January 26, 2026

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

SUBJECT: Advance Notice of Methodological Changes for Calendar Year (CY) 2027 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies

CMS is committed to ensuring that all Medicare beneficiaries are free to choose the health coverage that best meets their needs, and that such coverage aligns spending and value to the greatest extent possible. Establishing accurate payments in Medicare Advantage and Part D is foundational to this objective of aligning spending with value, and so, we have taken particular care in considering updates to our risk adjustment models. We believe that the policies in this Advance Notice, if finalized, will address coding differentials between Medicare Advantage and Original Medicare for CY 2027. We further believe that they will bring much-needed stability to prescription drug benefits for all Medicare beneficiaries.

In accordance with section 1853(b)(2) of the Social Security Act (the Act), we are notifying you of planned changes in the Medicare Advantage (MA) capitation rate methodology and risk adjustment methodology applied under Part C of the Medicare statute for CY 2027. Also included with this Advance Notice is a discussion of the annual adjustments for CY 2027 to the Medicare Part D benefit parameters for the defined standard benefit. CMS will announce the MA capitation rates and final payment policies for CY 2027 no later than Monday, April 6, 2026, in accordance with section 1853(b) of the Act, as established in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108-173) and amended by the Securing Fairness in Regulatory Timing Act of 2015 (Pub. L. 114-106). The Advance Notice of Methodological Changes is published no fewer than 60 days before the publication of the final Announcement of CY 2027 MA Capitation Rates and Part C and Part D Payment Policies (Rate Announcement) and provides a minimum 30-day period for public comment.

Attachment I of this document shows the preliminary estimates of the national per capita MA growth percentage and the national Medicare Fee-for-Service (FFS) growth percentage, which are key factors in determining the MA capitation rates. Attachment II sets forth changes in the Part C payment methodology for CY 2027. Attachment III presents the annual adjustments to the Medicare Part D benefit parameters for the defined standard benefit and sets forth the Part D payment methodology for CY 2027. For additional information about Part D policies related to the Inflation Reduction Act of 2022 (IRA) (Pub. L. 117-169) for 2027, see the CY 2027 proposed rule (CMS-4212-P, 90 FR 54894) titled "Contract Year 2027 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program," which appeared in the Federal Register on November 28, 2025. Attachment IV applies standards for certain updates for the MA and Part D Star Ratings. Attachment V contains economic information for significant provisions in the Advance Notice.

Attachment VI presents the risk adjustment factors for the proposed CMS-HCC risk adjustment model and RxHCC risk adjustment models.

As with prior Advance Notices and Rate Announcements, we are releasing a Fact Sheet, available through the Newsroom webpage on the CMS.gov website, to accompany this CY 2027 Advance Notice. The Fact Sheet provides additional information on the impact of the policies and updates on individual payment factors, such as the growth rates and risk adjustment changes, and the overall average impact of the factors on MA revenue.

CMS invites comments on the Advance Notice. To submit comments or questions electronically, go to https://www.regulations.gov, enter the docket number "CMS-2026-0034" in the "Search" field, and follow the instructions for "submitting a comment." Comments will be made public, so submitters should not include any confidential or personal information. It should be noted that CMS will not post on Regulations.gov public comments that make threats to individuals or institutions or suggest that the commenter will take actions to harm the individual. In order to receive consideration prior to the release of the Rate Announcement, comments on this Advance Notice must be received by 11:59 PM Eastern Time on February 25, 2026.

/ s /

Chris Klomp
Director, Center for Medicare

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 Advance Notice. My opinion is limited to the following sections of this Advance Notice: The growth percentages and United States per capita cost estimates provided in Attachment I; the qualifying county determination, calculations of Fee-for-Service cost, direct graduate medical education carve-out, kidney acquisition cost carve-out, indirect medical education (IME) phase out, MA benchmarks, Employer Group Waiver Plan (EGWP) rates, and End Stage Renal Disease (ESRD) rates discussed in Attachment II; Medicare Part D Benefit Parameters: Annual Adjustments for Defined Standard Benefit in 2027 described in Attachment III; and the economic information contained in Attachment V.

