS's proposal to exclude diagnoses from unlinked chart review records (CRRs) from risk score calculation. These commenters stated that diagnoses used for risk-adjusted payment should be tied to documented clinical encounters and expressed concern that unlinked CRRs have contributed to coding intensity and overpayments in the MA program. Several commenters cited prior findings by the Office of Inspector General (OIG) and the Medicare Payment Advisory Commission (MedPAC) in support of the proposal and stated that the exclusion would improve payment accuracy and promote a more level playing field across MA organizations. Some commenters encouraged CMS to go further by also excluding diagnoses derived from linked chart reviews or health risk assessments not associated with treatment.

Response: CMS appreciates the support expressed by these commenters. We are finalizing the proposal to exclude diagnoses from unlinked CRRs with an exception for beneficiaries who switch between MA organizations from one year to the next as discussed in more detail later in this section. We agree with commenters that excluding diagnoses from unlinked CRRs will improve payment accuracy and enhance data and program integrity.

Comment: Most commenters generally opposed the proposal to exclude diagnoses from unlinked CRRs from risk score calculation without exceptions. These commenters stated that while program integrity is an important objective, the proposed categorical exclusion would create

unintended payment inaccuracies, particularly where clinically valid diagnoses cannot be technically linked to an encounter data record (EDR) due to operational or data-sharing constraints. Commenters expressed concern that the proposal would disproportionately affect certain beneficiaries and smaller or regional plans and urged CMS to adopt targeted exceptions such as for beneficiaries switching between MA organizations from one year to the next, for clinical interactions that do not generate a claim, or additional safeguards to avoid undermining accurate risk adjustment by maintaining an alternate submission method. Commenters also requested that CMS provide detailed technical guidance to support implementation, and many commenters urged CMS to delay or phase in implementation of the exclusion of diagnoses from unlinked CRRs, citing bid development timelines, provider workflow adjustments, and encounter submission system changes. Commenters stated that immediate implementation would create operational disruption and argued that MA organizations have not had sufficient time to modify their submission processes.

Response: CMS guidance requires that items or services provided to an enrollee under the MA plan must be reported on an EDR; a CRR should not be the only record with information about a healthcare item or service provided to a plan enrollee. This includes the data for clinical interactions that do not generate a claim. EDRs are not claims and thus an EDR can be reported for items and services provided to beneficiary but not paid through a claim. When a CRR is submitted on an unlinked basis, the MA organization does not identify a previously submitted EDR with which the diagnoses should be associated, nor is information about which items and services were provided to the enrollee required to be included. As a result, for unlinked CRRs, it is unclear which service or services generated the diagnoses submitted for risk adjustment consideration. CMS has consistently emphasized that risk-adjusted payment should reflect the documented health status of beneficiaries as evidenced by clinical encounters. CMS has provided detailed guidance and technical assistance on the submission of data to the encounter data system and as a result there have been improvements in EDR submissions. We do not believe an alternative submission method is necessary. If additional diagnoses need to be submitted for an encounter, a CRR can be linked to the EDR. We recognize there may be challenges managing data for some plans and their vendors but given the maturity of the encounter data and the program integrity concerns with unlinked CRRs, for which there is no associated encounter, CMS believes that requiring diagnoses to be linked to an actual service record for risk score consideration supports ongoing efforts to ensure more accurate payments. Additional technical operational implementation information will be provided at a later date.

With respect to commenters' concerns regarding the disproportionate impact on high-risk and complex beneficiaries, CMS notes that MA organizations retain the ability to submit diagnoses for risk adjustment through EDRs and linked CRRs. The exclusion applies only to diagnoses submitted on unlinked CRRs and does not affect diagnoses that are associated with documented items and services. For commenters' concerns regarding the impact on smaller and regional

plans, CMS notes that the policy applies uniformly across all MA organizations and is intended to promote consistency and payment accuracy across the program.

CMS provided advance notice of this proposal in accordance with section 1853(b)(2) of the Act, and believes that MA organizations have sufficient time to adjust their submission practices prior to the effective date. MA organizations have until at least January 31, 2028 to submit data for payment. Delaying or phasing in the exclusion of diagnoses from unlinked CRRs would allow a data submission practice to continue that CMS believes jeopardizes data and program integrity. CMS analysis finds that a significant majority (approximately 85 percent) of the 88.8 million unlinked CRRs submitted in 2023 for 2024 payment could not be associated with any submitted encounter when matching on basic information like beneficiary, billing provider, and dates of service within three days. CMS believes a significant majority of these unlinked CRRs should have been submitted as an encounter that accurately documents the services provided that led to the diagnoses or can be linked to an existing encounter. However, we recognize that in situations where a beneficiary has switched between MA organizations from one year to the next the receiving plans may face operational constraints in linking diagnoses to prior-year encounter data. In order to mitigate the operational challenges in this circumstance, CMS is finalizing its proposal for CY 2027 with a modification. 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. In these circumstances, diagnoses reported on unlinked CRRs will be included for risk adjustment if they otherwise meet risk adjustment criteria. Thus, CMS is finalizing the proposal to exclude diagnoses from unlinked CRRs with an exception for beneficiaries who switch between MA organizations from one year to the next.

Comment: Several commenters expressed concern that certain chronic conditions may not generate claim-based encounters in every plan year and that categorical exclusion of unlinked CRRs could underrepresent the true disease burden of high-risk and complex beneficiaries. A few commenters noted that some clinically valid services do not generate traditional claims and argued that exclusion of unlinked CRRs in these circumstances could reduce payment accuracy.

Response: CMS appreciates the comments received. MA organizations are required under 42 CFR § 422.310 to submit encounter data for each item and service provided to a Medicare enrollee. As previously stated, the exclusion of unlinked CRRs from risk score calculation does not preclude MA organizations from submitting unlinked CRRs, or from ensuring that clinically valid diagnoses are captured for risk adjustment through submission of an EDR or a linked CRR to associate diagnoses with a known encounter.

Comment: A few commenters sought clarification on effective dates, date-of-service treatment, or model calibration impacts. These commenters did not clearly express support or opposition to the policy but requested technical confirmation. Several commenters requested additional operational guidance regarding how CMS would define and operationalize linkage between

chart review records and encounter data. Commenters requested clarification on acceptable linkage standards, timing requirements, technical parameters, and data-sharing mechanisms. Some commenters recommended CMS publish impact analyses, provide scorecards, or convene stakeholder discussions prior to implementation.

Response: The CY 2027 Rate Announcement announces the MA capitation rates and final payment policies that are effective for CY 2027. CMS-HCC risk adjustment models are prospective, meaning that they use diagnostic information from a base year to predict relative costs for the following year. Final risk adjusted payments for CY 2027 will be based on diagnoses from CY 2026 dates of service. The exclusion of diagnoses from unlinked CRRs from risk score calculation has no model calibration impact because the CMS-HCC models are based on diagnoses and costs from FFS where there is no analogous submission practice. CMS will continue to consider future opportunities to provide additional resources and engage with stakeholders as we evaluate and implement finalized risk adjustment policies.

PACE Organizations

Comment: All comments that CMS received related to the phase in of the submission of risk adjustment through the encounter data system for PACE organizations were supportive of the transition to a 50/50 blended methodology — comprising 50 percent of the risk score calculated using eligible diagnoses derived from the RAPS, encounter data, and FFS claims, and 50 percent of the risk score calculated using eligible diagnoses derived exclusively from encounter data and FFS claims. All of the commenters also expressed appreciation for CMS in providing ample support and guidance to facilitate as straightforward a transition as possible, with some commenters citing specific CMS resources as particularly helpful in that regard, such as the January 29, 2024, Health Plan Management System (HPMS) memorandum that provided specific instruction to PACE organizations on submission of encounter data to the encounter data system. Commenters noted their anticipation of continued collaboration with CMS throughout the implementation of the proposed accelerated transition timeline — one they acknowledged addresses the operational objectives of CMS while acknowledging the operational and administrative challenges associated with encounter data reporting that some PACE organizations may come across.

Response: CMS thanks commenters for their engagement and feedback on this matter. CMS is finalizing the proposal to calculate PACE risk scores using 50 percent of the risk score using eligible diagnoses derived from the RAPS, encounter data, and FFS claims, and 50 percent of the risk score calculated using eligible diagnoses derived exclusively from encounter data and FFS claims. CMS remains committed to working closely with PACE organizations and to providing ongoing technical assistance and guidance to support the successful submission of all necessary data. CMS will also continue to provide technical support to PACE organizations throughout this process and will actively monitor and engage in dialogue regarding the successes and challenges

PACE organizations experience in connection with encounter data submission, with the goal of ensuring a smooth and effective implementation.

Comment: A commenter expressed support for CMS's proposal to maintain the allowance for unlinked CRRs for PACE organizations in CY 2027. They stated that as PACE organizations continue transitioning toward full reliance on encounter data submissions, maintaining the CRR allowance provides operational continuity and mitigates disruption as encounter reporting processes mature. Furthermore, the commenter noted that preserving this flexibility in CY 2027 supports stability while shifting towards encounter-based risk adjustment.

Response: CMS thanks the commenter for their support. CMS is finalizing the proposal to include diagnoses from unlinked CRRs 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

Comment: A commenter expressed concern that the benefit parameters indexed by the Annual Percentage Increase (API), together with CMS's definition of incurred costs, are resulting in increases in the deductible and other benefit thresholds that may affect beneficiary affordability. The commenter requested that CMS leverage existing flexibility to refine the API calculation, reduce excessive volatility in benefit parameters, and ensure beneficiary affordability and access.

Response: We appreciate the commenter's concern regarding the impact of the API on the indexing of the Part D benefit parameters, including the deductible, and the potential implications for affordability. The methodology for calculating the API is specified in section 1860D-2(b)(6) of the Act, which requires CMS to determine the API based on the annual percentage increase in average per capita aggregate expenditures for covered Part D drugs in the United States for Part D eligible individuals. Additionally, in the CY 2027 final rule (CMS-4208-F3/CMS-4212-F) titled, "Contract Year 2027 and Certain Contract Year 2026 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program," CMS codified in regulation its longstanding methodology used to calculate the API to promote transparency and predictability in the determination of the Part D benefit parameters. As such, CMS does not have flexibility to change the API calculation methodology in this Rate Announcement.

CMS notes that the commenter's concerns regarding the definition of incurred costs is outside the scope of the CY 2027 Rate Announcement.

Comment: A commenter expressed support for IRA-related Part D benefit changes but requested CMS consider future modifications to beneficiary copay limits, particularly in light of rising specialty drug utilization (including GLP-1 therapies).

Response: CMS thanks the commenter for their support. CMS notes that the commenter's request for CMS to consider future modifications to beneficiary copay limits is outside the scope of the CY 2027 Rate Announcement.

Section B. Part D Premium Stabilization

Comment: A commenter referenced the expiration of the IRA premium stabilization provision after CY 2029 and suggested that CMS assess long-term policy options to mitigate potential future premium volatility. A commenter also recommended that CMS consider policy options to address a potential "premium cliff" when IRA premium stabilization ends after CY 2029.

Response: CMS thanks the commenters for their input and suggestions but notes that policy options regarding the expiration of the IRA premium stabilization provision after CY 2029 are outside the scope of the CY 2027 Rate Announcement.

Comment: Several commenters expressed support for continuation of the voluntary Part D premium stabilization demonstration for participating PDPs. Commenters noted that plans are currently managing significant structural changes in the Part D benefit, including elimination of beneficiary cost sharing in the catastrophic phase, increased plan liability, and evolving utilization patterns for high-cost specialty drugs, including GLP-1 therapies. In this context, commenters characterized the demonstration as a necessary bridge mechanism to reduce premium volatility and preserve stability in the standalone PDP market.

A few commenters opposed continuation of the voluntary PDP premium stabilization demonstration, arguing that the demonstration may complicate bid development and shift cost burden toward enrollees, distort market incentives, or delay necessary pricing adjustments under the redesigned Part D benefit structure. Some suggested that CMS consider additional mechanisms to support market stabilization and affordability beyond the voluntary PDP premium stabilization demonstration, such as extending the demonstration to MA-PD plans or exploring modifications to risk corridors.

Some commenters also requested that CMS confirm continuation of the premium stabilization demonstration in the CY 2027 Rate Announcement and release its parameters as early as possible in the bidding cycle to facilitate accurate bid development.

Response: CMS thanks the commenters for their input. For the voluntary Part D premium stabilization demonstration for CY 2026, CMS reduced the amount of premium stabilization from the government to facilitate the Part D program's return to operating under regular market conditions.

Without first receiving and analyzing bids submitted for CY 2027, CMS cannot assess whether additional premium stabilization may be necessary or determine the appropriate parameters for any potential continuation of the demonstration. Analysis of CY 2027 bid submissions will allow CMS to evaluate market conditions and determine whether Part D sponsors have sufficient experience with the redesigned benefit to develop stable actuarial projections for PDP bids without additional stabilization measures.

We also remind Part D plan sponsors that, under the statute per section 1860D–11 of the Act, the Secretary has the authority to negotiate the terms and conditions of proposed bids and does not have to accept any or every Part D bid submitted.

Consistent with the terms of the demonstration for CY 2026 as announced in July 2025, CMS will announce any additional premium stabilization for participating PDPs for CY 2027, if applicable, no later than the annual release of the National Average Monthly Bid Amount (NAMBA), Part D base beneficiary premium (BBP), and related Part D bid information in summer 2026.

Comment: A number of commenters expressed concern about additional uncertainty in the Part D market related to the planned start of the BALANCE (Better Approaches to Lifestyle and

Nutrition for Comprehensive hEalth) Model in CY 2027. Some of these commenters pointed to the Model rollout alongside other changes and challenges for the Part D market (e.g., proposed risk adjustment changes, increasing utilization, concurrent CMS Innovation Center models) as an area of concern. Another commenter requested that the performance period for the Medicare GLP-1 Bridge be extended to at least one calendar year before BALANCE begins. A few commenters expressed concern about the impact of BALANCE on specific market segments, such as EGWPs or PDPs.

Response: CMS thanks commenters for their input but notes that the design and implementation of CMS Innovation Center models and the Medicare GLP-1 Bridge are outside the scope of this Rate Announcement.

Section C. Part D Calendar Year EGWP Prospective Reinsurance Amount

Comment: A few commenters expressed support for continuing the CY 2025 methodology for calculating Part D Calendar Year EGWP prospective reinsurance payment amounts. Some of these commenters noted that employer group markets are particularly sensitive to premium volatility under the IRA redesign and encouraged CMS to prioritize stability for EGWP sponsors.

Response: CMS thanks the commenters for their support. CMS plans to announce the CY 2027 prospective reinsurance payment amount for Part D Calendar Year EGWPs with the annual release of the NAMBA, Part D BBP and related Part D bid information in the summer of 2026.

Section D. Part D Risk Sharing

Comment: A commenter expressed support for CMS's decision to eliminate narrowed risk corridors for the voluntary Part D premium stabilization demonstration for CY 2026.

Response: CMS thanks the commenter for their support. We refer you to Section B of this attachment for additional discussion of the Part D premium stabilization demonstration.

Comment: A commenter expressed support for CMS's proposal not to widen the risk corridors for CY 2027.

Response: CMS thanks the commenter for their support.

Comment: Some commenters requested that CMS narrow Part D risk corridors as a way to address heightened uncertainty with Part D redesign and specialty drug trends. Specifically, several commenters suggested CMS use demonstration authority under section 402 to adopt two-sided narrowed risk corridors for CY 2027 for both MA-PDs and PDPs. A few commenters expressed concern about increased uncertainty in the market because of concurrent program changes in Medicare (including IRA Part D redesign, MFPs taking effect for selected drugs under the Medicare Drug Price Negotiation Program, and CMS Innovation Center models).

Response: As noted in the CY 2027 Advance Notice, under section 1860D-15(e)(3)(C) of the Act and § 423.336(a)(2)(ii), CMS may establish a risk corridor with higher threshold risk percentages for Part D risk sharing. However, the statute does not permit CMS to narrow the corridors relative to the CY 2011 thresholds. While CMS acknowledges commenters' suggestions to use demonstration authority under section 402 of the Act to narrow the risk corridors, we note that doing so is outside of the scope of this document.

Section E. Retiree Drug Subsidy Amount

No comments received.

Section F. RxHCC Risk Adjustment Model

Comment: Many commenters expressed support for updating the RxHCC model to use diagnoses from 2023 FFS claims and MA encounter data and gross drug costs from 2024 prescription drug events (PDEs), as well as for updating the denominator year to 2024. Several commenters expressed support for updating the RxHCC models to account for changes in the Part D standard benefit design for CY 2027. Commenters in support of these proposed policies stated that the updates were needed to best reflect utilization and spending patterns in the payment year.

A commenter expressed support for the proposal to exclude diagnoses from audio-only services from the model calibration, stating that the RxHCC model should align with existing guidelines, as audio-only services have never been an allowable source of diagnoses for risk adjustment.

Several commenters also expressed support for the proposal to use separate continuing enrollee model segments for MA-PD plans and PDPs. Some of these commenters noted that using separate segments improved predictive accuracy by addressing historical overprediction of costs for MA-PD plans and underprediction of costs for PDPs. A commenter further expressed support for the proposal by saying that it would ensure sustainable drug coverage for beneficiaries in EGWPs. Other commenters stated that the proposal would have positive impacts on stability in the PDP market, with a commenter further stating that it would better account for increased plan liability for non-low-income beneficiaries.

Response: CMS thanks the commenters for their support and, for CY 2027, is finalizing the updates that reflect the CY 2027 Part D benefit, including the 2026 MFPs, for both RxHCC models (i.e., the 2023/2024 calibration and the 2018/2019 calibration), as proposed. Additionally, the 2023/2024 calibration being finalized uses updated data years, excludes diagnoses resulting from audio-only services identified by modifier "93" or "FQ," and has separate segments for PDPs and MA-PD plans, as proposed.

Comment: Several commenters were opposed to the proposal to use separate continuing enrollee model segments for MA-PD plans and PDPs. Some of these commenters stated that using

separate segments disadvantages MA-PD plans and would result in fragmented care for low-income beneficiaries, with one commenter stating that observed differences in risk scores and trends are driven in part by care coordination efforts inherent to the MA-PD model. Another commenter further stated that CMS should not use separate model segments for MA-PD plans without distinguishing between I-SNPs and other MA-PD plans because the commenter believed that I-SNPs have limited resources to devote to coding practices to optimize risk adjustment outcomes. A few additional commenters opposed the proposal by stating that using separate model segments would create negative financial impacts for MA-PD plans in the Part D market, expressing concerns related to decreased MA-PD plan revenue and reallocation of costs in the market from MA-PD plans to PDPs, as well as concerns about premium impacts for MA-PD plans. A commenter stated that differences between MA-PD plans and PDPs are driven in part by risk adjustment data asymmetry, suggesting that CMS provide additional data to PDP sponsors for risk adjustment purposes instead of using separate model segments.

Response: CMS appreciates the commenters' concerns. We have previously acknowledged that the differential in predicted costs in the risk adjustment model between MA-PD plans and PDPs is due in part to underlying differences in the MA-PD and PDP sectors themselves–including the lack of an ability by PDPs to affect the submission of diagnoses in FFS and available strategies used to manage Part D costs. The RxHCC risk adjustment model is intended to predict relative costs in the Part D market, for both MA-PD plans and PDPs. It is not intended to influence plan behavior around plan design or the provision of services to beneficiaries.

We believe that updating the model to use separate model segments results in more appropriate relative weights for the RxHCCs because the relative weights reflect the utilization and cost patterns of the MA-PD and PDP markets separately, thereby improving the model's predictive accuracy.

We regularly consider how to improve the RxHCC model and will continue to examine options for model refinements and data provision to plan sponsors for future years.

Comment: Several commenters expressed concern that the proposed model did not adjust gross drug costs to account for the MFPs of selected drugs for IPAY 2027 because the agreed-upon MFPs for selected drugs for IPAY 2027 were not available in time for calibration of the CY 2027 RxHCC models. Commenters stated that not adjusting for the MFPs for selected drugs for IPAY 2027 could result in inaccurate estimates of plan liability, with one commenter stating that costs for selected drugs for IPAY 2027 would be overpredicted while projected costs for other drugs would be underpredicted. Some of these commenters requested that CMS make adjustments for selected drugs for IPAY 2027 in the finalized model for the Rate Announcement since the agreed-upon MFPs for IPAY 2027 have been released, while others requested that CMS take steps to ensure that MFPs for selected drugs for IPAY 2028 are incorporated into the CY 2028 model calibration. A commenter further suggested that if agreed-upon MFPs are not

available in time for model calibration, CMS should use an MFP substitute (such as ceiling prices) in the model calibration for CY 2028.