/ s /
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Attachments

2027 ADVANCE NOTICE
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Attachment I. Preliminary Estimates of the National Per Capita MA Growth Percentage and the National Medicare Fee-for-Service Growth Percentage for Calendar Year 2027

Each year in the Advance Notice, CMS updates its historical estimates of per capita Medicare costs based on recent data and provides an estimate for an additional projection year. Specifically, CMS provides estimates of three separate United States Per Capita Costs (USPCCs) for each calendar year:

1. **Non-ESRD FFS USPCC**: the USPCC for FFS aged and disabled beneficiaries except those beneficiaries who are in End Stage Renal Disease (ESRD) status for payment purposes, i.e., those beneficiaries who are in dialysis, transplant, or functioning graft status. The non-ESRD FFS USPCC is used in the calculation of the specified amount in years in which CMS elects to rebase the adjusted average FFS per capita cost. CMS intends to rebase as part of the calculation of the rates for 2027. The statutory term "specified amount" is described in Attachment II Section A2 and is sometimes referred to as the "post-Affordable Care Act (ACA)" rate methodology. The non-ESRD FFS USPCC is also used in the calculation of the applicable amount, as described in Attachment II Section A1.
2. **Total USPCC non-ESRD**: the USPCC for Medicare Part C and FFS aged and disabled beneficiaries except those beneficiaries who are in ESRD status for payment purposes. The Total USPCC non-ESRD is used to calculate the national per capita MA growth percentage which is used in the calculation of the applicable amount. The statutory term "applicable amount" is described in Attachment II Section A1 and is sometimes referred to as the "pre-ACA" rate methodology used to determine the "benchmark cap" for each county, as described in Attachment II Section A5.
3. **FFS Dialysis ESRD USPCC**: the USPCC for beneficiaries in FFS with ESRD who are in dialysis status (i.e., "Dialysis ESRD").[1]

Based on these estimates, CMS calculates the change, or growth, in each of the USPCCs for the upcoming year. In this Advance Notice, we provide growth percentages from 2026 to 2027. These growth percentages represent the year-over-year changes to the USPCCs used to calculate the MA payment rates, or benchmarks, as discussed below. Throughout this document, we use the terms "benchmark" and "county rate" interchangeably, and the term "service area benchmark" indicates the bidding benchmark for an MA plan based on its specific service area.

The MA county rates are based on the specified amount as described in Attachment II Section A2. Section 1853(n)(2)(A) of the Act defines the specified amount as the base amount multiplied by the applicable percentage for the area (set under section 1853(n)(2)(B) through (D)). Section 1853(n)(4) requires that the benchmark for an area for a year (including increases for quality

[1] FFS Dialysis ESRD USPCCs are trended from a base year using the trend in total ESRD net of an adjustment factor for dialysis-only.

bonus percentages) be capped at the level of the applicable amount, as defined at section 1853(k)(1) and described in Attachment II Section A1.

The county rates for Programs of All-Inclusive Care for the Elderly (PACE) are established using the applicable amount as determined under section 1853(k)(1). This amount is calculated without excluding indirect medical education (IME) amounts under section 1853(k)(4) (as required by section 1894(d)(3)), or organ acquisition costs for kidney transplants, as discussed in Attachment II Section C of this document.

Section A. Data and Assumptions Supporting USPCCs

Background

In this section of the CY 2027 Advance Notice, we provide details and descriptions regarding the development of the USPCCs. Unless otherwise stated, the data and methodologies described in this section are a continuation of the data and methodologies used in the prior year. The historical and projected USPCCs are based on the most recent program experience and actuarial projections prepared by the CMS Office of the Actuary. The data is tabulated and projected separately for Medicare Part A and Medicare Part B on a quarterly basis. Enrollment and expenditures are summarized on an incurred basis.