Response: While we acknowledge that the agreed-upon MFPs for IPAY 2027 were released in November 2025, we reiterate that this timing did not allow for their incorporation into the RxHCC model calibration for the CY 2027 Advance Notice. Further, incorporating these agreed-upon MFPs into the Rate Announcement would not allow sufficient time for commenters to review and provide comment on the updated model. We anticipate incorporating MFPs for the selected drugs for IPAY 2027 into the RxHCC model calibration for CY 2028 and will assess options for incorporating alternatives to agreed-upon MFPs for future years.

Comment: A few commenters expressed concerns about the proposal to continue to reflect agreed-upon MFPs for selected drugs for which an MFP is in effect for IPAY 2026 in the CY 2027 calibration. These commenters stated that substituting gross drug costs with MFPs without accounting for direct and indirect renumeration (DIR) from manufacturer rebates could result in distorted plan liability estimates. Additionally, the commenters stated that CMS has not had time to assess the impact of MFPs on Part D spending and liability, noting that reduced-cost sharing for these drugs incentivizes higher utilization, which the commenters believed would result in misaligned cost estimates in the model. One of these commenters requested that CMS not finalize the proposal to continue to reflect IPAY 2026 MFPs in the model, while another commenter requested that CMS only update the RxHCC model to reflect MFPs once CMS has more data about utilization and beneficiary behavior due to the MFPs.

Response: CMS appreciates the commenters' concerns about the impact of MFPs on plan liability estimates. We continue to believe that using the agreed-upon MFPs that CMS published, when these MFPs are available in time for model calibration, rather than the gross drug costs on the PDE records for these drugs, allows the model to more accurately reflect plan liability in the model. If the model did not use the agreed-upon MFPs, it would likely overestimate the expected plan liability for conditions that are treated with these drugs. This would not only overestimate relative costs for RxHCCs with conditions that are prevalently treated using these drugs, but it would also likely underestimate relative costs for RxHCCs for which treatment for the conditions is not associated with these drugs.

Regarding the comments about the impact of MFPs on utilization, we do not believe it is appropriate to model expected changes in behavior for incorporation into the model. We believe that modeling future behavior would result in error in the model and inaccurate predictions of relative costs. Instead, we believe it is prudent to calibrate on the most recent available data and wait to account for changes in utilization in future iterations of the model.

With regard to the comment about use of DIR data, this data for non-selected drugs in 2027 is not known and will likely differ from the data currently available to CMS. We will continue to consider if and how to make adjustments for DIR in future recalibrations.

Comment: A commenter expressed concern about the proposal to exclude diagnoses from unlinked chart review records from the model calibration. The commenter stated that the risk adjustment model should reflect the most complete and accurate clinical picture and excluding them from the model calibration would understate morbidity and expected costs.

Response: CMS appreciates the commenter's concern. CMS has consistently emphasized that risk-adjusted payment should reflect the documented health status of beneficiaries as evidenced by clinical encounters. CMS guidance requires that items or services provided to an enrollee under the MA plan must be reported on an EDR; a CRR should not be the only record with information about a healthcare item or service provided to a plan enrollee. When a CRR is submitted on an unlinked basis, the MA organization does not identify a previously submitted EDR with which the diagnoses should be associated, nor is information about which items and services were provided to the enrollee required to be included. As a result, for unlinked CRRs, it is unclear which service or services generated the diagnoses submitted for risk adjustment consideration. CMS has provided detailed guidance and technical assistance on the submission of data to the encounter data system and as a result there have been improvements in EDR submissions. Given the maturity of the encounter data and the program integrity concerns with unlinked CRRs, for which there is no associated encounter, CMS believes that requiring diagnoses to be linked to an actual service record supports ongoing efforts to ensure more accurate payments.

Comment: Several commenters expressed general concerns about the use of historical data in the RxHCC model calibration sample, stating that data from before the IRA benefit changes took effect does not reflect the cost or utilization trends expected in the payment year after these benefit changes have taken effect. Some of these commenters stated examples such as rising GLP-1 usage or increased spending on specialty drugs. Additionally, a few commenters requested that CMS make adjustments to the model to reflect expected utilization changes or to account for new drugs entering the market. These commenters expressed belief that incorporating future cost or utilization trends into historical data would allow the model to better reflect expected market dynamics.

A few commenters requested that CMS delay implementation of the proposed 2027 RxHCC model until the model is calibrated using expenditure data from 2025. These commenters stated that because the prescription drug cost and utilization data used in the model calibration is from before most Part D benefit changes due to the IRA were implemented in CY 2025, CMS should delay implementation until the model can be calibrated with post-IRA data. Another commenter requested that CMS adopt a multi-year phase-in of the model to allow the industry time to adapt to model changes.

Response: CMS appreciates the comments and acknowledges the commenters' concerns. With regard to comments about expected utilization or new drugs entering the market, we continue to believe that modeling future behavior would result in error in the model and inaccurate

predictions of relative costs. Instead, we believe it is prudent to calibrate on the most recent available utilization data and wait to account for changes in utilization in future iterations of the model with more recent data. We believe that the proposed updates to the 2027 RxHCC model, including updating to the most recent data available, are essential for plan sponsors to develop accurate bids for CY 2027.

Comment: A few commenters expressed concern about the updated RxHCC model's impact on certain beneficiaries. Specifically, these commenters expressed a belief that the RxHCC model does not account for outlier beneficiaries (in terms of cost), as well as beneficiaries who are taking new, expensive specialty drugs. Some of these commenters suggested that CMS adjust model coefficients to account for conditions disproportionally represented among high-cost beneficiaries or include additional coefficients for severity (similar to the frailty factor used for SNPs) based on an outlier threshold.

Response: CMS acknowledges the commenters' concerns. We note that the RxHCC model is intended to predict expected relative expenditures across key subgroups of beneficiaries. The model is not intended to predict the costs of individual beneficiaries, nor is it intended to influence prescribing behavior, formulary structures, or beneficiary utilization of specific drugs. Overall expected costs for a plan's expected enrolled population are reflected in the bid, and the risk adjustment model is intended to ensure that the payments to the plan adequately reflect its expected relative cost, compared to the national average.

Comment: A few commenters expressed concern that the RxHCC model does not encourage Part D plans to promote early chronic kidney disease intervention by only including chronic kidney disease stages 4 and 5 in the model. A commenter suggested that CMS include an RxHCC for chronic kidney disease stage 3 into the payment model as is done in the CMS-HCC model.

Response: CMS appreciates the comment. While we regularly review the RxHCC model for improvements, it is important to note that the RxHCC model predicts plan costs for prescription drugs, not medical costs. As a result, payment RxHCCs are not always identical to payment CMS-HCCs.

Comment: A few commenters suggested that CMS examine modifying the underlying data and structure of the RxHCC model, such as incorporating prescription drug claims into the model to supplement medical diagnoses, incorporating concurrent data markers for drug conditions, or use DIR data to base the model on net plan spending. Several commenters suggested that CMS conduct ongoing monitoring of the Part D market to ensure that payment policies do not result in negative consequences for beneficiaries. These commenters suggested monitoring aspects of the market such as formulary design, trends in utilization management, plan entries or exits in the market, and beneficiary access to care.

Response: CMS thanks the commenters for their suggestions. We regularly review and conduct analysis of the RxHCC model and will take these suggestions into consideration.

Comment: A few commenters requested that CMS collaborate more with stakeholders prior to the publication of the Advance Notice regarding model changes. Additionally, several commenters requested that CMS publish additional analyses or provide more data to stakeholders regarding the model and its impacts prior to publication of the Advance Notice, while others suggested convening technical expert panels or publishing white papers when considering future updates to the risk adjustment model.

Response: CMS appreciates the commenters' feedback. In setting these timelines, we seek to achieve multiple goals, including providing the statutory-required amount of time for public comment while also releasing the Advance Notice using more current data to calculate the risk and other factors used to adjust MA capitation rates and ensuring that the Rate Announcement is published by the statutory deadline. Per section 1853(b)(2) of the Act, the Advance Notice of proposed changes to the methodology and assumptions used to determine annual MA capitation rates and the risk and other factors used in adjusting MA capitation rates under section 1853(a)(1)(C) is required to have a minimum 30-day comment period. Section 1860D-15(c)(1)(D) of the Act requires that CMS publish the risk adjustment factors for Part D at the time of publication of risk adjustment factors for Part C, which we propose in the Advance Notice and finalize in the Rate Announcement for the applicable year, per § 423.329(b)(4).

CMS acknowledges the commenters' requests for more data, analyses, and stakeholder engagement and will take these into consideration. When the CY 2027 Advance Notice was published, CMS provided model software on the CMS risk adjustment webpage[12] and posted estimated plan-level risk scores under the RxHCC models discussed in the CY 2027 Advance Notice.

Comment: A commenter requested that CMS verify the accuracy of beneficiary institutional status indicators used in the proposed 2027 RxHCC model calibration because of a previously-communicated technical issue where long-term institutionalized (LTI) beneficiaries were incorrectly classified with community factors during the payment year (PY) 2017 overpayment rerun.

Response: The technical issue referred to by the commenter was specific to the PY 2017 overpayment rerun and is outside the scope of the information presented in the CY 2027 Advance Notice.

Part D Risk Adjustment Models for PACE Organizations

CMS received no comments on the proposal to calculate Part D risk scores for PACE organizations using a blend of the RxHCC model being finalized for non-PACE organizations (i.e., 2023/2024 calibration) and the RxHCC model calibrated on 2018 diagnoses and 2019 expenditure data (i.e., 2018/2019 calibration). CMS will implement a blend of RxHCC models as

[12] CMS Risk Adjustment website.

proposed for CY 2027 by calculating risk scores as a blend of 50 percent of the risk score calculated using the MA-PD relative factors of the 2023/2024 RxHCC model and 50 percent of the risk score calculated using the 2018/2019 RxHCC model.

Comment: A commenter expressed appreciation for CMS's proposal to maintain a distinct Part D risk adjustment approach for PACE organizations in CY 2027 rather than incorporating PACE into the revised Part D risk score methodology applicable to MA-PD plans and standalone PDP sponsors. The commenter indicated that maintaining a PACE-specific methodology better supports more accurate prediction of drug costs for this high-need population and promotes stability during the model transition.

Response: CMS thanks the commenter for their support. CMS will implement a blend of the RxHCC models as proposed, using 50 percent of the risk score calculated with the 2018/2019 RxHCC model and 50 percent of the risk score calculated with the MA-PD relative factors of the 2023/2024 RxHCC model for CY 2027. As proposed, the 2018/2019 RxHCC model used solely for PACE organizations does not update the underlying data used in the model calibration or the denominator year, does not update the model to exclude diagnoses from audio-only services identified by modifier "93" or "FQ" or those submitted on unlinked CRRs, and does not update the model to use separate continuing enrollee model segments for beneficiaries in MA-PD plans and PDPs. We intend to fully transition PACE organizations to the Part D risk score methodology applicable to MA-PD plans and standalone PDP sponsors soon.

Section G. Normalization for the RxHCC Risk Adjustment Models

Comment: Some commenters supported CMS's proposal to continue calculating separate normalization factors for PDPs and MA-PD plans. Supportive commenters noted the diverging risk score trend between MA-PD plans and PDPs and believe that applying separate normalization factors appropriately accounts for actuarial risk differences while supporting compliance with statutory requirements. These commenters further highlighted the importance of stability and a level playing field given the increased liability Part D plans face following the implementation of the IRA.

Response: CMS thanks the commenters for their support. We are finalizing our proposal to apply separate normalization factors for PDPs and MA-PD plans calculated with the multiple linear regression methodology as proposed.

Comment: Several commenters supported or were neutral on the application of separate normalization factors for MA-PD plans or PDPs but opposed the methodology that CMS proposed for calculating separate normalization factors, because they believe that in doing so CMS is inappropriately adjusting for differences between the two market sectors. These commenters suggested alternatives that instead calculate separate normalization factors based on the risk score trend or diagnosis trend in each sector and do not account for risk score or diagnosis trend differences between sectors. A commenter encouraged CMS to continue

exploring ways to reduce inaccuracies in Part D risk adjustment with the goal of improving the fairness of payments to all Part D plans. This commenter believes that because the separate normalization factors proposed adjust for differences in risk score trends between market sectors it may introduce inaccuracies. The commenter noted that because CMS methodology assumes equal risk between PDPs and MA-PD plans, CMS could apply a demographic adjustment to the separate normalization factors to account for potential differences in populations between the two populations over time, although the commenter did not find that the assumption of equal risk led to significant inaccuracy presently.

Response: We appreciate the concerns and suggestions expressed by commenters regarding the use of separate normalization factors. However, we are finalizing the separate normalization factors for PDPs and MA-PD plans as proposed without an adjustment for demographic or other differences between PDPs and MA-PD plans. While we acknowledge this methodology assumes equal risk between PDPs and MA-PD plans, and that there are differences between MA-PD plans and PDPs being adjusted for, we believe the separate normalization factors calculated as proposed is a reasonable estimate of the difference in relative risk between PDPs and MA-PD plans in the payment year. In 2024 (the cost year for the 2027 RxHCC model) MA-PD gross drug costs were similar to PDP gross drug costs (per capita costs for continuing enrollees were 1.6 percent higher for MA-PD plans than PDPs) and because of a variety of market-based variables, including the overall benefits that plan sponsors are able to manage, the strategies available for managing Part D costs, and the inability of PDPs to affect the submission of diagnoses in FFS, CMS believes that assuming equal risk between sectors in 2027, given uncertainty amid the ongoing implementation of the Inflation Reduction Act, will ensure a level playing field, allowing for fairer competition between PDPs and MA-PD plans so that beneficiary options for Part D coverage are sustained. CMS further acknowledges that there is inherent uncertainty in our normalization factors because they are projections of the payment year risk scores, and any projection can be imprecise. We base our normalization factors on the data available to us at the time and whether or not the risk score projected (i.e., the normalization factor) is a reasonable estimate of the payment year risk score based on observed historical risk scores. By applying separate normalization factors calculated with the proposed multiple linear regression methodology, the relative risk scores will reasonably reflect the relative cost in each sector. CMS will continue to monitor PDP and MA-PD risk score trends and conduct analyses using 2025 data, which reflect the Inflation Reduction Act benefit changes, to determine the normalization methodology that results in the most reasonable predictions of the payment year risk scores, and how best to capture differences in relative risk between PDPs and MA-PD plans in future years to more accurately reflect Part D costs in each of these two sectors of the Part D market.

Comment: A couple of commenters requested more information or additional analysis. These commenters recommended that CMS evaluate whether payment changes are associated with measurable changes in plan behavior that could affect beneficiary access and that CMS provide

normalization factors for different models and years than what was proposed to assist with evaluating the impact of the proposed RxHCC model.

Response: CMS thanks the commenters for their suggestion and will continue monitoring beneficiary access to prescription drugs as Part D payment changes are implemented. Regarding the request for normalization factors for models and years not proposed in the CY 2027 Advance Notice, CMS provided PY 2024 risk scores and technical instructions to plan sponsors to evaluate the risk adjustment proposals in the CY 2027 Advance Notice through the Health Plan Management System (HPMS). In the technical instructions we provided adjustment factors that could be applied to the 2026 RxHCC model risk scores for PY 2024 to make them comparable to the proposed 2027 RxHCC model risk scores for PY 2024. The 2026 RxHCC model (2023/2024 calibration) has a 2023 denominator and the proposed 2027 RxHCC model has a 2024 denominator. Therefore, raw 2024 risk scores under the 2026 RxHCC model and the 2027 RxHCC model are not comparable without applying an adjustment factor. For the 2026 RxHCC model, an adjustment factor of 1.113 should be applied to the risk scores for MA-PD plans, while an adjustment factor of 0.879 should be applied to the risk scores for PDPs. These adjustment factors are the 2024 average risk scores for MA-PD plans and PDPs respectively, and equivalent to the normalization factor for this model if it had been in effect for PY 2024. Dividing the PY 2024 risk scores by the factors CMS provided will isolate the effects of changes in the RxHCC model from the trend between the 2026 RxHCC model denominator year (2023) and the year risk scores were calculated (2024). We did not provide CY 2027 normalization factors for the 2026 RxHCC model because we did not propose the 2026 RxHCC model for payment in CY 2027.

Comment: Several commenters thought CMS should switch to a single factor like was used prior to CY 2025. These commenters were opposed to applying separate normalization factors for reasons that include concern that doing so would lead to perverse incentives and fragmented care for low-income beneficiaries, as well as a belief that CMS is unfairly subsidizing PDPs at the expense of MA-PD plans and that applying separate normalization factors is inconsistent with Part C where the risk adjustment model has separate segments but a single normalization factor. A commenter supported efforts to accurately represent beneficiary diagnoses in all parts of the Medicare program rather than applying separate normalization factors that account for differing risk score trends between the two market sectors.

Response: Applying a single normalization factor, as we do for the Part C risk scores, would lead to risk adjustors that do not appropriately account for the variation in costs between MA-PD and PDP enrollees. The risk score and normalization factor combined account for the expected risk of a Part D enrollee relative to the expected average across Part D in the payment year. A single normalization factor results in a risk adjustor that overestimates actuarial risk for MA-PD plans and underestimates actuarial risk for PDPs. CMS's goal in applying separate normalization factors is to improve the predictive accuracy of PDP and MA-PD plan risk scores. The intent of normalization is to keep risk scores at consistent levels year over year so that the level of

payment is driven by the bid, not the risk scores, and normalization adjusts for any and all drivers of risk score trends. Applying separate normalization factors calculated with the multiple linear regression methodology will reflect the change in population and health status from the denominator year to the payment year, similar to how a single normalization factor would, but will better account for differences in costs between PDPs and MA-PD plans. In finalizing separate segments of the risk adjustment model for PDPs and MA-PD plans, we are more accurately predicting risk for each market sector despite differences in diagnosis coding practices. When the risk adjustment model predicted risk for PDPs and MA-PD plans together, differences in coding practices between sectors led to over and under predictions of actual risk. Now that risk is more accurately predicted by the model, separate normalization factors adjust for differences in risk score trend within each sector rather than differences in demographics and coding practices between sectors. Changing coding practices in the PDP sector would have significantly less effect on the normalization factor for the MA-PD sector and vice versa.

Section H. Source of Diagnoses for Part D Risk Score Calculation

Non-PACE Organizations: Refer to Attachment III, Section N for comments and responses regarding sources of diagnoses for risk score calculation. For CY 2027, CMS will calculate risk scores using eligible diagnoses derived from encounter data and FFS claims, excluding diagnoses from audio-only services as proposed, and from unlinked CRRs with an exception for beneficiaries who switch between MA organizations from one year to next.

PACE Organizations: Refer to Attachment III, Section N for comments and responses regarding sources of diagnoses for risk score calculation. For CY 2027, CMS will calculate risk scores using 50 percent of the risk score calculated using eligible diagnoses derived from RAPS, encounter data, and FFS claims, and 50 percent of the risk score calculated using eligible diagnoses derived exclusively from encounter data and FFS claims, excluding diagnoses from audio-only services as proposed. Diagnoses from unlinked CRRs will be included in the risk score calculation 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 V-1. 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, U.S. city average)	2.31%	0.67%	3.00%

Table V-2. Updated Part D Benefit Parameters for Defined Standard Benefit, Low-Income Subsidy (LIS) and Retiree Drug Subsidy

	2026	2027[13]
Standard Benefit		
Deductible	$615	$700
Out-of-Pocket Threshold	$2,100	$2,400
Full Subsidy-Full Benefit Dual Eligible (FBDE) Beneficiaries (1)		
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] (2)	$0.00	$0.00
Maximum Copayments for Non-Institutionalized Beneficiaries		
Up to or at 100% FPL [category code 2]		
Up to Out-of-Pocket Threshold		
Generic/Preferred Multi-Source Drug	$1.60	$1.65
Other	$4.90	$5.00
Between 100% and 150% of FPL [category code 1]		
Up to Out-of-Pocket Threshold		
Generic/Preferred Multi-Source Drug	$5.10	$5.80
Other	$12.65	$14.40

[13] These parameters reflect additional plan coverage required for covered insulin products under section 1860D-2(b)(9) of the Act, as added by section 11406 of the IRA, and ACIP-recommended adult vaccines under section 1860D-2(b)(8) of the Act, as added by section 11401 of the IRA.

	2026	2027[13]
Full Subsidy-Non-FBDE Beneficiaries (1)		
Applied or eligible for QMB/SLMB/QI or SSI, income at or below 150% FPL and resources ≤ $16,100 (individuals, 2025) or ≤ $32,130 (couples, 2025) [category code 1] (3)		
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

(1) The LIS eligibility categories and corresponding cost-sharing benefits are sometimes referred to using category codes as follows:

- Category Code 1 – Non-institutionalized FBDE beneficiaries with incomes between 100% and 150% of FPL and full-subsidy-non-FBDE beneficiaries.
- Category Code 2 – Non-institutionalized FBDE beneficiaries with incomes up to 100% of the FPL.
- Category Code 3 – FBDE beneficiaries who are institutionalized or would be institutionalized if they were not receiving home and community-based services.

(2) Per section 1860D-14(a)(1)(D)(i) of the Act, FBDE beneficiaries who are receiving certain home and community-based services qualify for zero cost sharing if the individuals (or couple) would have been institutionalized otherwise.

(3) The resource limits for CY 2027 will be provided via the annual HPMS memorandum entitled, "Calendar Year (CY) 2027 Resource and Cost-Sharing Limits for Low-Income Subsidy (LIS)" that is expected to be released during the usual timeframe after the September 2026 CPI has been made available by the Bureau of Labor Statistics. Additionally, these amounts are adjusted for beneficiaries that notified the SSA of their intent to use a portion of their resources for burial expenses. The CY 2026 resource limits, including $1,500 per person for burial expenses, are $18,090 ($36,100 if married). Also, beneficiaries that would have been eligible for the partial LIS benefit had the IRA not been enacted will be eligible for the full LIS benefit if they meet the resource standard described at section 1860D-14(a)(3)(E) of the Act.

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

Annual Percentage Increase in Consumer Price Index, September (September CPI)

Section 1860D-14(a)(4) of the Act requires CMS to use the annual percentage increase in the CPI for the 12-month period ending in September 2026 to update the maximum copayments up to the annual OOP threshold for full-benefit dually eligible beneficiaries with incomes not exceeding 100 percent of the FPL for CY 2026. These copayments are increased from $1.60 per

generic, preferred drug that is a multi-source drug, or biosimilar, and from $4.90 for all other drugs in CY 2026 and rounded to the nearest multiple of $0.05 and $0.10 respectively.[14]

Section B. Calculation Methodology

Annual Percentage Increase in Average Expenditures for Part D Drugs per Eligible Beneficiary (API)

For contract years 2006 and 2007, the APIs, as defined in section 1860D-2(b)(6) of the Act, were based on the National Health Expenditure (NHE) prescription drug per capita estimates because sufficient Part D program data was not available. Beginning with contract year 2008, the APIs are based on Part D program data. For the CY 2027 benefit parameters, Part D program data will be used to calculate the annual percentage trend as follows:

$$\frac{August\ 2025 - July\ 2026}{August\ 2024 - July\ 2025} = \frac{\$6{,}326.81}{\$5{,}784.86} = 1.0937$$

In the formula, the average per capita cost for August 2024 – July 2025 is calculated from actual Part D PDE data, and the average per capita cost for August 2025 – July 2026 is calculated based on actual Part D PDE data for prescription drug claims with service dates from August 2025 – December 2025 and projected through July 2026.

The 2027 benefit parameters reflect the 2026 annual percentage trend, as well as updates for revision to prior year estimates for API. Based on updated NHE prescription per capita costs and PDE data, the annual percentage increases are now calculated as summarized by Table V-3.

Table V-3. Revised Prior Years' Annual Percentage Trends

Year	Prior Estimates of Annual Percentage Trend	Revised Annual Percentage Trend
2006	7.30%	7.30%
2007	5.92%	5.92%
2008	4.69%	4.69%
2009	3.14%	3.14%
2010	2.36%	2.36%
2011	2.15%	2.15%
2012	2.53%	2.53%
2013	-3.14%	-3.14%
2014	10.12%	10.12%
2015	9.89%	9.89%

[14] Per section 1860D-14(a)(4)(A) of the Act, the copayments are increased from the unrounded 2026 values of $1.67 for multi-source generic or preferred drugs, and $5.01 for all other drugs.

Year	Prior Estimates of Annual Percentage Trend	Revised Annual Percentage Trend
2016	4.02%	4.02%
2017	1.87%	1.87%
2018	4.06%	4.06%
2019	4.92%	4.92%
2020	5.06%	5.06%
2021	4.68%	4.68%
2022	7.36%	7.36%
2023	9.54%	9.54%
2024	4.07%	4.69%
2025	5.69%	9.19%

Accordingly, the CY 2027 benefit parameters reflect a multiplicative update of 3.92 percent for prior year revisions. In summary, the 2026 parameters outlined in Section A are updated by 13.65 percent for 2027, as summarized by Table V-4.

Table V-4. Annual Percentage Increase

Annual percentage trend for July 2026	9.37%
Prior year revisions	3.92%
Annual percentage increase for 2027	13.65%

Note: Percentages are multiplicative, not additive. Values are carried to additional decimal places and may not agree to the rounded values presented above.

Annual Percentage Increase in Consumer Price Index, September (September CPI)

To ensure that plan sponsors and CMS have sufficient time to incorporate cost-sharing requirements into the development of the benefit, any marketing materials, and necessary systems, CMS includes in its methodology to calculate the annual percentage increase in the CPI for the 12-month period ending in September 2026, an estimate of the September 2026 CPI based on projections from the President's FY2027 Budget.

The September 2026 value is from the Bureau of Labor Statistics. The annual percentage trend in the September CPI for CY 2027 is calculated as follows:

$$\frac{Projected\ September\ 2026\ CPI}{Actual\ September\ 2025\ CPI} = \frac{\$332.31}{\$324.80} = 1.0231$$

(Source: President's FY2027 Budget and Bureau of Labor Statistics, Department of Labor)

The CY 2027 benefit parameters reflect the CY 2026 annual percentage trend in the September CPI of 2.31 percent, as well as a 0.67 percent multiplicative correction for the revision to last year's estimate. The CY 2026 annual percentage trend in the CPI can be found in Table V-5 below.

Table V-5. Cumulative Annual Percentage Increase in September CPI

Annual percentage trend for September 2026	2.31%
Prior year revisions	0.67%
Annual percentage increase for 2027	3.00%

Note: Percentages are multiplicative, not additive. Values are carried to additional decimal places and may not agree to the rounded values presented above.

Section C. Annual Percentage Increase in Average Expenditures for Part D Drugs Per Eligible Beneficiary

Section 1860D-2(b)(6) of the Act defines the API as "the annual percentage increase in average per capita aggregate expenditures for covered Part D drugs in the United States for Part D eligible individuals, as determined by the Secretary for the 12-month period ending in July of the previous year using such methods as the Secretary shall specify." The following defined standard Part D prescription drug benefit parameters are updated using the "annual percentage increase":

For CY 2027, the defined standard deductible amount is updated by multiplying the 2026 amount of $615 by the 2027 API and rounding to the nearest multiple of $5. Under section 1860D-2(b)(4)(B) of the Act, for CY 2027, the annual OOP threshold is updated by multiplying the CY 2026 amount of $2,100 by the 2027 API and rounding to the nearest multiple of $50.

Table V-6. Part D Benefit Parameters for Defined Standard Benefit for CY 2026 and CY 2027 for Non-LIS Beneficiaries[15]

	2026		2027	
Deductible Phase	Cost sharing: 100%		Cost sharing: 100%	
	Deductible: $615		Deductible: $700	
Initial Coverage Phase	Applicable Drugs Cost sharing: 25%	Non-applicable Drugs and Selected Drugs Cost sharing: 25%	Applicable Drugs Cost sharing: 25%	Non-applicable Drugs and Selected Drugs Cost sharing: 25%
	Out-of-Pocket Threshold: $2,100		Out-of-Pocket Threshold: $2,400	

[15] These parameters reflect additional plan coverage required for covered insulin products under section 1860D-2(b)(9) of the Act, as added by section 11406 of the IRA, and ACIP-recommended adult vaccines under section 1860D-2(b)(8) of the Act, as added by section 11401 of the IRA.

Section D. Retiree Drug Subsidy Amounts

While the IRA significantly redesigned the Part D benefit, the IRA did not change the statutory requirements for retiree drug subsidy plans (as defined in section 1860D-22 of the Act). Specifically, the IRA did not change the requirements related to the methodology for calculating the cost limit and threshold for the CY 2027 retiree drug subsidy amounts for retiree drug subsidy plans.[16]

Per section 1860D-22(a)(3)(B) of the Act and § 423.886(b)(3), the cost threshold and cost limit for qualified retiree prescription drug plans are updated using the API, as defined previously in this document.[17] The updated cost threshold is rounded to the nearest multiple of $5 and the updated cost limit is rounded to the nearest multiple of $50. The cost threshold and cost limit are defined as $615 and $12,650, respectively, for plans that end in CY 2026, and as $700 and $14,400 for plans that end in CY 2027, as noted in Table V-7.

Table V-7. Updated Retiree Drug Subsidy Amounts in CY 2026

	2026	2027
Retiree Drug Subsidy Amounts		
Cost Threshold	$615	$700
Cost Limit	$12,650	$14,400

[16] Please see the Final CY 2025 Part D Redesign Program Instructions (https://www.cms.gov/files/document/final-cy-2025-part-d-redesign-program-instructions.pdf) and the Final CY 2026 Part D Redesign Program Instructions (https://www.cms.gov/files/document/final-cy-2026-part-d-redesign-program-instruction.pdf).

[17] The cost threshold is the amount of gross retiree costs that a retiree must incur before the retiree drug subsidy applies. The cost limit is the maximum amount of gross retiree costs that the retiree drug subsidy will cover after a retiree hits the cost threshold.

Attachment VI. Updates for Part C and D Star Ratings

Section A. Part C and D Star Ratings and Future Measurement Concepts

The Part C and D Star Ratings measure the quality of and reflect the experiences of beneficiaries in MA and PDPs, assist beneficiaries in finding the best plan for their needs, and determine eligibility for MA Quality Bonus Payments (QBPs). The Star Ratings assess MA and PDP contract efforts on prevention, wellness, and chronic disease, and support CMS's efforts to make all of our programs patient-centric.

The methodology for the Star Ratings system for the Part C and D programs is codified at §§ 422.160 - 422.166 and 423.180 - 423.186. In the CY 2027 Advance Notice, we provided information and updates as required by §§ 422.164(c)(2), (d), (e)(2), and (f)(1); 422.166(f)(2); 423.184(c)(2), (d), (e)(2), and (f)(1); and 423.186(f)(2). We reviewed the comments and will consider them as we identify future enhancements to the Star Ratings program.

Section B. Reminders for 2027 Star Ratings and Beyond

As a reminder, the Star Ratings plan previews codified at §§ 422.166(h)(2) and 423.186(h)(2) are an opportunity for Part C and D sponsors to preview their Star Ratings data in HPMS and raise any questions prior to display on the Medicare Plan Finder. The two plan preview periods allow for any necessary corrections to be made prior to the Star Ratings data being public. During the first plan preview in August, we expect Part C and D sponsors to closely review the Star Ratings methodology and their posted numeric data for each measure. The second plan preview in September includes any revisions made as a result of the first plan preview and provides a preview of the preliminary Star Ratings for each measure, domain, summary score, and overall score. During the second plan preview, we expect Part C and D sponsors to again closely review the methodology and their posted data for each measure, as well as their preliminary Star Rating assignments. Please note that any questions asked during the plan preview periods are not part of the formal appeals process under § 422.260.

Prior to the preview periods, various datasets and reports are available for sponsors to review their underlying measure data as detailed in the annual HPMS memorandum "Information to Review Data Used for Medicare Part C and D Star Ratings and Display Measures." Sponsors should review the data detailed in this memorandum and alert CMS of potential errors or anomalies in advance of CMS's plan preview periods to allow sufficient time to investigate and resolve any issues. Data shared prior to the release of the final Star Ratings in October are preliminary and subject to change.

Under § 422.260, CMS has made an administrative review process available to MA organizations for payment determinations based on the quality bonuses. MA organizations can request a formal appeal of their QBP rating after CMS releases the preliminary QBP ratings in HPMS, typically in November of each year. CMS anticipates that issues addressed during the

preview periods will reduce the need for MA organizations to request an administrative review of QBP determinations. The administrative review is a two-step process that begins with a request for reconsideration. This review is not intended to repeat the preview periods in giving contracts another opportunity to raise general questions about how CMS calculates the Star Ratings, nor is it intended to review how every measure was calculated. Instead, this review affords an MA organization the opportunity to request review of specific measure values and stars that may affect the calculation of the contract's QBP status.

As described at §§ 422.164(h) and 423.184(h), CMS annually sets and announces a deadline for MA and Part D organizations to request that CMS or the Independent Review Entity (IRE) review its appeals data or CMS review its Complaints Tracking Module (CTM) or Patient Safety measure data.

For the 2027 Star Ratings:

- CMS finalized a deadline of May 18, 2026,[18] for all contracts to request a review of their administrative data used for the Part D Patient Safety Star Ratings measures[19] for the 2025 measurement year for the 2027 Star Ratings. CMS reports the Patient Safety measures through the Patient Safety Analysis Web Portal each month to Part D sponsors. Sponsors should review their underlying measure data in the monthly reports and alert CMS if any potential issues are identified in the rate calculations per the measure specifications. Sponsors should refer to the annual HPMS memorandum released each April, "Information to Review Data Used for Medicare Part C and D Star Ratings and Display Measures," which describes the process of submitting the requests.[20] We also encourage sponsors to submit requests for review of their administrative data for the Part D Patient Safety display measures on the 2027 display page (2025 measurement year) by May 18, 2026.
- CMS announced a deadline of March 31, 2026, for all contracts to request a review of 2025 CTM data for the 2027 Star Ratings.
- CMS announced a deadline of June 30, 2026, for all contracts to request a review of 2025 appeals data. Sponsors can view and monitor their Part C appeals timeliness and effectuation compliance data on the Medicare Appeal Search website.

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[18] Contract Year 2025 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly. https://www.federalregister.gov/documents/2024/04/23/2024-07105/medicare-program-changes-to-the-medicare-advantage-and-the-medicare-prescription-drug-benefit.

[19] Includes Medication Adherence for Cholesterol (Statins) (ADH-Statins), Medication Adherence for Hypertension (RAS Antagonists) (ADH-RAS), Medication Adherence for Diabetes Medications (ADH-Diabetes), Statin Use in Persons with Diabetes (SUPD), Concurrent Use of Opioids and Benzodiazepines (COB), and Polypharmacy: Use of Multiple Anticholinergics (ACH) Medications in Older Adults (Poly-ACH) measures.

[20] April 16, 2025, HPMS memorandum, *Information to Review Data Used for Medicare Part C and D Star Ratings and Display Measures*.

For the 2028 Star Ratings:

- CMS announced a deadline of March 31, 2027, for all contracts to request a review of 2026 CTM data for the 2028 Star Ratings. We announced this deadline in advance due to the timing of the publication of the CY 2028 Advance Notice and CY 2028 Rate Announcement.
- CMS announced a deadline of May 18, 2027, for all contracts to request a review of their administrative data used for the Part D Patient Safety Star Ratings measures for the 2026 measurement year for the 2028 Star Ratings. We also encourage sponsors to submit requests for review of their administrative data for the Part D Patient Safety display measures on the 2028 display page (2026 measurement year) by May 18, 2027.

As a reminder, there are four new or updated measures being added beginning with the 2027 Star Ratings:[21]

- Colorectal Cancer Screening
- Care for Older Adults – Functional Status Assessment
- Concurrent Use of Opioids and Benzodiazepines (COB)
- Polypharmacy: Use of Multiple Anticholinergic Medications in Older Adults (Poly-ACH)

The Colorectal Cancer Screening measure is being replaced by a respecified version and is treated as a new measure. The other three measures are process measures developed from evidence-based clinical treatment guidelines, each with a weight of one. These three clinical process measures are critical for measuring health care and medication use quality, ensuring that care is delivered effectively, and preventing long-term health consequences by addressing potential health concerns early in the beneficiary's care. Care for Older Adults – Functional Status Assessment is returning to the Star Ratings after a substantive specification change and is treated as a new measure.

There are three measures being removed beginning with the 2027 Star Ratings:

- Care for Older Adults – Pain Assessment
- Medication Reconciliation Post-Discharge
- Medication Therapy Management (MTM) Program Completion Rate for Comprehensive Medication Review (CMR)

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[21] Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Program for Contract Year 2024-Remaining Provisions and Contract Year 2025 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly (PACE). https://www.federalregister.gov/documents/2024/04/23/2024-07105/medicare-program-changes-to-the-medicare-advantage-and-the-medicare-prescription-drug-benefit

As noted in the Announcement of Calendar Year (CY) 2026 MA Capitation Rates and Part C and Part D Payment Policies, NCQA reevaluated the Statin Therapy for Patients with Cardiovascular Disease (Part C) measure for the 2026 measurement year. As a result of this reevaluation, NCQA updated the measure specifications to expand the eligible population, which is considered a substantive change to the measure. As a result, CMS will include the updated version of the Statin Therapy for Patients with Cardiovascular Disease measure on the 2028 display page. Though this measure is already set to be moved to the 2028 display page in light of the substantive changes, CMS has finalized the removal of this measure from the Star Ratings.[22] The updated measure will remain on the display page. The MTM Program Completion Rate for CMR measure will be on the display page for measurement years 2025 and 2026 and will return to the Star Ratings as a new measure beginning with the 2029 Star Ratings (measurement year 2027).

For the 2027 Star Ratings, we will begin to use data collected through the Part C Reporting Requirements (as described at § 422.516(a)) to confirm the completeness of the IRE data used in the calculation of the Plan Makes Timely Decisions about Appeals and Reviewing Appeals Decisions measures. As codified at § 422.164(g)(1)(iii)(A), we will use these data to implement scaled reductions if data integrity issues are identified.

Additionally, starting with the 2027 Star Ratings, we will implement a change in how we calculate the Categorical Adjustment Index when there is a contract consolidation. We will determine the percentage of low income subsidy (LIS)/Dual Eligible (DE) enrollees and the percentage of disabled enrollees for the surviving contract for the first two years following a consolidation by combining the enrollment data for the month of December for the measurement period of the Star Ratings year across all contracts in the consolidation as described at §§ 422.166(f)(2)(i)(B) and 423.186(f)(2)(i)(B).

Section C. Measure Updates for 2027 Star Ratings

The measures that will be used to calculate the 2027 Star Ratings are listed in Table VI-1 with information about the measure type, weight, and measurement year. Table VI-1 no longer includes the measures considered for inclusion in the Excellent Health Outcomes for All (EHO4all) reward (also known as the Health Equity Index reward), because CMS will not implement the EHO4all reward and will keep the historical reward factor in the Star Ratings methodology, consistent with policies finalized in the "Contract Year 2027 and Certain Contract Year 2026 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program" final rule.

[22] Contract Year 2027 and Certain Contract Year 2026 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program final rule section V.B.1.g.