Historical Enrollment

Historical total Medicare enrollment is developed on a quarterly basis from CMS's administrative records. Historical MA enrollment is tabulated from the Monthly Membership Report (MMR)[2] data files. Medicare FFS enrollment is the difference between total Medicare enrollment and MA enrollment.

MA enrollment is further categorized based on the beneficiary's ESRD status into non-ESRD MA enrollment and ESRD MA enrollment. ESRD MA enrollment includes beneficiaries with ESRD who are in dialysis, transplant, and post-transplant statuses. The ESRD status is consistent with the risk adjustment classification.[3] Non-ESRD MA enrollment is the difference between total MA enrollment and ESRD MA enrollment.

Medicare FFS enrollment is also categorized based on the beneficiary's ESRD status into non-ESRD FFS enrollment and ESRD FFS enrollment. ESRD FFS enrollment includes beneficiaries with ESRD who are in dialysis status, transplant status, and post-transplant beneficiaries with

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[2] For more information on the MMR, refer to the Plan Communication User Guide available at https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/mapdhelpdesk/Plan_Communications_User_Guide.

[3] See Section H of the CY 2023 Advance Notice for more information regarding ESRD risk adjustment: https://www.cms.gov/files/document/2023-advance-notice.pdf.

functioning graft for up to 36 months. Non-ESRD FFS enrollment is the difference between Medicare total FFS enrollment and ESRD FFS enrollment.

Projected Enrollment

Total Medicare enrollment projections are generally based on certain percentages of the Social Security Administration's (SSA's) population projections. The percentages used to project total Medicare enrollment as percentages of SSA's population projections have been stable over time. For Part A, the projected number of aged beneficiaries averages 92 percent of the Social Security area population[4] aged 65 and older. The disabled enrollment projection is slightly more than the portion of SSA's disabled beneficiary population that has been on the rolls for at least 2 years, because an individual is eligible for Part A even if they have had 2 non-consecutive years of disability. For Part B, the aged enrollment averages 87 percent of the Social Security area population aged 65 and older. The Part B disabled enrollment is 93 percent of the Part A disabled enrollment.

The increase in the MA projected enrollment is based on an enrollment model which incorporates the historical growth in penetration rates to estimate the MA enrollment growth rates for future years. Projected FFS enrollment is calculated as the difference between projected total Medicare enrollment and projected MA enrollment.

Historical Benefit Expenditures

The primary source for historical FFS claims is the National Claims History (NCH) file.[5] Additional sources of FFS expenditures include payments to providers based on cost reports, payments for pass through costs, and payment adjustments authorized by law or in connection with participation in the Medicare Shared Savings Program or Innovation Center models or demonstrations or Advanced Alternative Payment Models. Historical experience for more recent years is grossed up to account for claims incurred but not paid using completion factors developed from recent program experience.

Historical MA expenditures are tabulated from the MMR files, which is the same source as for MA historical enrollment. The historical experience for more recent years is grossed up to reflect estimated outstanding risk adjustment reconciliations.

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[4] Social Security area population is defined in the Glossary of the 2023 OASDI Trustees Report (The 2023 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Federal Disability Insurance Trust Funds) available at https://www.ssa.gov/OACT/TR/2023/VI_I_glossary.html

[5] For more information on the NCH, refer to the System of Records Notice available at https://www.hhs.gov/foia/privacy/sorns/09700558/index.html

Projected Benefit Expenditures

Projected expenditures for FFS beneficiaries are developed separately for each type of service reflected in the NCH file, cost report settlements, pass through costs, and payments in the Medicare Shared Savings Program or Innovation Center models or demonstrations or Advanced Alternative Payment Models.[6]

The projection of NCH costs is based on reimbursements or allowed charges incurred per beneficiary during the base fiscal year. For the CY 2027 Advance Notice USPCCs, the base fiscal year for expenditures is 2025 for most services.

The projections take into account various trends known at the time of development of the Advance Notice, including:

- Unit cost changes tied to market baskets and productivity adjustments, fee schedule updates, and/or the consumer price index (CPI). These updates are based on economic assumptions provided by the Office of Management and Budget (OMB).
- Utilization and intensity of services, which are generally based on historical trends.
- Impact of changes in population mix as measured by age, sex, and time-to-death.
- Changes in Medicare coverage due to legislation, regulation, and national coverage determinations (NCDs).