Table VI-1. 2027 Star Ratings Measures

Part C or D	Measure	Measure Type	Weight	Measurement Year	Improvement Measure	Included in the 2027 CAI Values
C	Breast Cancer Screening	Process Measure	1	1/1/2025 – 12/31/2025	**Yes**	**Yes**
C	Colorectal Cancer Screening	Process Measure	1	1/1/2025 – 12/31/2025	**No**	**No**
C	Annual Flu Vaccine	Process Measure	1	3/2026 – 6/2026	**Yes**	**Yes**
C	Improving or Maintaining Physical Health	Outcome Measure	3	7/2025 – 11/2025	**No**	**No**
C	Improving or Maintaining Mental Health	Outcome Measure	3	7/2025 – 11/2025	**No**	**No**
C	Monitoring Physical Activity	Process Measure	1	7/2025 – 11/2025	**Yes**	**Yes**
C	Special Needs Plan (SNP) Care Management	Process Measure	1	1/1/2025 – 12/31/2025	**Yes**	**No**
C	Care for Older Adults – Medication Review	Process Measure	1	1/1/2025 – 12/31/2025	**Yes**	**No**
C	Care for Older Adults – Functional Status Assessment	Process Measure	1	1/1/2025 – 12/31/2025	**No**	**No**
C	Osteoporosis Management in Women who had a Fracture	Process Measure	1	1/1/2025 – 12/31/2025	**Yes**	**Yes**

Part C or D	Measure	Measure Type	Weight	Measurement Year	Improvement Measure	Included in the 2027 CAI Values
C	Diabetes Care – Eye Exam	Process Measure	1	1/1/2025 – 12/31/2025	**Yes**	**Yes**
C	Diabetes Care – Blood Sugar Controlled	Intermediate Outcome Measure	3	1/1/2025 – 12/31/2025	**Yes**	**Yes**
C	Kidney Health Evaluation for Patients with Diabetes	Process Measure	1	1/1/2025 – 12/31/2025	**Yes**	**Yes**
C	Controlling Blood Pressure	Intermediate Outcome Measure	3	1/1/2025 – 12/31/2025	**Yes**	**Yes**
C	Reducing the Risk of Falling	Process Measure	1	7/2025 – 11/2025	**Yes**	**Yes**
C	Improving Bladder Control	Process Measure	1	7/2025 – 11/2025	**Yes**	**Yes**
C	Plan All-Cause Readmissions	Outcome Measure	3	1/1/2025 – 12/31/2025	**Yes**	**Yes**
C	Statin Therapy for Patients with Cardiovascular Disease	Process Measure	1	1/1/2025 – 12/31/2025	**Yes**	**Yes**
C	Transitions of Care	Process Measure	1	1/1/2025 – 12/31/2025	**Yes**	**Yes**
C	Follow-up after Emergency Room Visit	Process Measure	1	1/1/2025 – 12/31/2025	**Yes**	**Yes**

Part C or D	Measure	Measure Type	Weight	Measurement Year	Improvement Measure	Included in the 2027 CAI Values
C	Getting Needed Care	Patients' Experience and Complaints Measure	2	3/2026 – 6/2026	**Yes**	**No**
C	Getting Appointments and Care Quickly	Patients' Experience and Complaints Measure	2	3/2026 – 6/2026	**Yes**	**No**
C	Customer Service	Patients' Experience and Complaints Measure	2	3/2026 – 6/2026	**Yes**	**No**
C	Rating of Health Care Quality	Patients' Experience and Complaints Measure	2	3/2026 – 6/2026	**Yes**	**No**
C	Rating of Health Plan	Patients' Experience and Complaints Measure	2	3/2026 – 6/2026	**Yes**	**No**
C	Care Coordination	Patients' Experience and Complaints Measure	2	3/2026 – 6/2026	**Yes**	**No**
C	Complaints about the Health Plan	Patients' Experience and	2	1/1/2025 – 12/31/2025	**Yes**	**No**

Part C or D	Measure	Measure Type	Weight	Measurement Year	Improvement Measure	Included in the 2027 CAI Values
		Complaints Measure				
C	Members Choosing to Leave the Plan	Patients' Experience and Complaints Measure	2	1/1/2025 – 12/31/2025	**Yes**	**No**
C	Health Plan Quality Improvement	Improvement Measure	5	NA	**No**	**No**
C	Plan Makes Timely Decisions about Appeals	Measures Capturing Access	2	1/1/2025 – 12/31/2025	**Yes**	**No**
C	Reviewing Appeals Decisions	Measures Capturing Access	2	1/1/2025 – 12/31/2025	**Yes**	**No**
C	Call Center – Foreign Language Interpreter and TTY Availability	Measures Capturing Access	2	2/2026 – 5/2026	**Yes**	**No**
D	Call Center – Foreign Language Interpreter and TTY Availability	Measures Capturing Access	2	2/2026 – 5/2026	**Yes**	**No**
D	Complaints about the Drug Plan	Patients' Experience and Complaints Measure	2	1/1/2025 – 12/31/2025	**Yes**	**No**
D	Members Choosing to Leave the Plan	Patients' Experience and	2	1/1/2025 – 12/31/2025	**Yes**	**No**

Part C or D	Measure	Measure Type	Weight	Measurement Year	Improvement Measure	Included in the 2027 CAI Values
		Complaints Measure				
D	Drug Plan Quality Improvement	Improvement Measure	5	NA	**No**	**No**
D	Rating of Drug Plan	Patients' Experience and Complaints Measure	2	3/2026 – 6/2026	**Yes**	**No**
D	Getting Needed Prescription Drugs	Patients' Experience and Complaints Measure	2	3/2026 – 6/2026	**Yes**	**No**
D	MPF Price Accuracy	Process Measure	1	1/1/2025 – 9/30/2025	**Yes**	**No**
D	Medication Adherence for Diabetes Medications	Intermediate Outcome Measure	3	1/1/2025 – 12/31/2025	**Yes**	**Yes**
D	Medication Adherence for Hypertension (RAS antagonists)	Intermediate Outcome Measure	3	1/1/2025 – 12/31/2025	**Yes**	**Yes**
D	Medication Adherence for Cholesterol (Statins)	Intermediate Outcome Measure	3	1/1/2025 – 12/31/2025	**Yes**	**Yes**
D	Statin Use in Persons with Diabetes	Process Measure	1	1/1/2025 – 12/31/2025	**Yes**	**Yes**

Part C or D	Measure	Measure Type	Weight	Measurement Year	Improvement Measure	Included in the 2027 CAI Values
D	Concurrent Use of Opioids and Benzodiazepines (COB)	Process Measure	1	1/1/2025 – 12/31/2025	**No**	**No**
D	Polypharmacy: Use of Multiple Anticholinergic Medications in Older Adults (Poly-ACH)	Process Measure	1	1/1/2025 – 12/31/2025	**No**	**No**

Section D. Improvement Measures (Part C & D) for the 2027 Star Ratings

Under §§ 422.164(f) and 423.184(f), improvement measures are calculated using performance measures that meet specific conditions. Table VI-1 includes information about which measures will be used to calculate the improvement measures for the 2027 Star Ratings. As stated in §§ 422.164(f)(4)(i) and 423.184(f)(4)(i), CMS will only include measures in the improvement calculations at the contract level if numeric value scores are available for both the current and prior year.

Section E. Categorical Adjustment Index for the 2027 Star Ratings

The methodology for the Categorical Adjustment Index (CAI) is described at §§ 422.166(f)(2) and 423.186(f)(2), as well as in the annual Medicare Part C & D Star Ratings Technical Notes available on CMS's Part C and D Star Ratings website. As finalized at §§ 422.166(f)(2) and 423.186(f)(2), all measures identified as candidate measures will be included in the determination of the 2027 CAI values. The measure set for the 2027 CAI (for both Part C and D) is identified in Table VI-1.

In keeping with our commitment to transparency, a summary of the analysis of the candidate measure set that includes the minimum, median, and maximum values for the within-contract variation for the low-income subsidy (LIS)/dual eligible (DE) differences are posted with the 2027 CAI values on CMS's Part C and D Star Ratings website.

Section F. Extreme and Uncontrollable Circumstances Policy for the 2027 Star Ratings

Extreme and uncontrollable circumstances such as natural disasters can directly affect Medicare beneficiaries and providers, as well as the Parts C and D organizations that provide beneficiaries

with important medical care and prescription drug coverage. An affected contract is identified based on these criteria:

(1) Its service area is within an "emergency area" during an "emergency period" as defined in section 1135(g)(1) of the Act;

(2) Its service area is within a geographic area designated in a major disaster declaration under the Stafford Act and the Secretary exercised authority under section 1135 of the Act based on the same triggering event(s); and

(3) A certain minimum percentage (25 percent) of the enrollees under the contract must reside in a Federal Emergency Management Agency (FEMA)-designated Individual Assistance area at the time of the extreme and uncontrollable circumstance. (See §§ 422.166(i) and 423.186(i)).

We use the start date of the incident period to determine which year of Star Ratings could be affected, regardless of whether the incident period extends to another calendar year (§§ 422.166(i) and 423.186(i)).

Under the 25 percent rules at §§ 422.166(i)(2)–(6) and 423.186(i)(2)–(4), contracts with at least 25 percent of enrollees in a FEMA-designated Individual Assistance area in 2025 will receive the higher of their measure-level rating from the current and prior Star Ratings years for purposes of calculating the 2027 Star Ratings (thus, for 2027 Star Ratings, affected contracts will receive the higher of their measure-level ratings from the 2026 rating or 2027 rating for the applicable measures). Table VI-2 lists the emergency areas affected by emergency declarations first issued in 2025, as defined in section 1135 of the Act, and the exercise of the Secretary's authority under section 1135 of the Act.

Table VI-2. List of Section 1135 Waivers Issued in Relation to the FEMA Major Disaster Declarations

Section 1135 Waiver Date Issued	Waiver or Modification of Requirements Under Section 1135 of the Social Security Act	FEMA Incident Type	Affected State	Incident Start Date
January 10, 2025	Wildfires	Wildfires and Straight-line Winds	California	January 7, 2025
July 8, 2025	Severe Storms, Straight-line Winds, and Flooding	Severe Storms, Straight-line Winds, and Flooding	Texas	July 2, 2025

Table VI-3 lists the states and territories with Individual Assistance designations from the FEMA major disaster declarations.

Table VI-3. Individual Assistance Counties and County-Equivalents in FEMA Major Disaster Declared States/Territories

FEMA Declaration	State	FEMA Individual Assistance Counties or County-Equivalents
DR-4856-CA	California	Los Angeles
DR-4879-TX	Texas	Burnet, Guadalupe, Kerr, Kimble, McCulloch, Menard, San Saba, Tom Green, Travis, Williamson

Further, as part of our Part C and D Star Ratings disaster policy at §§ 422.166(i)(2)(ii) and 423.186(i)(2)(ii), we codified that if at least 25 percent of a contract's enrollees resided in a FEMA-designated Individual Assistance area at the time of a qualifying extreme and uncontrollable circumstance, the contract may be exempt from administering the MA and PDP CAHPS survey if it demonstrates that the required sample for the survey cannot be contacted because a substantial number of the contract's enrollees are displaced due to the qualifying disaster in the calendar year prior to the relevant Star Ratings year and requests and receives a CMS-approved exemption. If an affected contract meeting the criteria requests and receives this exemption, the contract receives the MA and PDP CAHPS measure-level Star Ratings and scores from the prior year. The January 2025 wildfires in Los Angeles County were a qualifying disaster for purposes of §§ 422.166(i)(2)(ii) and 423.186(i)(2)(ii). Therefore, eligible contracts that requested and received an exemption from the 2025 MA and PDP CAHPS survey as a result of the Los Angeles County wildfires did not have the 2025 MA and PDP CAHPS surveys administered and received the CAHPS stars and measure scores from the 2025 Star Ratings for the 2026 Star Ratings CAHPS measures.

For all contracts affected by the 2025 Los Angeles County wildfires (i.e., at least 25 percent of their enrollees resided in Los Angeles County at the time of the disaster), the CAHPS measure-level better-of policy codified at §§ 422.166(i)(2)(iv) and 423.186(i)(2)(iv) will again be implemented for the 2027 Star Ratings. That is, we will compare the CAHPS measure-level stars to the prior year and give these contracts impacted by the Los Angeles County wildfires the higher CAHPS measure star and associated score. The 2027 CAHPS measure-level Star Ratings would be the better of the 2027 and 2026 CAHPS measure-level Star Ratings.

Section G. Changes to Existing Star Ratings Measures for the 2027 Measurement Year and Beyond

CMS solicits feedback on new measure concepts as well as measure updates through the annual Advance Notice and Rate Announcement process. We also provide advance notice regarding

measures considered for implementation as future Star Ratings measures. As codified at §§ 422.164(c)(2)(4), 422.164(d)(2), 423.184(c)(2)(4), and 423.184(d)(2), new measures and measures with substantive specification changes 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. CMS uses the Advance Notice and Rate Announcement process to announce non-substantive specification changes as described at §§ 422.164(d)(1) and 423.184(d)(1).

We also encourage interested parties to provide comments directly to measure developers during their public comment periods. For example, the National Committee for Quality Assurance (NCQA) and the Pharmacy Quality Alliance (PQA) regularly solicit public comments on new measures, changes to existing measures, and measure retirements.

Plan All-Cause Readmissions (Part C). To ensure continued measure validity, NCQA is considering an update to this measure to include denied claims for capturing measure denominator (index hospital stay) and numerator (readmission) events. In addition, NCQA is planning to re-estimate the risk adjustment models to account for more recent utilization patterns and align with updates to the CMS Hierarchical Condition Category (HCC) model. Any updates would be for measurement year 2028. If NCQA proceeds with adding denied claims, this would be considered a substantive change as described at § 422.164(d)(2); thus, the updated measure would be on the display page for two or more years and proposed through rulemaking prior to adding it to the Part C Star Ratings.

There was mixed support among commenters regarding the inclusion of denied claims in the Plan All-Cause Readmissions measure. Some supported the change, citing improved comparability and completeness, while others opposed it, citing concerns about validity due to appeals, reversals, or resubmissions and the potential for the measure to penalize appropriate utilization management activities. Several commenters recommended establishing a standardized approach to consolidating denied claims to prevent double counting or artificial inflation of numerator and denominator events, clarifying how claims that are later overturned, appealed, or resubmitted would be handled within the specifications, conducting validity testing and a "dry run" analysis before final adoption, and publishing impact analyses and technical results to ensure transparency and allow stakeholders to assess potential unintended consequences. We have shared this feedback with NCQA for their consideration.

Transitions of Care (Part C). NCQA is reevaluating this measure, which includes four indicators related to care coordination after a patient is discharged from an inpatient setting to home. The first two indicators relate to notification of inpatient admission and receipt of discharge information and currently use the hybrid reporting method only. The second two indicators, patient engagement after discharge and medication reconciliation, utilize hybrid and administrative reporting methods. NCQA intends to develop a new ECDS-reported version of the measure that will consider changes to the current specification based on expert feedback, testing, digital feasibility, and available data standards. NCQA plans to conduct measure testing in 2026

and implement any updates for measurement year 2028. CMS will follow NCQA's testing to determine whether any of the updates to the measure technical specification are substantive and must be proposed through rulemaking. NCQA plans to maintain the current measure alongside the updated measure to allow for transition to ECDS-only reporting in measurement year 2029.

For measurement year 2027, NCQA will expand the pharmacist type. This is a non-substantive change as defined at § 422.164(d)(1)(iv)(A). In addition to developing an ECDS-reported version of the measure, NCQA is considering additional changes to the hybrid-reported version. For measurement year 2028, NCQA is considering shortening the timeframe for the patient engagement after discharge and medication reconciliation indicators from 30 days to 14 days and adding a long term institution (LTI) flag so members who remain in long term care are not included in the measure. Shortening the timeframe for patient engagement would be substantive; therefore, the measure would need to be moved to display and proposed and finalized through rulemaking if NCQA proceeds with these changes.

Commenters generally supported technical refinements to the measure, such as adding an LTI flag and expanding pharmacist types. Some commenters supported the transition to ECDS reporting, while others emphasized the need for a phased implementation and additional testing due to ongoing interoperability challenges and uneven provider readiness. Many commenters opposed shortening the patient engagement and medication reconciliation timeframe from 30 to 14 days, citing access barriers, scheduling constraints, and concerns that it would disadvantage plans serving complex populations while prioritizing administrative speed over meaningful care coordination. Commenters also raised implementation concerns, requesting clearer guidance on data sources and attribution, extended transition timelines, risk adjustment for population complexity, and SNP-specific testing before full rollout. We have shared this feedback with NCQA for their consideration.

Diabetes Care – Blood Sugar Controlled (Part C). This measure is calculated from the HEDIS Glycemic Status Assessment for Patients With Diabetes hybrid measure. NCQA is developing an ECDS-reported version of this measure for measurement year 2027. Prior to implementation, NCQA is conducting testing for ECDS feasibility. Based on findings, NCQA plans to maintain the hybrid measure in HEDIS, in parallel with the ECDS measure, during a two-year transition period (measurement years 2027 – 2028), until the hybrid measure is replaced with the new ECDS-only measure in measurement year 2029. We will provide additional information when available. Many commenters appreciated the development of the ECDS-reported version and the proposed two-year transition period, but they urged NCQA and CMS to assess challenges related to ECDS reporting, including feasibility, validity, and adequate time for health plans to adapt and, if needed, to extend the transition period. We have shared this feedback with NCQA for their consideration.

Statin Use in Persons with Diabetes (SUPD) (Part D). The PQA updated the SUPD measure specifications in the 2026 PQA Measure Manual to add a denominator exception for those

individuals with diabetes who do not have a prescription claim for a statin but do have one or more prescription claims for either a proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor or bempedoic acid. The PQA revised the measure specifications to align with the 2024 American Diabetes Association (ADA) Standards of Care in Diabetes[23] updates on primary and secondary prevention of atherosclerotic cardiovascular disease (ASCVD).

According to the ADA Standards of Care, for primary prevention (10.24), the guidelines recommend that patients who are intolerant to statin therapy be treated with bempedoic acid as an alternative cholesterol-lowering drug to reduce cardiovascular event rates. Additionally, for secondary prevention (10.28), the guidelines recommend that for patients with diabetes and ASCVD who are intolerant to statin therapy, either a PCSK9 inhibitor therapy with monoclonal antibody treatment, bempedoic acid therapy, or a PCSK9 inhibitor therapy with inclisiran siRNA be considered as an alternative cholesterol-lowering therapy.

Therefore, the PQA updated the SUPD measure specifications to add a denominator exception for beneficiaries from the eligible population without one or more prescription claims for a statin medication and with one or more prescription claims for either bempedoic acid or one or more prescription claims for a PCSK9 inhibitor during the measurement year; a beneficiary is removed from the denominator after determining whether the numerator criteria are met and whether the beneficiary meets the exception criteria. However, if a beneficiary has one or more prescription claims for a statin medication during the measurement year, the beneficiary is still included in the denominator and numerator and is not eligible for the denominator exception. This measure specification update was approved by both the PQA's Measure Update Panel (MUP) and the PQA's Quality Metrics Expert Panel (QMEP).

Our analysis found that including the exception criteria had a negligible impact on the year of service (YOS) 2024 SUPD rates overall across all contract types. Most contracts with a denominator of 30 or more beneficiaries had zero to minimal change. For MA-PD contracts with a denominator of 30 or more beneficiaries, there was an increase in rates of about 0.57 percentage points, while the difference in rounded rates was zero percentage points. For PDP contracts with a denominator of 30 or more beneficiaries, there was an increase in rates of about 0.85 percentage points, while the difference in rounded rates was around 1 percentage point.

This change is a non-substantive update under § 423.184(d)(1)(i) because it is expected to slightly narrow the denominator population covered by the SUPD measure. CMS plans to add the denominator exception to the SUPD measure beginning with the 2026 measurement year (2028 Star Ratings).

Commenters supported updating the SUPD measure to add a denominator exception for beneficiaries with diabetes who do not have a statin claim but have one or more claims for a

[23] ADA Standards of Care in Diabetes- 2024 https://diabetesjournals.org/care/issue/47/Supplement_1.

PCSK9 inhibitor or bempedoic acid. Therefore, this update will be applied for the 2026 measurement year. A few suggested additional updates, such as adding additional exceptions for institutionalized beneficiaries or other conditions where statin therapy may be contraindicated or including other data source claims. We will investigate these ideas and share these comments with the measure steward.

Polypharmacy: Use of Multiple Anticholinergic Medications in Older Adults (Poly-ACH) (Part D). The PQA added clarity in the 2026 Measure Manual for identifying beneficiaries in the eligible population with two or more prescription claims for the same target medication on different dates of service during the measurement period. The same target medication refers to medications with the same anticholinergic active ingredient. This is a non-substantive update under § 423.184(d)(1) since it does not change the measure calculation. CMS plans to make this update to the Poly-ACH measure beginning with the 2026 measurement year (2028 Star Ratings).

Commenters supported this clarification to the Poly-ACH measure, and it will be implemented for the 2026 measurement year.

Section H. Efforts to Simplify and Refocus the Measure Set to Improve the Impact of the Star Ratings Program

As the Star Ratings program continues to evolve, we solicited feedback on new measures or measurement concepts that would incentivize plans from providing unnecessary, inappropriate, or low-value care. We stated we are also interested in measures related to medical errors or misdiagnoses. This could include measures focused on the clinical appropriateness of care or measures focused on ensuring diagnoses are not missed. There was mixed reaction to development of measures in these areas. Many commenters emphasized the importance of careful measure design, robust testing, and proper risk adjustment to avoid unintended consequences and ensure clinical appropriateness. A few commenters noted that plans often lack direct visibility into the clinical nuances needed to determine appropriateness. In considering new measures aimed at discouraging low-value care, commenters recommended that CMS ensure measures are grounded in strong clinical evidence and incorporate appropriate exclusions and risk adjustment for medical complexity. Some commenters expressed caution about misdiagnosis and medical error measures, citing limited standardized data and concerns about accurately attributing outcomes. We will take these comments into consideration as we consider future enhancements to the Star Ratings program.

Section I. Display Measures

Display measures on CMS.gov are published separately from the Star Ratings and include measures that are transitioned from inclusion in the Star Ratings, new or updated measures before inclusion into the Star Ratings, and informational-only measures. Organizations and sponsors have the opportunity to preview the data for their display measures prior to release on

CMS.gov. We anticipate all 2026 display measures will continue to be shown on CMS.gov in 2027 unless noted below. As we look for ways to simplify the program and reduce reporting burden, we also solicited feedback on display measures that could be removed.

Follow-up After Hospitalization for Mental Illness (Part C). NCQA is considering the addition of code POS 55 (Residential Substance Abuse Treatment Facility) to the measure's numerator and removing the remaining mental health provider type requirement to ensure alignment between all the HEDIS behavioral health care continuity measures by measurement year 2027. There is no expected impact to measure performance. There was mixed support for these potential changes. Commenters emphasized that the measure should not unfairly penalize plans or providers for factors beyond their control, such as the availability of behavioral health services within a given community or region. Some commenters raised concerns about limiting the provider type when calculating measure results. However, removing the remaining mental health provider type requirement means that any qualified healthcare provider (such as a primary care physician) can now perform the follow-up visit and have it count towards the measure, making it more flexible and easier to report; thus, this change is not limiting. We have shared this feedback with NCQA for their consideration.

Pharmacotherapy Management of Chronic Obstructive Pulmonary Disease (COPD) Exacerbation (Part C). NCQA is reevaluating this measure to ensure alignment with recent updates to clinical guidelines for COPD. Based on clinical and expert guidance, the reevaluation may result in the measure being updated or replaced. Any updates or new measures would be for measurement year 2027. All commenters supported this potential change. We have shared this feedback with NCQA.

Hospitalization for Potentially Preventable Complications (Part C). To ensure continued measure validity, NCQA is considering an update to this measure to allow the use of denied claims for capturing numerator events. In addition, NCQA is planning to re-estimate the risk adjustment models to account for more recent utilization patterns and align with updates to the CMS HCC model. Any updates would be introduced for measurement year 2028. There was mixed feedback on these potential updates. Several commenters expressed concern that counting denied claims would unfairly penalize health plans by including admissions that were found, through medical review, to be noncompliant with clinical guidelines, which could misrepresent actual plan quality and disregard effective utilization management and care coordination efforts. Commenters also highlighted the need for clear guidance and transparency around risk adjustment changes, as these methodologies could significantly impact reported plan performance. We have shared this feedback with NCQA for their consideration.

Initiation and Engagement of Substance Use Disorder Treatment (Part C). NCQA plans to add guidance for measurement year 2027 to clarify that multi-day substance use withdrawal events must be deduplicated if a claim was generated daily for one withdrawal episode. Most commenters supported the clarification, but a couple of commenters raised issues regarding data

sharing and the importance of testing this measure among D-SNPs. A commenter raised concerns that this is a claims-based measure so it does not account for community-level service availability, workforce shortages, and other barriers outside the control of physicians and plans. We have shared this feedback with NCQA for their consideration.

Antipsychotic Use in Persons with Dementia (APD) (Part D). Currently, brexpiprazole is included in the PQA Value Set and National Drug Codes (NDCs) for the APD measure. However, in 2023, the FDA approved a new indication for brexpiprazole for treatment of agitation associated with dementia due to Alzheimer's disease. Based on current measure specifications, beneficiaries in the denominator who receive a prescription for brexpiprazole for the new indication would be included in the numerator, despite using brexpiprazole for an indicated condition. In 2025, the PQA's MUP and QMEP approved the removal of brexpiprazole, an atypical antipsychotic, from the medication lists of drugs that are included for the APD measure. Additionally, brexpiprazole will be removed from the measure algorithm in determining whether a beneficiary is taking an antipsychotic medication indicated for the treatment of major depression. CMS plans to remove brexpiprazole from the APD measure beginning with the 2026 measurement year (2028 display page).

Commenters supported removing brexpiprazole from the APD measure list, and we will implement this update for the 2026 measurement year. A few commenters noted that some use of antipsychotics among residents with dementia living in a nursing facility may be appropriate and requested additional updates, such as excluding beneficiaries who are receiving hospice care, or commented about the use of antipsychotics among residents with dementia living in a nursing facility. We will share this feedback with the measure steward.

Use of Opioids at High Dosage in Persons without Cancer (OHD) (Part D). The PQA updated the OHD measure specifications in the 2026 PQA Measure Manual to revise the methodology for daily morphine milligram equivalent (MME) calculation and to update the MME conversion factors. Daily MME is calculated for each opioid prescription claim with a date of service during each opioid episode for the OHD measure. The daily MME is calculated by the following equation as updated by the PQA:

> *MME/day = (# of opioid dosage units per day) × (opioid strength per unit) × (MME conversion factor)*

The number of opioid dosage units per day is equal to the claim quantity dispensed divided by the claim days' supply. The opioid strength per unit and updated MME conversion factor are provided for each NDC in the PQA's Value Set, Opioids. When applying this updated formula to transdermal fentanyl patches, the opioid dosage units per day should always be 1, regardless of the claim's quantity dispensed or days' supply. Additionally, the PQA's Value Set, Opioids expresses weight-based strengths in milligrams, while the Centers for Disease Control and Prevention (CDC) MME conversion factors are based on micrograms. Thus, the PQA uses an adjusted MME conversion factor of 2,400 for transdermal fentanyl patches reported in

milligrams (conversion factor of 2.4 for transdermal fentanyl patches reported in micrograms). This conversion factor accounts for the change in unit compared to the CDC and should be applied directly in the PQA's formula for calculating daily MME. Finally, this methodology aligns with opioid MME calculation methodology used in the CMS Part D Opioid Drug Utilization Review (DUR) policy and Overutilization Monitoring System (OMS), described in the OMS technical guidance.[24]

The PQA QMEP voted to approve these changes in 2025. CMS plans to incorporate the updated MME calculation methodology beginning with the 2026 measurement year (2028 display page) at the earliest.

Most commenters supported updating the MME calculation and conversion factors, and we will implement the updates to the OHD measure for the 2026 measurement year (2028 display page).

A few commenters raised concerns that the measure was duplicative of other Part D opioid-related policies or would cause unintended consequences. The Part D opioid-related policies were carefully developed to balance the need to address opioid misuse with the need to maintain a positive patient-doctor relationship, preserve access to medically necessary drug regimens, and reduce the potential for unintended consequences. The OHD measure complements existing policies, such as drug management programs (DMPs) and point-of-sale opioid safety edits. We will continue to monitor the impact of these policies and measures. As a reminder, the OHD measure is not a prescribing limit and should not replace clinical judgment.

Section J. Retirement of Display Measures

Disenrollment Reasons Survey measures (Part C and D). The Disenrollment Reasons Survey is no longer being conducted. Therefore, starting with the 2027 display page, CMS will no longer have data to calculate the following measures: Disenrollment Reasons – Problems Getting the Plan to Provide and Pay for Needed Care (MA-PD, MA-only); Disenrollment Reasons – Problems with Coverage of Doctors and Hospitals (MA-PD, MA-only); Disenrollment Reasons – Financial Reasons for Disenrollment (MA-PD, MA-only, PDP); Disenrollment Reasons – Problems with Prescription Drug Benefits and Coverage (MA-PD, PDP); and Disenrollment Reasons – Problems Getting Information and Help from the Plan (MA-PD, PDP). There was mixed support for the removal of these measures; however, given that the survey is no longer being conducted, these measures will be removed from the display page.

Antipsychotic Use in Persons with Dementia for Long-Term Nursing Home Residents (APD-LTNH) (Part D). CMS plans to retire the APD-LTNH measure and retain the consensus-based APD measure that focuses on all enrollees regardless of setting. CMS previously retired the APD for Community-Only Residents (APD-COMM) measure.

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[24] OMS Technical Guidance available at: https://www.cms.gov/medicare/coverage/prescription-drug-coverage-contracting/improving-drug-utilization-review-controls-part-d.

Based on CMS's analysis of the APD and APD-LTNH measure rates from measurement years 2020 to 2023, the APD-LTNH mean rates were better than the APD mean rates across all contracts and when stratified by MA-PDs and PDPs. Since retiring the APD-COMM measure in 2020, the MA-PD and PDP rates for the overall APD measure have been gradually increasing (worsening), while the APD-LTNH measure rates have been generally decreasing (improving). Therefore, we can attribute the worsening performance to the APD community population.

CMS plans to retire the APD-LTNH measure from the 2028 display page (measurement year 2026) to reduce administrative burden and potential duplication of efforts. The APD-LTNH measure is a CMS-developed measure, whereas the PQA-endorsed APD measure is a standardized measure developed through a consensus-based process. The APD-LTNH measure rates are improving, and all beneficiaries in the APD-LTNH measure are captured in the APD measure. Therefore, we can refocus on the community population and maintain focus on the long-term nursing home population with the APD measure.

All commenters supported retiring the APD-LTNH measure, and this measure will be retired for the 2026 measurement year (2028 display page).

Section K. Potential Methodological Enhancements for Future Years

As we continue efforts to simplify the Star Ratings program, we are considering methodological enhancements to make the calculations easier to understand and implement, such as changes to simplify the methodology for determining measure thresholds. For example, one such approach could involve using percentile distribution cut offs to assign measure stars instead of the current clustering methodology for non-CAHPS measures.

Some commenters expressed support for moving away from clustering and adopting percentile-based methods for Star Ratings, emphasizing the potential for improved transparency, predictability, and interpretability. Others opposed replacing clustering, expressing concerns about arbitrary cut point shifts, artificial distinctions between similar plans, and possible confusion for beneficiaries. Many commenters recommended that CMS offer more detailed methodological information and conduct impact analyses before implementing changes, proposing a transparent, phased-in approach with opportunities for feedback. Additional suggestions included using pre-determined cut points, simplifying scoring for narrowly distributed measures, and considering alternative statistical methods to enhance stability and predictability. We will take these comments into consideration as we consider ways to simplify the Star Ratings methodology. Any changes to the methodology would need to be made through notice and comment rulemaking.

Attachment VII. Economic Information for the CY 2027 Rate Announcement

Below, we provide the economic information for significant provisions in the CY 2027 Rate Announcement. Provisions not specifically addressed below are intended to represent a continuation of the policies established for CY 2026 and, as a result, do not have an impact associated with them.

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

A1. Medicare Advantage and PACE non-ESRD Ratebook

The FFS growth percentage for the 2027 MA non-ESRD rates is estimated to be 5.46 percent, and the MA growth percentage for the 2027 MA non-ESRD rates is estimated to be 4.40 percent. The MA non-ESRD ratebook impact summarized here is calculated by comparing 2027 Part C expenditures reflecting these growth rate assumptions to the expected 2027 Part C expenditures assuming the MA non-ESRD ratebook remains unchanged from that finalized for 2026. The net impact on the Medicare Trust Funds for CY 2027 is expected to be $23.16 billion. This figure accounts for the impact of the benchmark rate cap, MA rebate, and MA EGWP policies, as well as the portion of the difference between benchmarks and bids that the government retains, and the portion of the program costs covered by Part B premiums.

The MA growth percentage, used to calculate the 2027 PACE non-ESRD rates as well as in development of the applicable amount used in setting MA non-ESRD rates, is estimated to be 4.40 percent. The PACE non-ESRD ratebook impact is calculated by comparing the 2027 PACE expenditures reflecting this growth rate assumption to the expected 2027 PACE expenditures assuming that the PACE non-ESRD ratebook remains unchanged from the CY 2026 PACE non-ESRD ratebook. The net impact on the Medicare Trust Funds for CY 2027 for the PACE ratebook change is expected to be $160 million. This figure accounts for the portion of the program costs covered by Part B premiums.

The net impact on the Medicare Trust Funds for CY 2027 of implementing the zero-claims adjustment in Puerto Rico is expected to be $350 million.

A2. Medicare Advantage and PACE ESRD Ratebooks

The FFS growth percentage for the 2027 MA ESRD rates is estimated to be 6.96 percent. The impact on the MA and PACE ESRD ratebooks is calculated by comparing projected 2027 Part C expenditures with this growth rate assumption to the expected 2027 Part C expenditures with the assumption that the MA and PACE ESRD ratebooks would have been unchanged from those finalized for CY 2026. The net impact on the Medicare Trust Funds for CY 2027 is expected to be $2.27 billion. This figure accounts for the portion of the program costs covered by Part B premiums.

A3. Sources of Diagnoses

For CY 2027, CMS is excluding diagnoses from audio-only services and those from unlinked CRRs, with an exception for beneficiaries who switch from one MA organization to another, from risk score calculation. This is expected to have a $6.84 billion net savings to the Medicare Trust Funds in CY 2027. When estimating the impact of the unlinked CRR diagnoses exclusion, with the switcher exception, the impact takes into account the portion of the difference between benchmarks and bids that the government retains, and the portion of the program costs covered by Part B premiums.

A4. ESRD Risk Adjustment Model

For CY 2027, CMS is continuing the use of the ESRD risk adjustment models used for MA payment in CY 2026. Therefore, no economic impact is applicable.

A5. Frailty Adjustment for FIDE SNPs

For CY 2027, CMS is continuing the CY 2026 policy to use the frailty factors associated with the 2024 CMS-HCC risk adjustment model and, therefore, no economic impact is applicable.

A6. MA Coding Pattern Difference Adjustment

For CY 2027, CMS will continue to apply the statutory minimum coding pattern difference adjustment (5.90 percent). There is no change in policy from CY 2026 and therefore, the year-over-year impact is zero and no economic impact is applicable.

A7. Part C Normalization[25]

The normalization factors serve to offset the trend in risk scores and maintain a 1.0 average FFS risk score for the CMS-HCC models. For CY 2027, for all CMS-HCC risk adjustment models, CMS is calculating the normalization factors using a four-year simple linear regression methodology and average historical FFS risk scores from 2022-2025. Since normalization is applied to risk scores to maintain the same average risk score year-over-year, the economic impact of normalization is zero.

Section B. Changes in the Payment Methodology for Medicare Part D for CY 2026

B1. Annual Percentage Increase for Part D Parameters

The methodology for updating other Part D parameters for CY 2027 generally remains unchanged from that used for CY 2026. However, statutory changes may result in potential payment impacts for CY 2027. At this time, the impact on the Medicare Trust Fund is uncertain

[25] Because CMS is continuing the CY 2026 policy of using the 2024 CMS-HCC risk adjustment for MA payment, there is no risk model revision so the year-over-year impact of the risk adjustment model is zero. Therefore, there is no economic impact of the model for CY 2027.

since the impact of such parameter updates is generally dependent on the behavior and bid assumptions of Part D plan sponsors.

B2. Part D Risk Adjustment Model

For CY 2027, we are implementing RxHCC risk adjustment models with updates that include revisions to reflect the statutory changes in the Part D benefit structure for CY 2027. CMS is using a model calibrated on 2023 diagnoses and 2024 expenditures with separate segments for MA-PD plans and PDPs and, for PACE organizations, a model that continues to be calibrated on 2018 diagnoses and 2019 expenditures. In order to calculate risk scores for payment, the dollar coefficients must be denominated to create relative factors. The denominator is the average predicted per capita expenditure predicted by the payment model for a given year. To calculate the denominator, we use the recalibrated model and diagnosis data for Medicare beneficiaries enrolled in both MA-PD plans and PDPs, which results in an average risk score of 1.0 for the enrolled Part D population in the denominator year. Recalibration of the RxHCC model can result in changes in risk scores for individual beneficiaries and for plan level risk scores; however, the average risk score in the denominator year remains 1.0, and the application of the normalization factor functions to maintain the 1.0 in the payment year. Since the average risk score is 1.0 under the existing model and the recalibrated model, the economic impact of the recalibrated model is zero.

B3. Part D Normalization

The normalization factors serve to offset the trend in risk scores and maintain a 1.0 average risk score across the Part D program (MA-PD plans and PDPs) for the RxHCC model. For CY 2027, CMS is calculating separate MA-PD and PDP normalization factors for the RxHCC model (2023/2024 calibration) being finalized for MA (and partially for PACE organizations) using the multiple linear regression methodology and average historical risk scores from 2020 through 2024 and, for the 2018/2019 calibration being finalized solely for PACE organizations, using the historical linear slope methodology and average historical risk scores from 2016 through 2020. Since normalization is applied to risk scores to maintain the same average risk score of 1.0 year-over-year, the impact of normalization is zero.

Attachment VIII. RxHCC Risk Adjustment Factors

RxHCC Risk Adjustment Factor Tables for Medicare Advantage Prescription Drug Plan (MA-PD)

Table VIII-1. 2027 RxHCC Model Relative Factors for Continuing Enrollees (2023/2024 Calibration; Medicare Advantage Prescription Drug Plan (MA-PD))

Variable	Description Label	Community, Non-Low Income, Age≥65	Community, Non-Low Income, Age<65	Community, Low Income, Age≥65	Community, Low Income, Age<65	Institutional
Female						
0-34 Years		-	0.282	-	0.649	1.653
35-44 Years		-	0.395	-	0.745	2.522
45-54 Years		-	0.322	-	0.706	1.720
55-59 Years		-	0.166	-	0.401	1.647
60-64 Years		-	0.089	-	0.131	1.195
65-69 Years		0.114	-	0.050	-	1.220
70-74 Years		0.013	-	0.050	-	0.852
75-79 Years		0.013	-	0.050	-	0.479
80-84 Years		0.013	-	0.050	-	0.026
85-89 Years		0.013	-	0.050	-	0.026
90-94 Years		0.013	-	0.050	-	0.026
95 Years or Over		0.013	-	0.050	-	0.026
Male						
0-34 Years		-	0.130	-	0.623	1.916
35-44 Years		-	0.170	-	0.566	1.730
45-54 Years		-	0.151	-	0.379	1.579
55-59 Years		-	0.106	-	0.186	1.121
60-64 Years		-	0.080	-	0.046	0.933
65-69 Years		0.144	-	0.288	-	0.856
70-74 Years		0.117	-	0.193	-	0.598
75-79 Years		0.026	-	0.015	-	0.355
80-84 Years		0.026	-	0.015	-	0.075
85-89 Years		0.026	-	0.015	-	0.075
90-94 Years		0.026	-	0.015	-	0.075
95 Years or Over		0.026	-	0.015	-	0.075
Originally Disabled Interactions with Sex						
Originally Disabled Female		0.046	-	0.384	-	0.282
Originally Disabled Male		-	-	0.125	-	0.282
Disease Coefficients						
RXHCC1	HIV/AIDS	8.304	9.870	9.495	9.413	7.923
RXHCC5	Opportunistic Infections	0.603	0.251	0.784	0.572	0.350
RXHCC15	Chronic Myeloid Leukemia	5.500	5.147	15.374	21.584	8.699
RXHCC16	Multiple Myeloma and Other Hematologic Cancers	13.265	11.777	12.257	11.198	5.921
RXHCC17	Secondary Cancer of Bone and Kidney	5.500	5.147	12.166	11.198	5.594
RXHCC18	Secondary Cancer of Lung, Liver, Brain, and Other Sites	2.953	2.851	4.487	3.908	1.605
RXHCC19	Leukemias and Other Hematologic Cancers	2.953	2.851	4.076	3.601	1.605
RXHCC20	Lung, Kidney, and Other Cancers; Secondary Cancer of Lymph Nodes and Other Sites	0.678	0.489	1.315	0.885	0.312
RXHCC21	Lymphomas and Other Hematologic Cancers	0.678	0.489	0.706	0.364	0.312
RXHCC22	Prostate, Breast, Bladder, and Other Cancers and Tumors	0.152	0.101	0.427	0.319	0.243
RXHCC30	Diabetes with Complications	0.429	0.618	0.852	1.443	0.633
RXHCC31	Diabetes without Complication	0.232	0.325	0.418	0.734	0.259
RXHCC40	Alpha-1-Antitrypsin Deficiency	2.285	5.523	6.326	7.217	1.638
RXHCC41	Lysosomal Storage Disorders	4.133	11.642	4.392	20.324	0.141
RXHCC42	Acromegaly and Other Endocrine and Metabolic Disorders	2.505	6.368	2.390	6.599	1.212
RXHCC43	Pituitary, Adrenal Gland, and Other Endocrine and Metabolic Disorders	0.023	0.086	0.025	0.053	0.141
RXHCC44	Thyroid Disorders	0.054	0.169	0.116	0.310	0.159