Projected cost report settlements and pass through costs are developed as a percentage add-on basis to the NCH costs and are projected to remain at the same percentage level throughout the projection.

The Medicare Shared Savings Program or Innovation Center model/demonstration payments are projected based on the estimates developed for each model/demonstration and any historical experience of each model/demonstration.

MA per capita historical bids, rebates, and benchmarks are summarized on an incurred basis by Medicare Status Code, insurance market (EGWP, individual/non-EGWP), and coverage/plan type (Health Maintenance Organization (HMO), Local Preferred Provider Organization (LPPO), Regional Preferred Provider Organization (RPPO), Special Needs Plan (SNP), etc.). Projections are performed separately for payments from the Part A and Part B Trust Funds.[7] Aggregate projected MA payments are calculated as the projected MA per capita costs times the projected enrollment.

CY 2025 is the base year for expenditures for the MA experience reflected in the CY 2027 Advance Notice. The 2026 risk-adjusted benchmarks, bids, and rebates are estimated based on

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[6] Attachment II Section B contains additional information regarding the Medicare Shared Savings Program and Innovation Center models and demonstrations, and Advanced Alternative Payment Models.

[7] MA and PACE plans receive prospective capitated payments for enrollees from the Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) trust fund accounts.

the growth rates that are derived from the summarized 2026 bids and using plans' projections of enrollment and risk scores. Trends in per capita bids for 2027 and later are tied to the per capita FFS growth rates, calculated using the non-ESRD FFS USPCCs and the per capita benchmark increases. Trends in the MA benchmarks reflect the FFS growth rates, adjustment to MA risk scores for differences in diagnosis coding between MA and FFS beneficiaries, projected changes in quality bonus (county-specific), and projected phase-out of IME (county-specific).

Two documents are published on this website in support of the non-ESRD FFS USPCCs: https://www.cms.gov/medicare/payment/medicare-advantage-rates-statistics/ffs-trends. The first document represents the current estimate of the FFS unit cost increases for 2025 - 2027 and the second is an illustration of the components of the growth rates for 2023 - 2027.

Adjustments from the Program Baseline to Develop the USPCC Baseline

There are several adjustments made to the program baseline to develop the USPCC projection. Given that MA bids do not include coverage for hospice, payments to hospices are excluded from the USPCCs. Also, per section 1853(c)(1)(D)(i) of the Act, incentive payments under sections 1848(o) and 1886(n) of the Act[8] for adoption and meaningful use of certified EHR technology are not included in the USPCCs. Additionally, claim expenditures in the NCH for cost plan enrollees are removed from the non-ESRD FFS USPCC. Finally, the MA ratebook and MA bids are presented on a pre-sequestration basis and, accordingly, the historical and projected sequestration reduction is added back to the USPCC baseline.

As first discussed on pages 16, 30 and 31 of the CY 2026 Advance Notice, beginning with 2023 experience data, additional adjustments are incorporated into the FFS baseline calculation to develop the non-ESRD FFS USPCC projections:

- Exclusion of FFS hospice enrollment;
- Exclusion of FFS non-hospice spending for beneficiaries in hospice status; and
- Exclusion of Medicare Advantage claims reflected in the NCH.

Further, as finalized in the CY 2024 Rate Announcement, starting with the CY 2024 ratebook, additional payment amounts for indirect medical education (IME) and direct graduate medical education (DGME) costs associated with services furnished to MA enrollees are excluded from

[8] Sections 1848(o) and 1886(n) of the Act provide for incentive payments under the Medicare FFS program for eligible professionals and eligible hospitals, respectively, for meaningful use of certified EHR technology (CEHRT). 2016 was the final year that eligible professionals, as well as eligible hospitals outside of Puerto Rico, could earn incentive payments under these provisions; eligible hospitals in Puerto Rico could earn incentive payments for meaningful use of CEHRT through 2021. Sections 1848(a)(7) and 1886(b)(3)(B)(ix) require a reduction in Medicare FFS payments for eligible professionals and eligible hospitals that are not meaningful users of CEHRT, starting in 2015 for eligible professionals and eligible hospitals outside of Puerto Rico and in 2022 for eligible hospitals in Puerto Rico. 2018 was the final year that eligible professionals who were not meaningful users of CEHRT could be subject to negative payment adjustments under section 1848(a)(7).

the non-ESRD FFS USPCC baseline. The IME and DGME exclusion is 33 percent in 2024, 52 percent in 2025, and 100 percent for years 2026 and later.

Adjustment for Medical Education Payments in the Non-ESRD USPCC Baseline

Section 1886(d)(11) of the Act directs the Secretary to provide inpatient prospective payment system hospitals with an additional payment amount for IME costs for discharges of MA enrollees, and section 1886(h)(3)(D) of the Act directs the Secretary to provide hospitals with an additional payment amount for DGME costs associated with services furnished to MA enrollees. These MA medical education expenditures are not costs for FFS beneficiaries.

Prior to the CY 2024 ratebook, the tabulation of non-ESRD FFS USPCCs had included both IME and DGME costs paid to inpatient facilities on behalf of MA enrollees because the inpatient cost report experience supporting the baseline modeling did not separately identify these payments from those made on behalf of FFS beneficiaries. Consequently, MA rates had included these admissions-related costs, even though CMS, and not MA organizations, had been paying these costs associated with MA enrollees directly to hospitals.

Beginning with the CY 2024 ratebook, the baseline development and modeling supporting the USPCCs was updated to separate these payments and identify the historical and projected costs of IME and DGME paid to inpatient facilities by CMS associated with services furnished to MA enrollees.

Therefore, beginning with the CY 2024 ratebook, we started removing MA-related IME and DGME costs from the historical and projected expenditures supporting the non-ESRD FFS USPCCs. The removal was phased in over a 3-year period for CYs 2024 through 2026.

For CY 2027, we will continue to remove MA-related medical education costs from the historical and projected expenditures supporting the estimates of the 2027 non-ESRD FFS USPCCs, which are used to determine the 2027 growth percentages.

The methodology described in this section has no impact on the exclusion of medical education costs from the Average Geographic Adjustments (AGAs) used to create the ratebook, because the adjustment described in this section is limited to the non-ESRD FFS USPCCs. Refer to Attachment II, Sections C1 (DGME) and C3 (IME) for descriptions of the adjustments to the AGAs pertaining to the FFS experience and projections used to develop the ratebook. As we explained on page 31 of the CY 2024 Rate Announcement, the adjustments to the non-ESRD FFS USPCCs and AGAs are developed using different sources of data and pertain to two different groups of Medicare beneficiaries: the adjustment to the non-ESRD FFS USPCC pertains to excluding IME and DGME costs associated with *MA enrollees* (paid directly by CMS to hospitals), whereas the county level adjustment to the AGA pertains to IME and DGME costs associated with *FFS beneficiaries* (paid directly by CMS to hospitals) to determine MA capitation rates using FFS per capita costs as required by section 1853 of the Act.

Section B. 2027 Growth Percentage Estimates

The MA growth percentage, as defined at section 1853(c)(6), reflects the growth in per capita costs for non-ESRD beneficiaries enrolled in either FFS or Medicare health plans,[9] excluding expenditures attributable to sections 1848(a)(7), 1848(o), 1886(b)(3)(B)(ix), and 1886(n) of the Act, based upon estimates of the Total USPCC. The MA growth percentage is also referred to as the total growth percentage and the national per capita MA growth percentage. The MA growth percentage is used in calculating the applicable amount for a county, as required under section 1853(k)(1).