Variable	Description Label	Community, Non-Low Income, Age≥65	Community, Non-Low Income, Age<65	Community, Low Income, Age≥65	Community, Low Income, Age<65	Institutional
RXHCC47	Disorders of Lipoid Metabolism	-	-	0.055	0.095	0.057
RXHCC54	Chronic Viral Hepatitis C	0.211	0.165	0.300	0.102	0.533
RXHCC55	Acute or Unspecified Viral Hepatitis C	0.211	0.165	0.300	0.102	0.533
RXHCC56	Chronic Viral Hepatitis B and Other Specified Chronic Viral Hepatitis	0.140	0.463	1.090	0.624	0.931
RXHCC59	Primary Biliary Cirrhosis	1.035	1.090	1.709	2.428	1.447
RXHCC65	Chronic Pancreatitis	0.202	0.498	0.678	1.027	0.902
RXHCC66	Pancreatic Disorders and Intestinal Malabsorption, Except Pancreatitis	0.202	0.498	0.642	1.027	0.483
RXHCC67	Inflammatory Bowel Disease	0.362	0.843	1.250	2.757	0.370
RXHCC80	Aseptic Necrosis of Bone	0.103	0.262	0.155	0.350	0.543
RXHCC81	Psoriatic Arthropathy	0.719	0.838	6.691	9.325	4.194
RXHCC82	Systemic Sclerosis	1.429	1.919	1.718	2.080	0.599
RXHCC83	Rheumatoid Arthritis and Other Inflammatory Polyarthropathy	0.139	0.244	1.225	2.080	0.599
RXHCC84	Systemic Lupus Erythematosus and Other Systemic Connective Tissue Disorders	0.114	0.136	0.339	0.426	0.422
RXHCC87	Osteoporosis, Vertebral and Pathological Fractures	0.050	0.231	0.182	0.468	0.049
RXHCC95	Sickle Cell Anemia	0.014	0.071	-	1.061	-
RXHCC96	Acquired Hemolytic, Aplastic, and Sideroblastic Anemias	1.076	1.469	1.108	1.344	0.274
RXHCC98	Hereditary Angioedema and Other Defects in the Complement System	6.992	38.627	7.999	38.405	4.374
RXHCC99	Immune Disorders	0.418	0.448	0.831	1.414	0.374
RXHCC100	Immune Thrombocytopenic Purpura	0.449	0.266	2.418	2.726	1.800
RXHCC111	Alzheimer's Disease	-	-	-	-	-
RXHCC112	Dementia, Except Alzheimer's Disease	-	-	-	-	-
RXHCC130	Schizophrenia and Other Psychosis	0.249	0.279	0.949	1.594	0.753
RXHCC131	Bipolar Disorders	0.225	0.151	0.680	0.755	0.629
RXHCC132	Depression	0.040	0.033	0.083	0.212	0.169
RXHCC133	Anxiety and Other Psychiatric Disorders	0.023	0.020	-	0.024	-
RXHCC146	Profound or Severe Intellectual Disability/Developmental Disorder	0.811	-	0.331	0.143	-
RXHCC147	Moderate Intellectual Disability/Developmental Disorder	0.811	-	0.175	-	-
RXHCC148	Mild or Unspecified Intellectual Disability/Developmental Disorder	0.811	-	0.030	-	-
RXHCC153	Myasthenia Gravis and Other Myoneural Disorders	2.067	3.552	2.466	4.059	1.073
RXHCC154	Amyotrophic Lateral Sclerosis and Other Motor Neuron Disease	3.827	3.734	2.505	3.786	0.549
RXHCC155	Spinal Cord Disorders	0.054	0.113	-	0.053	-
RXHCC157	Chronic Inflammatory Demyelinating Polyneuritis	4.803	9.149	6.163	9.272	1.510
RXHCC158	Inflammatory and Toxic Neuropathy	-	0.064	-	-	0.202
RXHCC159	Multiple Sclerosis	0.681	1.127	2.629	4.810	1.376
RXHCC160	Huntington Disease	1.957	2.356	5.473	6.735	5.822
RXHCC161	Parkinson Disease	0.320	0.754	0.592	1.351	1.094
RXHCC163	Intractable Epilepsy	-	0.204	0.229	1.798	0.023
RXHCC164	Epilepsy and Other Seizure Disorders, Except Intractable Epilepsy	-	-	-	-	-
RXHCC166	Migraine Headaches	0.107	0.180	0.466	0.811	0.687
RXHCC168	Trigeminal and Postherpetic Neuralgia	0.039	0.268	0.134	0.365	-
RXHCC183	Pulmonary Arterial Hypertension	1.901	8.900	2.495	8.337	0.638

Variable	Description Label	Community, Non-Low Income, Age≥65	Community, Non-Low Income, Age<65	Community, Low Income, Age≥65	Community, Low Income, Age<65	Institutional
RXHCC184	Pulmonary Hypertension, Except Arterial, and Other Pulmonary Heart Disease	0.232	0.419	0.210	0.475	0.327
RXHCC186	Heart Failure	0.163	0.183	0.170	0.249	0.220
RXHCC187	Hypertension	0.045	0.077	0.069	0.161	0.048
RXHCC188	Coronary Artery Disease	0.066	-	0.129	-	-
RXHCC191	Ventricular Septal Defect and Major Congenital Heart Disorders	0.138	0.520	0.506	-	-
RXHCC193	Atrial Arrhythmias	0.231	0.087	0.237	0.089	0.220
RXHCC207	Spastic Hemiplegia	-	0.074	-	0.163	-
RXHCC215	Venous Thromboembolism	0.257	0.238	0.264	0.353	0.178
RXHCC225	Cystic Fibrosis	8.032	42.156	6.036	41.202	5.260
RXHCC226	Idiopathic Pulmonary Fibrosis and Systemic Sclerosis with Lung Involvement	2.752	3.365	5.621	6.036	1.241
RXHCC227	Pulmonary Fibrosis, Except Idiopathic	0.273	0.622	0.457	1.103	0.460
RXHCC228	Severe Persistent Asthma	0.904	0.877	3.068	3.510	1.685
RXHCC229	Chronic Obstructive Pulmonary Disease, Bronchiectasis, and Other Asthma	0.170	0.103	0.365	0.317	0.460
RXHCC243	Glaucoma, Open-Angle or Moderate/Severe Stage	0.095	0.155	0.269	0.485	0.281
RXHCC244	Other Non-Acute Glaucoma	0.022	0.063	0.072	0.025	0.009
RXHCC260	Kidney Transplant Status	-	-	-	-	-
RXHCC261	Dialysis Status, Including End Stage Renal Disease	-	-	-	-	-
RXHCC262	Chronic Kidney Disease Stage 5	-	-	-	-	-
RXHCC263	Chronic Kidney Disease Stage 4	-	-	-	-	-
RXHCC311	Chronic Ulcer of Skin, Except Pressure	0.071	0.023	0.070	0.016	0.037
RXHCC314	Pemphigus, Pemphigoid, and Other Bullous Skin Disorders	0.295	0.541	0.997	1.805	0.431
RXHCC316	Psoriasis, Except with Arthropathy	0.198	0.393	2.104	3.443	1.427
RXHCC317	Discoid Lupus Erythematosus	0.064	-	-	-	-
RXHCC355	Narcolepsy and Cataplexy	0.888	2.987	2.211	4.675	0.898
RXHCC395	Stem Cell, Including Bone Marrow, Transplant Status/Complications	3.930	3.941	5.263	3.899	3.069
RXHCC396	Heart, Lung, Liver, Intestine, or Pancreas Transplant Status	-	-	-	-	-
Non-Aged Disease Interactions						
NonAged_RXHCC1	NonAged * HIV/AIDS	-	-	-	-	1.715
NonAged_RXHCC130	NonAged * Schizophrenia and Other Psychosis	-	-	-	-	1.009
NonAged_RXHCC131	NonAged * Bipolar Disorders	-	-	-	-	0.394
NonAged_RXHCC132	NonAged * Depression	-	-	-	-	0.206
NonAged_RXHCC133	NonAged * Anxiety and Other Psychiatric Disorders	-	-	-	-	-
NonAged_RXHCC159	NonAged * Multiple Sclerosis	-	-	-	-	1.361
NonAged_RXHCC163	NonAged * Intractable Epilepsy	-	-	-	-	0.297

NOTE: The Part D Denominator used to calculate relative factors is $2,544.56. This Part D Denominator is based on the combined PDP and MA-PD populations.

SOURCE: RTI Analysis of 100% 2023-2024 Medicare Enrollment Data, 2024 Prescription Drug Event (PDE) Data, 2023 Professional Claims (Carrier), 2023 Inpatient Claims, 2023 Outpatient Claims, and 2023 Medicare Advantage Encounter Data.

Table VIII-2. 2027 RxHCC Model Relative Factors for New Enrollees, Non-Low Income (2023/2024 Calibration; Medicare Advantage Prescription Drug Plan (MA-PD))

Variable	Not Concurrently ESRD, Not Originally Disabled	Concurrently ESRD, Not Originally Disabled	Not Concurrently ESRD, Originally Disabled	Concurrently ESRD, Originally Disabled
Female				
0-34 Years	1.968	1.968	-	-
35-44 Years	1.968	1.968	-	-
45-54 Years	1.556	1.556	-	-
55-59 Years	1.556	1.556	-	-
60-64 Years	1.556	1.556	-	-

Variable	Not Concurrently ESRD, Not Originally Disabled	Concurrently ESRD, Not Originally Disabled	Not Concurrently ESRD, Originally Disabled	Concurrently ESRD, Originally Disabled
65 Years	0.425	1.133	1.149	1.133
66 Years	0.445	1.133	1.136	1.133
67 Years	0.466	1.133	1.136	1.133
68 Years	0.501	1.133	1.136	1.133
69 Years	0.503	1.133	1.051	1.133
70-74 Years	0.536	1.133	1.051	1.133
75-79 Years	0.625	1.133	1.051	1.133
80-84 Years	0.590	1.133	0.590	1.133
85-89 Years	0.590	1.133	0.590	1.133
90-94 Years	0.187	1.133	0.187	1.133
95 Years or Over	0.187	1.133	0.187	1.133
Male				
0-34 Years	1.262	1.262	-	-
35-44 Years	1.262	1.262	-	-
45-54 Years	1.400	1.400	-	-
55-59 Years	1.400	1.400	-	-
60-64 Years	1.400	1.400	-	-
65 Years	0.531	1.226	1.269	1.226
66 Years	0.575	1.226	1.269	1.226
67 Years	0.588	1.226	1.229	1.226
68 Years	0.669	1.226	1.115	1.226
69 Years	0.669	1.226	0.913	1.226
70-74 Years	0.669	1.226	0.913	1.226
75-79 Years	0.804	1.226	0.804	1.226
80-84 Years	0.804	1.226	0.804	1.226
85-89 Years	0.762	1.226	0.762	1.226
90-94 Years	0.762	1.226	0.762	1.226
95 Years or Over	0.762	1.226	0.762	1.226

NOTES:

1. The Part D Denominator used to calculate relative factors is $2,544.56. This Part D Denominator is based on the combined PDP and MA-PD populations.
2. Originally Disabled is defined as originally entitled to Medicare by disability only (OREC = 1).
3. For new enrollees, the concurrent ESRD marker is defined as at least one month in the payment year of ESRD status—dialysis, transplant, or functioning graft.

SOURCE: RTI Analysis of 100% 2023-2024 Medicare Enrollment Data, 2024 Prescription Drug Event (PDE) Data, 2023 Professional Claims (Carrier), 2023 Inpatient Claims, 2023 Outpatient Claims, and 2023 Medicare Advantage Encounter Data.

Table VIII-3. 2027 RxHCC Model Relative Factors for New Enrollees, Low Income (2023/2024 Calibration; Medicare Advantage Prescription Drug Plan (MA-PD))

Variable	Not Concurrently ESRD, Not Originally Disabled	Concurrently ESRD, Not Originally Disabled	Not Concurrently ESRD, Originally Disabled	Concurrently ESRD, Originally Disabled
Female				
0-34 Years	2.789	2.789	-	-
35-44 Years	2.789	2.789	-	-
45-54 Years	2.789	2.789	-	-
55-59 Years	2.452	2.452	-	-
60-64 Years	2.452	2.452	-	-
65 Years	1.205	1.935	2.112	1.935
66 Years	0.895	1.935	1.581	1.935
67 Years	0.828	1.935	1.195	1.935
68 Years	0.783	1.935	0.827	1.935
69 Years	0.739	1.935	0.827	1.935
70-74 Years	0.721	1.935	0.827	1.935
75-79 Years	0.721	1.935	0.710	1.935
80-84 Years	0.664	1.935	0.664	1.935
85-89 Years	0.664	1.935	0.664	1.935
90-94 Years	0.377	1.935	0.377	1.935
95 Years or Over	0.377	1.935	0.377	1.935
Male				
0-34 Years	1.990	1.990	-	-
35-44 Years	1.990	1.990	-	-
45-54 Years	1.990	1.990	-	-
55-59 Years	1.990	1.990	-	-
60-64 Years	1.990	1.990	-	-
65 Years	1.122	1.954	1.575	1.954
66 Years	0.830	1.954	1.575	1.954

Variable	Not Concurrently ESRD, Not Originally Disabled	Concurrently ESRD, Not Originally Disabled	Not Concurrently ESRD, Originally Disabled	Concurrently ESRD, Originally Disabled
67 Years	0.803	1.954	0.868	1.954
68 Years	0.803	1.954	0.868	1.954
69 Years	0.724	1.954	0.754	1.954
70-74 Years	0.657	1.954	0.657	1.954
75-79 Years	0.657	1.954	0.657	1.954
80-84 Years	0.591	1.954	0.591	1.954
85-89 Years	0.591	1.954	0.591	1.954
90-94 Years	0.466	1.954	0.466	1.954
95 Years or Over	0.466	1.954	0.466	1.954

NOTES:

1. The Part D Denominator used to calculate relative factors is $2,544.56. This Part D Denominator is based on the combined PDP and MA-PD populations.
2. Originally Disabled is defined as originally entitled to Medicare by disability only (OREC = 1).
3. For new enrollees, the concurrent ESRD marker is defined as at least one month in the payment year of ESRD status—dialysis, transplant, or functioning graft.

SOURCE: RTI Analysis of 100% 2023-2024 Medicare Enrollment Data, 2024 Prescription Drug Event (PDE) Data, 2023 Professional Claims (Carrier), 2023 Inpatient Claims, 2023 Outpatient Claims, and 2023 Medicare Advantage Encounter Data.

Table VIII-4. 2027 RxHCC Model Relative Factors for New Enrollees, Institutional (2023/2024 Calibration; Medicare Advantage Prescription Drug Plan (MA-PD))

Variable	Not Concurrently ESRD	Concurrently ESRD
Female		
0-34 Years	3.356	2.649
35-44 Years	3.356	2.649
45-54 Years	3.356	2.649
55-59 Years	2.961	2.649
60-64 Years	2.637	2.649
65 Years	2.637	2.649
66 Years	2.637	2.649
67 Years	1.982	2.649
68 Years	1.982	2.649
69 Years	1.724	2.649
70-74 Years	1.724	2.649
75-79 Years	1.724	2.649
80-84 Years	1.059	2.649
85-89 Years	1.059	2.649
90-94 Years	0.591	2.649
95 Years or Over	0.591	2.649
Male		
0-34 Years	2.667	2.279
35-44 Years	2.667	2.279
45-54 Years	2.391	2.279
55-59 Years	2.087	2.279
60-64 Years	2.087	2.279
65 Years	2.087	2.279
66 Years	2.087	2.279
67 Years	1.805	2.279
68 Years	1.805	2.279
69 Years	1.501	2.279
70-74 Years	1.501	2.279
75-79 Years	1.315	2.279
80-84 Years	1.315	2.279
85-89 Years	1.315	2.279
90-94 Years	0.834	2.279
95 Years or Over	0.527	2.279

NOTES:

1. The Part D Denominator used to calculate relative factors is $2,544.56. This Part D Denominator is based on the combined PDP and MA-PD populations.
2. For new enrollees, the concurrent ESRD marker is defined as at least one month in the payment year of ESRD status—dialysis, transplant, or functioning graft.

SOURCE: RTI Analysis of 100% 2023-2024 Medicare Enrollment Data, 2024 Prescription Drug Event (PDE) Data, 2023 Professional Claims (Carrier), 2023 Inpatient Claims, 2023 Outpatient Claims, and 2023 Medicare Advantage Encounter Data.

RxHCC Risk Adjustment Factor Tables for Standalone Prescription Drug Plan (PDP)

Table VIII-5. 2027 RxHCC Model Relative Factors for Continuing Enrollees (2023/2024 Calibration; Standalone Prescription Drug Plan (PDP))

Variable	Description Label	Community, Non-Low Income, Age≥65	Community, Non-Low Income, Age<65	Community, Low Income, Age≥65	Community, Low Income, Age<65	Institutional
Female						
0-34 Years		-	0.675	-	0.525	3.226
35-44 Years		-	0.581	-	0.694	2.241
45-54 Years		-	0.457	-	0.616	1.614
55-59 Years		-	0.196	-	0.411	1.505
60-64 Years		-	0.222	-	0.280	1.286
65-69 Years		0.136	-	0.076	-	1.233
70-74 Years		0.036	-	0.076	-	0.984
75-79 Years		0.036	-	0.076	-	0.714
80-84 Years		0.036	-	0.076	-	0.415
85-89 Years		0.036	-	0.076	-	0.253
90-94 Years		0.036	-	0.076	-	0.069
95 Years or Over		0.036	-	0.076	-	0.069
Male						
0-34 Years		-	0.372	-	0.617	2.637
35-44 Years		-	0.305	-	0.581	2.103
45-54 Years		-	0.270	-	0.506	1.443
55-59 Years		-	0.309	-	0.352	1.165
60-64 Years		-	0.288	-	0.296	0.992
65-69 Years		0.215	-	0.300	-	0.966
70-74 Years		0.201	-	0.268	-	0.724
75-79 Years		0.175	-	0.210	-	0.520
80-84 Years		0.072	-	0.113	-	0.350
85-89 Years		0.072	-	0.054	-	0.235
90-94 Years		0.072	-	0.054	-	0.096
95 Years or Over		0.072	-	0.054	-	0.025
Originally Disabled Interactions with Sex						
Originally Disabled Female		0.045	-	0.317	-	0.305
Originally Disabled Male		-	-	0.152	-	0.305
Disease Coefficients						
RXHCC1	HIV/AIDS	9.794	10.931	10.513	9.946	7.831
RXHCC5	Opportunistic Infections	0.612	0.237	0.625	0.093	0.191
RXHCC15	Chronic Myeloid Leukemia	6.057	5.951	14.475	21.701	9.849
RXHCC16	Multiple Myeloma and Other Hematologic Cancers	14.286	11.089	12.949	12.082	5.840
RXHCC17	Secondary Cancer of Bone and Kidney	6.057	5.951	12.055	10.885	5.840
RXHCC18	Secondary Cancer of Lung, Liver, Brain, and Other Sites	3.401	3.448	4.667	4.731	1.461
RXHCC19	Leukemias and Other Hematologic Cancers	3.401	3.448	4.667	4.542	1.461
RXHCC20	Lung, Kidney, and Other Cancers; Secondary Cancer of Lymph Nodes and Other Sites	0.832	0.859	1.442	1.113	0.460
RXHCC21	Lymphomas and Other Hematologic Cancers	0.832	0.849	1.203	0.685	0.460
RXHCC22	Prostate, Breast, Bladder, and Other Cancers and Tumors	0.150	0.060	0.549	0.599	0.266
RXHCC30	Diabetes with Complications	0.616	0.629	0.953	1.306	0.602
RXHCC31	Diabetes without Complication	0.299	0.530	0.442	0.726	0.295
RXHCC40	Alpha-1-Antitrypsin Deficiency	2.285	9.734	7.528	7.492	0.481
RXHCC41	Lysosomal Storage Disorders	8.193	17.187	10.641	22.270	0.446
RXHCC42	Acromegaly and Other Endocrine and Metabolic Disorders	3.420	3.618	2.404	6.539	0.196
RXHCC43	Pituitary, Adrenal Gland, and Other Endocrine and Metabolic Disorders	0.072	0.027	-	0.224	0.045
RXHCC44	Thyroid Disorders	0.052	0.054	0.170	0.285	0.167
RXHCC47	Disorders of Lipoid Metabolism	-	-	0.091	0.081	0.015

Variable	Description Label	Community, Non-Low Income, Age≥65	Community, Non-Low Income, Age<65	Community, Low Income, Age≥65	Community, Low Income, Age<65	Institutional
RXHCC54	Chronic Viral Hepatitis C	0.104	0.309	0.157	0.060	0.483
RXHCC55	Acute or Unspecified Viral Hepatitis C	0.104	0.309	0.157	0.060	0.483
RXHCC56	Chronic Viral Hepatitis B and Other Specified Chronic Viral Hepatitis	0.533	0.091	1.362	1.135	0.087
RXHCC59	Primary Biliary Cirrhosis	1.089	0.960	1.751	1.849	0.777
RXHCC65	Chronic Pancreatitis	0.423	1.254	0.889	1.495	0.596
RXHCC66	Pancreatic Disorders and Intestinal Malabsorption, Except Pancreatitis	0.299	1.254	0.889	1.495	0.535
RXHCC67	Inflammatory Bowel Disease	0.551	1.344	1.463	3.538	0.483
RXHCC80	Aseptic Necrosis of Bone	0.230	0.696	0.420	0.516	-
RXHCC81	Psoriatic Arthropathy	0.933	1.212	6.741	9.493	3.567
RXHCC82	Systemic Sclerosis	1.691	1.179	1.954	2.809	0.489
RXHCC83	Rheumatoid Arthritis and Other Inflammatory Polyarthropathy	0.172	0.517	1.619	2.809	0.489
RXHCC84	Systemic Lupus Erythematosus and Other Systemic Connective Tissue Disorders	0.146	0.375	0.478	0.690	0.085
RXHCC87	Osteoporosis, Vertebral and Pathological Fractures	0.060	0.141	0.307	0.651	0.078
RXHCC95	Sickle Cell Anemia	-	0.117	0.380	1.515	-
RXHCC96	Acquired Hemolytic, Aplastic, and Sideroblastic Anemias	1.038	1.554	1.177	1.464	0.264
RXHCC98	Hereditary Angioedema and Other Defects in the Complement System	11.918	59.861	23.444	54.317	0.044
RXHCC99	Immune Disorders	0.948	0.427	1.012	1.122	0.450
RXHCC100	Immune Thrombocytopenic Purpura	0.700	0.218	2.993	2.378	1.697
RXHCC111	Alzheimer's Disease	-	-	-	-	-
RXHCC112	Dementia, Except Alzheimer's Disease	-	-	-	-	-
RXHCC130	Schizophrenia and Other Psychosis	0.362	0.361	0.972	1.729	0.669
RXHCC131	Bipolar Disorders	0.324	0.198	0.704	0.862	0.451
RXHCC132	Depression	0.039	-	0.255	0.277	0.110
RXHCC133	Anxiety and Other Psychiatric Disorders	0.009	-	-	0.155	-
RXHCC146	Profound or Severe Intellectual Disability/Developmental Disorder	1.009	-	0.303	0.106	-
RXHCC147	Moderate Intellectual Disability/Developmental Disorder	1.009	-	0.224	0.106	-
RXHCC148	Mild or Unspecified Intellectual Disability/Developmental Disorder	1.009	-	0.166	0.068	-
RXHCC153	Myasthenia Gravis and Other Myoneural Disorders	2.558	5.852	3.713	6.817	0.493
RXHCC154	Amyotrophic Lateral Sclerosis and Other Motor Neuron Disease	4.954	5.955	3.108	4.788	1.723
RXHCC155	Spinal Cord Disorders	0.099	0.363	-	0.541	0.101
RXHCC157	Chronic Inflammatory Demyelinating Polyneuritis	5.388	12.024	7.375	11.003	1.000
RXHCC158	Inflammatory and Toxic Neuropathy	0.085	0.172	0.084	0.318	-
RXHCC159	Multiple Sclerosis	1.087	1.266	3.313	5.281	1.411
RXHCC160	Huntington Disease	2.477	3.268	5.604	5.907	5.534
RXHCC161	Parkinson Disease	0.498	1.129	0.775	1.254	0.985
RXHCC163	Intractable Epilepsy	0.107	0.359	0.533	3.471	-
RXHCC164	Epilepsy and Other Seizure Disorders, Except Intractable Epilepsy	-	-	-	0.209	-
RXHCC166	Migraine Headaches	0.139	0.364	1.023	0.800	0.425
RXHCC168	Trigeminal and Postherpetic Neuralgia	0.045	-	0.289	0.149	0.194
RXHCC183	Pulmonary Arterial Hypertension	3.492	12.784	4.137	12.805	0.719
RXHCC184	Pulmonary Hypertension, Except Arterial, and Other Pulmonary Heart Disease	0.357	0.782	0.226	0.530	0.188
RXHCC186	Heart Failure	0.260	0.074	0.226	0.229	0.149

Variable	Description Label	Community, Non-Low Income, Age≥65	Community, Non-Low Income, Age<65	Community, Low Income, Age≥65	Community, Low Income, Age<65	Institutional
RXHCC187	Hypertension	0.032	-	0.094	0.106	0.040
RXHCC188	Coronary Artery Disease	0.036	-	0.184	-	-
RXHCC191	Ventricular Septal Defect and Major Congenital Heart Disorders	0.335	0.280	0.107	-	0.200
RXHCC193	Atrial Arrhythmias	0.238	-	0.134	-	0.226
RXHCC207	Spastic Hemiplegia	-	-	0.492	-	-
RXHCC215	Venous Thromboembolism	0.239	0.493	0.100	0.117	0.154
RXHCC225	Cystic Fibrosis	19.750	47.448	6.369	56.541	7.056
RXHCC226	Idiopathic Pulmonary Fibrosis and Systemic Sclerosis with Lung Involvement	3.873	1.606	5.809	4.774	1.395
RXHCC227	Pulmonary Fibrosis, Except Idiopathic	0.576	0.541	0.902	1.574	0.393
RXHCC228	Severe Persistent Asthma	0.795	0.991	2.942	3.063	1.435
RXHCC229	Chronic Obstructive Pulmonary Disease, Bronchiectasis, and Other Asthma	0.192	0.123	0.387	0.320	0.393
RXHCC243	Glaucoma, Open-Angle or Moderate/Severe Stage	0.124	0.219	0.476	0.477	0.296
RXHCC244	Other Non-Acute Glaucoma	0.019	0.140	0.093	-	0.019
RXHCC260	Kidney Transplant Status	-	-	-	-	-
RXHCC261	Dialysis Status, Including End Stage Renal Disease	-	-	-	-	-
RXHCC262	Chronic Kidney Disease Stage 5	-	-	-	-	-
RXHCC263	Chronic Kidney Disease Stage 4	-	-	-	-	-
RXHCC311	Chronic Ulcer of Skin, Except Pressure	0.047	-	-	-	0.046
RXHCC314	Pemphigus, Pemphigoid, and Other Bullous Skin Disorders	0.348	1.523	1.376	2.015	0.207
RXHCC316	Psoriasis, Except with Arthropathy	0.286	0.596	2.492	3.842	1.250
RXHCC317	Discoid Lupus Erythematosus	0.146	0.375	0.457	-	0.085
RXHCC355	Narcolepsy and Cataplexy	1.515	4.057	2.090	6.008	0.594
RXHCC395	Stem Cell, Including Bone Marrow, Transplant Status/Complications	4.047	3.927	4.204	2.826	2.180
RXHCC396	Heart, Lung, Liver, Intestine, or Pancreas Transplant Status	-	-	-	-	-
Non-Aged Disease Interactions						
NonAged _RXHCC1	NonAged * HIV/AIDS	-	-	-	-	0.965
NonAged _RXHCC130	NonAged * Schizophrenia and Other Psychosis	-	-	-	-	1.054
NonAged _RXHCC131	NonAged * Bipolar Disorders	-	-	-	-	0.823
NonAged _RXHCC132	NonAged * Depression	-	-	-	-	0.275
NonAged _RXHCC133	NonAged * Anxiety and Other Psychiatric Disorders	-	-	-	-	0.275
NonAged _RXHCC159	NonAged * Multiple Sclerosis	-	-	-	-	1.982
NonAged _RXHCC163	NonAged * Intractable Epilepsy	-	-	-	-	0.285

NOTE: The Part D Denominator used to calculate relative factors is $2,544.56. This Part D Denominator is based on the combined PDP and MA-PD populations.

SOURCE: RTI Analysis of 100% 2023-2024 Medicare Enrollment Data, 2024 Prescription Drug Event (PDE) Data, 2023 Professional Claims (Carrier), 2023 Inpatient Claims, 2023 Outpatient Claims, and 2023 Medicare Advantage Encounter Data.

Table VIII-6. 2027 RxHCC Model Relative Factors for New Enrollees, Non-Low Income (2023/2024 Calibration; Standalone Prescription Drug Plan (PDP))

Variable	Not Concurrently ESRD, Not Originally Disabled	Concurrently ESRD, Not Originally Disabled	Not Concurrently ESRD, Originally Disabled	Concurrently ESRD, Originally Disabled
Female				
0-34 Years	1.968	1.968	-	-
35-44 Years	1.968	1.968	-	-
45-54 Years	1.556	1.556	-	-
55-59 Years	1.556	1.556	-	-
60-64 Years	1.556	1.556	-	-
65 Years	0.425	1.133	1.149	1.133
66 Years	0.445	1.133	1.136	1.133
67 Years	0.466	1.133	1.136	1.133

Variable	Not Concurrently ESRD, Not Originally Disabled	Concurrently ESRD, Not Originally Disabled	Not Concurrently ESRD, Originally Disabled	Concurrently ESRD, Originally Disabled
68 Years	0.501	1.133	1.136	1.133
69 Years	0.503	1.133	1.051	1.133
70-74 Years	0.536	1.133	1.051	1.133
75-79 Years	0.625	1.133	1.051	1.133
80-84 Years	0.590	1.133	0.590	1.133
85-89 Years	0.590	1.133	0.590	1.133
90-94 Years	0.187	1.133	0.187	1.133
95 Years or Over	0.187	1.133	0.187	1.133
Male				
0-34 Years	1.262	1.262	-	-
35-44 Years	1.262	1.262	-	-
45-54 Years	1.400	1.400	-	-
55-59 Years	1.400	1.400	-	-
60-64 Years	1.400	1.400	-	-
65 Years	0.531	1.226	1.269	1.226
66 Years	0.575	1.226	1.269	1.226
67 Years	0.588	1.226	1.229	1.226
68 Years	0.669	1.226	1.115	1.226
69 Years	0.669	1.226	0.913	1.226
70-74 Years	0.669	1.226	0.913	1.226
75-79 Years	0.804	1.226	0.804	1.226
80-84 Years	0.804	1.226	0.804	1.226
85-89 Years	0.762	1.226	0.762	1.226
90-94 Years	0.762	1.226	0.762	1.226
95 Years or Over	0.762	1.226	0.762	1.226

NOTES:

1. The Part D Denominator used to calculate relative factors is $2,544.56. This Part D Denominator is based on the combined PDP and MA-PD populations.
2. Originally Disabled is defined as originally entitled to Medicare by disability only (OREC = 1).
3. For new enrollees, the concurrent ESRD marker is defined as at least one month in the payment year of ESRD status—dialysis, transplant, or functioning graft.

SOURCE: RTI Analysis of 100% 2023-2024 Medicare Enrollment Data, 2024 Prescription Drug Event (PDE) Data, 2023 Professional Claims (Carrier), 2023 Inpatient Claims, 2023 Outpatient Claims, and 2023 Medicare Advantage Encounter Data.

Table VIII-7. 2027 RxHCC Model Relative Factors for New Enrollees, Low Income (2023/2024 Calibration; Standalone Prescription Drug Plan (PDP))

Variable	Not Concurrently ESRD, Not Originally Disabled	Concurrently ESRD, Not Originally Disabled	Not Concurrently ESRD, Originally Disabled	Concurrently ESRD, Originally Disabled
Female				
0-34 Years	2.789	2.789	-	-
35-44 Years	2.789	2.789	-	-
45-54 Years	2.789	2.789	-	-
55-59 Years	2.452	2.452	-	-
60-64 Years	2.452	2.452	-	-
65 Years	1.205	1.935	2.112	1.935
66 Years	0.895	1.935	1.581	1.935
67 Years	0.828	1.935	1.195	1.935
68 Years	0.783	1.935	0.827	1.935
69 Years	0.739	1.935	0.827	1.935
70-74 Years	0.721	1.935	0.827	1.935
75-79 Years	0.721	1.935	0.710	1.935
80-84 Years	0.664	1.935	0.664	1.935
85-89 Years	0.664	1.935	0.664	1.935
90-94 Years	0.377	1.935	0.377	1.935
95 Years or Over	0.377	1.935	0.377	1.935
Male				
0-34 Years	1.990	1.990	-	-
35-44 Years	1.990	1.990	-	-
45-54 Years	1.990	1.990	-	-
55-59 Years	1.990	1.990	-	-
60-64 Years	1.990	1.990	-	-
65 Years	1.122	1.954	1.575	1.954
66 Years	0.830	1.954	1.575	1.954
67 Years	0.803	1.954	0.868	1.954
68 Years	0.803	1.954	0.868	1.954
69 Years	0.724	1.954	0.754	1.954
70-74 Years	0.657	1.954	0.657	1.954

Variable	Not Concurrently ESRD, Not Originally Disabled	Concurrently ESRD, Not Originally Disabled	Not Concurrently ESRD, Originally Disabled	Concurrently ESRD, Originally Disabled
75-79 Years	0.657	1.954	0.657	1.954
80-84 Years	0.591	1.954	0.591	1.954
85-89 Years	0.591	1.954	0.591	1.954
90-94 Years	0.466	1.954	0.466	1.954
95 Years or Over	0.466	1.954	0.466	1.954

NOTES:

1. The Part D Denominator used to calculate relative factors is $2,544.56. This Part D Denominator is based on the combined PDP and MA-PD populations.
2. Originally Disabled is defined as originally entitled to Medicare by disability only (OREC = 1).
3. For new enrollees, the concurrent ESRD marker is defined as at least one month in the payment year of ESRD status—dialysis, transplant, or functioning graft.

SOURCE: RTI Analysis of 100% 2023-2024 Medicare Enrollment Data, 2024 Prescription Drug Event (PDE) Data, 2023 Professional Claims (Carrier), 2023 Inpatient Claims, 2023 Outpatient Claims, and 2023 Medicare Advantage Encounter Data.

Table VIII-8. 2027 RxHCC Model Relative Factors for New Enrollees, Institutional (2023/2024 Calibration; Standalone Prescription Drug Plan (PDP))

Variable	Not Concurrently ESRD	Concurrently ESRD
Female		
0-34 Years	3.356	2.649
35-44 Years	3.356	2.649
45-54 Years	3.356	2.649
55-59 Years	2.961	2.649
60-64 Years	2.637	2.649
65 Years	2.637	2.649
66 Years	2.637	2.649
67 Years	1.982	2.649
68 Years	1.982	2.649
69 Years	1.724	2.649
70-74 Years	1.724	2.649
75-79 Years	1.724	2.649
80-84 Years	1.059	2.649
85-89 Years	1.059	2.649
90-94 Years	0.591	2.649
95 Years or Over	0.591	2.649
Male		
0-34 Years	2.667	2.279
35-44 Years	2.667	2.279
45-54 Years	2.391	2.279
55-59 Years	2.087	2.279
60-64 Years	2.087	2.279
65 Years	2.087	2.279
66 Years	2.087	2.279
67 Years	1.805	2.279
68 Years	1.805	2.279
69 Years	1.501	2.279
70-74 Years	1.501	2.279
75-79 Years	1.315	2.279
80-84 Years	1.315	2.279
85-89 Years	1.315	2.279
90-94 Years	0.834	2.279
95 Years or Over	0.527	2.279

NOTES:

1. The Part D Denominator used to calculate relative factors is $2,544.56. This Part D Denominator is based on the combined PDP and MA-PD populations.
2. For new enrollees, the concurrent ESRD marker is defined as at least one month in the payment year of ESRD status—dialysis, transplant, or functioning graft.

SOURCE: RTI Analysis of 100% 2023-2024 Medicare Enrollment Data, 2024 Prescription Drug Event (PDE) Data, 2023 Professional Claims (Carrier), 2023 Inpatient Claims, 2023 Outpatient Claims, and 2023 Medicare Advantage Encounter Data.

RxHCC Risk Adjustment Factor Tables for PACE

Table VIII-9. 2027 RxHCC Model Relative Factors for Continuing Enrollees (2018/2019 Calibration; PACE Part D)

Variable	Description Label	Community, Non-Low Income, Age≥65	Community, Non-Low Income, Age<65	Community, Low Income, Age≥65	Community, Low Income, Age<65	Institutional
Female						
0-34 Years		-	0.217	-	0.492	2.364
35-44 Years		-	0.327	-	0.689	2.659
45-54 Years		-	0.360	-	0.711	2.020
55-59 Years		-	0.324	-	0.557	1.667
60-64 Years		-	0.250	-	0.348	1.385
65-69 Years		0.123	-	0.299	-	1.448
70-74 Years		0.114	-	0.045	-	1.104
75-79 Years		0.040	-	0.045	-	0.793
80-84 Years		0.040	-	0.045	-	0.546
85-89 Years		0.040	-	0.045	-	0.353
90-94 Years		0.040	-	0.045	-	0.196
95 Years or Over		0.040	-	0.045	-	0.039
Male						
0-34 Years		-	0.177	-	0.596	2.494
35-44 Years		-	0.225	-	0.642	2.208
45-54 Years		-	0.287	-	0.582	1.870
55-59 Years		-	0.299	-	0.477	1.422
60-64 Years		-	0.284	-	0.357	1.096
65-69 Years		0.168	-	0.308	-	1.094
70-74 Years		0.144	-	0.225	-	0.793
75-79 Years		0.061	-	0.133	-	0.640
80-84 Years		0.061	-	0.029	-	0.459
85-89 Years		0.061	-	0.029	-	0.279
90-94 Years		0.061	-	0.029	-	0.169
95 Years or Over		0.061	-	0.029	-	0.033
Originally Disabled Interactions with Sex						
Originally Disabled Female		0.064	-	0.314	-	0.238
Originally Disabled Male		-	-	0.175	-	0.238
Disease Coefficients						
RXHCC1	HIV/AIDS	8.600	10.526	9.721	10.232	6.509
RXHCC5	Opportunistic Infections	0.462	0.602	0.655	0.541	0.513
RXHCC15	Chronic Myeloid Leukemia	6.212	5.290	15.122	20.493	10.251
RXHCC16	Multiple Myeloma and Other Hematologic Cancers	14.258	15.781	12.415	13.095	4.537
RXHCC17	Secondary Cancer of Bone and Kidney	6.212	5.290	10.006	9.133	4.537
RXHCC18	Secondary Cancer of Lung, Liver, Brain, and Other Sites	1.926	1.980	3.424	3.361	0.944
RXHCC19	Leukemias and Other Hematologic Cancers	1.926	1.705	2.526	2.436	0.944
RXHCC20	Lung, Kidney, and Other Cancers; Secondary Cancer of Lymph Nodes and Other Sites	0.494	0.387	1.023	0.748	0.312
RXHCC21	Lymphomas and Other Hematologic Cancers	0.399	0.134	0.362	0.267	0.144
RXHCC22	Prostate, Breast, Bladder, and Other Cancers and Tumors	0.125	0.134	0.281	0.267	0.144
RXHCC30	Diabetes with Complications	0.499	0.539	0.944	1.432	0.908
RXHCC31	Diabetes without Complication	0.172	0.162	0.329	0.497	0.350
RXHCC40	Alpha-1-Antitrypsin Deficiency	3.764	8.639	7.461	10.248	1.434
RXHCC41	Lysosomal Storage Disorders	3.086	14.007	2.582	19.376	0.304
RXHCC42	Acromegaly and Other Endocrine and Metabolic Disorders	2.104	4.202	2.702	6.142	0.703
RXHCC43	Pituitary, Adrenal Gland, and Other Endocrine and Metabolic Disorders	0.063	0.153	-	0.146	0.098
RXHCC44	Thyroid Disorders	0.071	0.160	0.153	0.294	0.148
RXHCC47	Disorders of Lipoid Metabolism	-	-	0.033	0.113	0.058

Variable	Description Label	Community, Non-Low Income, Age≥65	Community, Non-Low Income, Age<65	Community, Low Income, Age≥65	Community, Low Income, Age<65	Institutional
RXHCC54	Chronic Viral Hepatitis C	0.721	0.851	1.004	0.825	1.120
RXHCC55	Acute or Unspecified Viral Hepatitis C	0.721	0.851	1.004	0.825	1.120
RXHCC56	Chronic Viral Hepatitis B and Other Specified Chronic Viral Hepatitis	0.353	0.669	1.235	0.770	0.343
RXHCC59	Primary Biliary Cirrhosis	1.090	1.452	1.463	2.257	1.319
RXHCC65	Chronic Pancreatitis	0.355	0.650	0.603	0.923	0.585
RXHCC66	Pancreatic Disorders and Intestinal Malabsorption, Except Pancreatitis	0.246	0.650	0.481	0.923	0.358
RXHCC67	Inflammatory Bowel Disease	0.499	0.510	1.131	2.321	0.454
RXHCC80	Aseptic Necrosis of Bone	0.207	0.213	0.194	0.361	0.199
RXHCC81	Psoriatic Arthropathy	0.760	0.602	4.634	7.477	2.561
RXHCC82	Systemic Sclerosis	0.979	0.638	1.810	1.964	0.472
RXHCC83	Rheumatoid Arthritis and Other Inflammatory Polyarthropathy	0.222	0.308	1.115	1.964	0.472
RXHCC84	Systemic Lupus Erythematosus and Other Systemic Connective Tissue Disorders	0.114	0.236	0.248	0.349	0.127
RXHCC87	Osteoporosis, Vertebral and Pathological Fractures	0.056	0.198	0.228	0.431	-
RXHCC95	Sickle Cell Anemia	-	0.576	-	1.822	0.015
RXHCC96	Acquired Hemolytic, Aplastic, and Sideroblastic Anemias	0.710	0.549	0.812	1.035	0.221
RXHCC98	Hereditary Angioedema and Other Defects in the Complement System	12.130	57.852	16.993	54.598	0.320
RXHCC99	Immune Disorders	0.939	0.619	1.451	1.292	0.823
RXHCC100	Immune Thrombocytopenic Purpura	0.301	0.157	1.507	1.740	0.981
RXHCC111	Alzheimer's Disease	-	-	-	-	-
RXHCC112	Dementia, Except Alzheimer's Disease	-	-	-	-	-
RXHCC130	Schizophrenia and Other Psychosis	0.238	0.265	0.719	1.419	0.348
RXHCC131	Bipolar Disorders	0.238	0.133	0.578	0.747	0.348
RXHCC132	Depression	0.070	0.050	0.183	0.255	0.161
RXHCC133	Anxiety and Other Psychiatric Disorders	0.036	0.050	0.078	0.167	0.074
RXHCC146	Profound or Severe Intellectual Disability/Developmental Disorder	0.522	0.125	0.421	0.384	-
RXHCC147	Moderate Intellectual Disability/Developmental Disorder	0.522	-	0.198	0.125	-
RXHCC148	Mild or Unspecified Intellectual Disability/Developmental Disorder	0.522	-	0.030	0.021	-
RXHCC153	Myasthenia Gravis and Other Myoneural Disorders	1.088	2.424	1.670	2.460	0.382
RXHCC154	Amyotrophic Lateral Sclerosis and Other Motor Neuron Disease	0.755	1.442	0.433	1.621	0.171
RXHCC155	Spinal Cord Disorders	0.087	-	0.075	-	-
RXHCC157	Chronic Inflammatory Demyelinating Polyneuritis	3.778	6.876	5.273	7.772	1.813
RXHCC158	Inflammatory and Toxic Neuropathy	0.077	0.148	0.028	0.233	0.158
RXHCC159	Multiple Sclerosis	3.765	5.515	5.266	9.290	2.778
RXHCC160	Huntington Disease	3.247	4.041	3.448	5.552	3.440
RXHCC161	Parkinson Disease	0.548	0.794	0.601	0.846	0.607
RXHCC163	Intractable Epilepsy	0.314	0.473	0.793	2.854	0.457
RXHCC164	Epilepsy and Other Seizure Disorders, Except Intractable Epilepsy	0.069	-	0.052	0.184	-
RXHCC166	Migraine Headaches	0.100	0.126	0.288	0.332	0.407
RXHCC168	Trigeminal and Postherpetic Neuralgia	0.094	0.275	0.263	0.416	0.286
RXHCC183	Pulmonary Arterial Hypertension	1.163	4.044	1.666	6.326	0.617
RXHCC184	Pulmonary Hypertension, Except Arterial, and Other Pulmonary Heart Disease	0.151	0.294	0.195	0.380	0.224
RXHCC186	Heart Failure	0.110	0.019	0.195	0.103	0.224

Variable	Description Label	Community, Non-Low Income, Age≥65	Community, Non-Low Income, Age<65	Community, Low Income, Age≥65	Community, Low Income, Age<65	Institutional
RXHCC187	Hypertension	0.057	0.005	0.113	0.084	0.077
RXHCC188	Coronary Artery Disease	0.052	-	0.183	-	-
RXHCC191	Ventricular Septal Defect and Major Congenital Heart Disorders	0.152	0.708	0.521	0.313	0.264
RXHCC193	Atrial Arrhythmias	0.210	0.019	0.133	-	0.118
RXHCC207	Spastic Hemiplegia	0.150	0.099	0.165	-	-
RXHCC215	Venous Thromboembolism	0.225	0.236	0.231	0.237	0.142
RXHCC225	Cystic Fibrosis	4.674	25.855	2.618	31.030	1.390
RXHCC226	Idiopathic Pulmonary Fibrosis and Systemic Sclerosis with Lung Involvement	4.908	3.807	5.034	4.187	1.500
RXHCC227	Pulmonary Fibrosis, Except Idiopathic	0.400	0.570	0.530	1.345	0.433
RXHCC228	Severe Persistent Asthma	0.862	0.617	1.913	1.909	1.359
RXHCC229	Chronic Obstructive Pulmonary Disease, Bronchiectasis, and Other Asthma	0.239	0.103	0.494	0.399	0.433
RXHCC243	Glaucoma, Open-Angle or Moderate/Severe Stage	0.198	0.225	0.459	0.534	0.399
RXHCC244	Other Non-Acute Glaucoma	0.067	-	0.103	-	0.046
RXHCC260	Kidney Transplant Status	-	-	-	-	-
RXHCC261	Dialysis Status, Including End Stage Renal Disease	0.017	-	-	-	-
RXHCC262	Chronic Kidney Disease Stage 5	0.017	-	-	-	-
RXHCC263	Chronic Kidney Disease Stage 4	0.017	-	-	-	-
RXHCC311	Chronic Ulcer of Skin, Except Pressure	0.175	0.137	0.201	0.304	0.066
RXHCC314	Pemphigus, Pemphigoid, and Other Bullous Skin Disorders	0.315	0.828	0.518	0.727	0.330
RXHCC316	Psoriasis, Except with Arthropathy	0.168	0.183	1.203	2.291	0.812
RXHCC317	Discoid Lupus Erythematosus	0.114	0.236	0.041	-	-
RXHCC355	Narcolepsy and Cataplexy	1.089	2.433	1.428	3.501	0.807
RXHCC395	Stem Cell, Including Bone Marrow, Transplant Status/Complications	4.447	2.350	6.133	3.958	2.413
RXHCC396	Heart, Lung, Liver, Intestine, or Pancreas Transplant Status	-	-	-	-	-
Non-Aged Disease Interactions						
NonAged _RXHCC1	NonAged * HIV/AIDS	-	-	-	-	2.755
NonAged _RXHCC130	NonAged * Schizophrenia and Other Psychosis	-	-	-	-	0.749
NonAged _RXHCC131	NonAged * Bipolar Disorders	-	-	-	-	0.749
NonAged _RXHCC132	NonAged * Depression	-	-	-	-	0.358
NonAged _RXHCC133	NonAged * Anxiety and Other Psychiatric Disorders	-	-	-	-	0.011
NonAged _RXHCC159	NonAged * Multiple Sclerosis	-	-	-	-	3.441
NonAged _RXHCC163	NonAged * Intractable Epilepsy	-	-	-	-	0.705

NOTE: The Part D Denominator used to calculate relative factors is $2,089.09. This Part D Denominator is based on the combined PDP and MA-PD populations.

SOURCE: RTI Analysis of 100% 2018-2019 Medicare Enrollment Data, 2019 Prescription Drug Event (PDE) Data, 2018 Professional Claims (Carrier), 2018 Inpatient Claims, 2018 Outpatient Claims, and 2018 Medicare Advantage Encounter Data.

Table VIII-10. 2027 RxHCC Model Relative Factors for New Enrollees, Non-Low Income (2018/2019 Calibration; PACE Part D)

Variable	Not Concurrently ESRD, Not Originally Disabled	Concurrently ESRD, Not Originally Disabled	Not Concurrently ESRD, Originally Disabled	Concurrently ESRD, Originally Disabled
Female				
0-34 Years	1.444	1.444	-	-
35-44 Years	1.444	1.444	-	-
45-54 Years	1.260	1.260	-	-
55-59 Years	1.260	1.260	-	-
60-64 Years	1.260	1.260	-	-
65 Years	0.383	1.303	1.143	1.303
66 Years	0.411	1.303	1.143	1.303
67 Years	0.422	1.303	1.143	1.303

Variable	Not Concurrently ESRD, Not Originally Disabled	Concurrently ESRD, Not Originally Disabled	Not Concurrently ESRD, Originally Disabled	Concurrently ESRD, Originally Disabled
68 Years	0.443	1.303	1.028	1.303
69 Years	0.475	1.303	1.028	1.303
70-74 Years	0.498	1.303	1.028	1.303
75-79 Years	0.559	1.303	0.832	1.303
80-84 Years	0.522	1.303	0.522	1.303
85-89 Years	0.522	1.303	0.522	1.303
90-94 Years	0.397	1.303	0.397	1.303
95 Years or Over	0.397	1.303	0.397	1.303
Male				
0-34 Years	1.142	1.142	-	-
35-44 Years	1.142	1.142	-	-
45-54 Years	1.181	1.181	-	-
55-59 Years	1.181	1.181	-	-
60-64 Years	1.181	1.181	-	-
65 Years	0.467	1.547	1.011	1.547
66 Years	0.488	1.547	0.961	1.547
67 Years	0.526	1.547	0.526	1.547
68 Years	0.526	1.547	0.526	1.547
69 Years	0.526	1.547	0.526	1.547
70-74 Years	0.619	1.547	0.619	1.547
75-79 Years	0.619	1.547	0.619	1.547
80-84 Years	0.619	1.547	0.619	1.547
85-89 Years	0.708	1.547	0.708	1.547
90-94 Years	0.708	1.547	0.708	1.547
95 Years or Over	0.708	1.547	0.708	1.547

NOTES:

1. The Part D Denominator used to calculate relative factors is $2,089.09. This Part D Denominator is based on the combined PDP and MA-PD populations.
2. Originally Disabled is defined as originally entitled to Medicare by disability only (OREC = 1).
3. For new enrollees, the concurrent ESRD marker is defined as at least one month in the payment year of ESRD status—dialysis, transplant, or functioning graft.

SOURCE: RTI Analysis of 100% 2018-2019 Medicare Enrollment Data, 2019 Prescription Drug Event (PDE) Data, 2018 Professional Claims (Carrier), 2018 Inpatient Claims, 2018 Outpatient Claims, and 2018 Medicare Advantage Encounter Data.

Table VIII-11. 2027 RxHCC Model Relative Factors for New Enrollees, Low Income (2018/2019 Calibration; PACE Part D)

Variable	Not Concurrently ESRD, Not Originally Disabled	Concurrently ESRD, Not Originally Disabled	Not Concurrently ESRD, Originally Disabled	Concurrently ESRD, Originally Disabled
Female				
0-34 Years	2.271	2.271	-	-
35-44 Years	2.271	2.271	-	-
45-54 Years	2.271	2.271	-	-
55-59 Years	2.014	2.014	-	-
60-64 Years	2.014	2.014	-	-
65 Years	1.119	2.131	1.638	2.131
66 Years	0.791	2.131	1.213	2.131
67 Years	0.709	2.131	1.010	2.131
68 Years	0.705	2.131	1.010	2.131
69 Years	0.758	2.131	1.010	2.131
70-74 Years	0.758	2.131	0.953	2.131
75-79 Years	0.687	2.131	0.687	2.131
80-84 Years	0.687	2.131	0.687	2.131
85-89 Years	0.687	2.131	0.687	2.131
90-94 Years	0.423	2.131	0.423	2.131
95 Years or Over	0.423	2.131	0.423	2.131
Male				
0-34 Years	1.839	1.839	-	-
35-44 Years	1.839	1.839	-	-
45-54 Years	1.839	1.839	-	-
55-59 Years	1.801	1.956	-	-
60-64 Years	1.631	2.068	-	-
65 Years	1.122	2.215	1.448	2.215
66 Years	0.762	2.215	0.927	2.215
67 Years	0.762	2.215	0.927	2.215
68 Years	0.705	2.215	0.927	2.215
69 Years	0.666	2.215	0.679	2.215

Variable	Not Concurrently ESRD, Not Originally Disabled	Concurrently ESRD, Not Originally Disabled	Not Concurrently ESRD, Originally Disabled	Concurrently ESRD, Originally Disabled
70-74 Years	0.650	2.215	0.650	2.215
75-79 Years	0.650	2.215	0.650	2.215
80-84 Years	0.589	2.215	0.589	2.215
85-89 Years	0.589	2.215	0.589	2.215
90-94 Years	0.334	2.215	0.334	2.215
95 Years or Over	0.334	2.215	0.334	2.215

NOTES:

1. The Part D Denominator used to calculate relative factors is $2,089.09. This Part D Denominator is based on the combined PDP and MA-PD populations.
2. Originally Disabled is defined as originally entitled to Medicare by disability only (OREC = 1).
3. For new enrollees, the concurrent ESRD marker is defined as at least one month in the payment year of ESRD status—dialysis, transplant, or functioning graft.

SOURCE: RTI Analysis of 100% 2018-2019 Medicare Enrollment Data, 2019 Prescription Drug Event (PDE) Data, 2018 Professional Claims (Carrier), 2018 Inpatient Claims, 2018 Outpatient Claims, and 2018 Medicare Advantage Encounter Data.

Table VIII-12. 2027 RxHCC Model Relative Factors for New Enrollees, Institutional (2018/2019 Calibration; PACE Part D)

Variable	Not Concurrently ESRD	Concurrently ESRD
Female		
0-34 Years	3.655	2.538
35-44 Years	3.655	2.538
45-54 Years	3.655	2.538
55-59 Years	2.855	2.538
60-64 Years	2.791	2.538
65 Years	2.791	2.538
66 Years	2.791	2.538
67 Years	2.338	2.538
68 Years	2.338	2.538
69 Years	1.609	2.538
70-74 Years	1.609	2.538
75-79 Years	1.609	2.538
80-84 Years	1.054	2.538
85-89 Years	1.054	2.538
90-94 Years	0.658	2.538
95 Years or Over	0.658	2.538
Male		
0-34 Years	3.300	2.349
35-44 Years	3.300	2.349
45-54 Years	2.868	2.349
55-59 Years	2.728	2.349
60-64 Years	2.365	2.349
65 Years	2.365	2.349
66 Years	2.365	2.349
67 Years	1.670	2.349
68 Years	1.670	2.349
69 Years	1.668	2.349
70-74 Years	1.668	2.349
75-79 Years	1.668	2.349
80-84 Years	1.046	2.349
85-89 Years	1.046	2.349
90-94 Years	0.740	2.349
95 Years or Over	0.605	2.349

NOTES:

1. The Part D Denominator value used to calculate relative factors is $2,089.09. This Part D Denominator is based on the combined PDP and MA-PD populations.
2. For new enrollees, the concurrent ESRD marker is defined as at least one month in the payment year of ESRD status—dialysis, transplant, or functioning graft.

SOURCE: RTI Analysis of 100% 2018-2019 Medicare Enrollment Data, 2019 Prescription Drug Event (PDE) Data, 2018 Professional Claims (Carrier), 2018 Inpatient Claims, 2018 Outpatient Claims, and 2018 Medicare Advantage Encounter Data.

Table VIII-13. 2027 RxHCC Payment Models with Disease Hierarchies

RxHCC	If the Disease Group is listed in this column…	…Then drop the RxHCC(s) listed in this column
	RxHCC Model Hierarchical Condition Category Label	
15	Chronic Myeloid Leukemia	17, 18, 19, 20, 21, 22
16	Multiple Myeloma and Other Hematologic Cancers	17, 18, 19, 20, 21, 22
17	Secondary Cancer of Bone and Kidney	18, 19, 20, 21, 22

RxHCC	If the Disease Group is listed in this column…	…Then drop the RxHCC(s) listed in this column
	RxHCC Model Hierarchical Condition Category Label	
18	Secondary Cancer of Lung, Liver, Brain, and Other Sites	19, 20, 21, 22
19	Leukemias and Other Hematologic Cancers	20, 21, 22
20	Lung, Kidney, and Other Cancers; Secondary Cancer of Lymph Nodes and Other Sites	21, 22
21	Lymphomas and Other Hematologic Cancers	22
30	Diabetes with Complications	31
40	Alpha-1-Antitrypsin Deficiency	43
41	Lysosomal Storage Disorders	43
42	Acromegaly and Other Endocrine and Metabolic Disorders	43
54	Chronic Viral Hepatitis C	55
65	Chronic Pancreatitis	66
81	Psoriatic Arthropathy	83, 84, 316
82	Systemic Sclerosis	83, 84
83	Rheumatoid Arthritis and Other Inflammatory Polyarthropathy	84
84	Systemic Lupus Erythematosus and Other Systemic Connective Tissue Disorders	317
111	Alzheimer's Disease	112
130	Schizophrenia and Other Psychosis	131, 132, 133
131	Bipolar Disorders	132, 133
132	Depression	133
146	Profound or Severe Intellectual Disability/Developmental Disorder	147, 148
147	Moderate Intellectual Disability/Developmental Disorder	148
157	Chronic Inflammatory Demyelinating Polyneuritis	158
163	Intractable Epilepsy	164
183	Pulmonary Arterial Hypertension	184, 186, 187
184	Pulmonary Hypertension, Except Arterial, and Other Pulmonary Heart Disease	186, 187
186	Heart Failure	187
225	Cystic Fibrosis	229
226	Idiopathic Pulmonary Fibrosis and Systemic Sclerosis with Lung Involvement	227, 229
227	Pulmonary Fibrosis, Except Idiopathic	229
228	Severe Persistent Asthma	229
243	Glaucoma, Open-Angle or Moderate/Severe Stage	244
260	Kidney Transplant Status	261, 262, 263, 396
261	Dialysis Status, Including End Stage Renal Disease	262, 263
262	Chronic Kidney Disease Stage 5	263

NOTE: This table applies to all RxHCC models

How Payments are Made with a Disease Hierarchy:
EXAMPLE: If a beneficiary triggers RxHCCs 163 (Intractable Epilepsy) and 164 (Epilepsy and Other Seizure Disorders, Except Intractable Epilepsy), then RxHCC 164 will be dropped. In other words, payment will always be associated with the RxHCC in column 1 if an RxHCC in column 3 also occurs during the same collection period. Therefore, the organization's payment will be based on RxHCC 163 rather than RxHCC 164.

SOURCE: RTI International.