The FFS growth percentage reflects the growth in per capita costs based upon estimates of the non-ESRD FFS USPCC. As required by section 1853(n)(2)(E)(ii)(II) of the Act, the non-ESRD FFS USPCC calculated under section 1853(c)(1)(D) is used to calculate the specified amount in years in which CMS elects to rebase the adjusted average FFS per capita cost.

The ESRD growth percentage reflects the growth in per capita costs based on the FFS Dialysis ESRD USPCC. MA ESRD rates are determined by applying a historical average geographic adjustment to a projected FFS Dialysis ESRD USPCC.

Table I-1 below provides the current estimate of the change in the three USPCC estimates. The percentage change in each USPCC is shown as the current projected USPCC for 2027 divided by the prior projected USPCC for 2026.

Table I-1. Increase in the USPCC Growth Percentage for CY 2027[10]

	Total USPCC Non-ESRD	Non-ESRD FFS USPCC	FFS Dialysis ESRD USPCC
Current projected 2027 USPCC	$1,362.64	$1,293.23	$11,013.30
Prior projected 2026 USPCC	$1,309.71	$1,230.52	$10,372.92
Percent increase	4.04%	5.10%	6.17%

The current estimate of the MA growth percentage* (or change in the Total USPCC non-ESRD) for aged and disabled enrollees combined in CY 2027 is 4.04%. This estimate reflects an underlying trend change for CY 2027 in per capita cost of 5.39% and, as required under section

[9] "Medicare health plans" include MA plans, Cost plans, and PACE organizations.

[10] Growth rates and USPCC estimates reflect the methodology described in Attachment II, section B2. Tabulation of Ratebook FFS Experience for 2023 and thereafter.

1853(c)(6)(C) of the Act, adjustments to the estimates for prior years as indicated in the table below.

Table I-2 below provides additional detail on the estimates for the change in the Total USPCC non-ESRD or national per capita MA growth percentage for aged and disabled beneficiaries.

Table I-2. Increase in the MA Growth Percentage for 2027

	Prior Increases	Current Increases			MA Growth Percentage for 2027 with § 1853(c)(6)(C) Adjustment**
	2003 to 2026	2003 to 2026	2026 to 2027	2003 to 2027	
Aged+Disabled	140.826%	137.748%	5.388%	150.558%	4.04%

* The MA growth percentage is also known as the national per capita MA growth percentage and is equal to change in the Total USPCC non-ESRD.

** (1 + current increases for 2003 to 2027) divided by (1 + prior increases for 2003 to 2026) minus 1.

Section C. USPCC Estimates

Table I-3 compares last year's estimate of the Total USPCC non-ESRD with current estimates for 2003 to 2029; Table I-4 compares last year's non-ESRD FFS USPCC estimates with current estimates; and Table I-5 compares last year's FFS Dialysis ESRD USPCC estimates with current estimates. In addition, these tables show the current projections of the USPCCs through 2029. 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 prescription drug benefit.

The tabulation of FFS costs supporting the USPCCs includes payments made outside the FFS claim systems, such as provider settlements via cost reports, Innovation Center model and demonstration payments, Medicare Shared Savings Program shared savings settlements, Advanced Alternative Payment Model incentive payments, and other adjustments. Also included in the USPCCs are the cost impacts of program changes enacted through known legislation, regulation, and NCDs applicable for the contract year (2027). Attachment II Section B contains additional information regarding the calculation of FFS costs used in setting MA rates and benchmarks.

COVID-19

See the CY 2026 Advance Notice (page 17) for information regarding the impacts to the USPCC estimates for 2020 and subsequent years related to the COVID-19 pandemic.

Part B Provisions of the Inflation Reduction Act

See the CY 2026 Advance Notice (pages 17-18) for information regarding the impacts to the USPCC estimates for 2022 and subsequent years related to the Part B provisions of the IRA.

Remedy for the 340B-Acquired Drug Payment Policy for Calendar Years 2018-2022

In light of the Supreme Court's decision in *American Hospital Association v. Becerra* on June 15, 2022, and the district court's remand to the agency, CMS issued the Hospital Outpatient Prospective Payment System Remedy for the 340B-Acquired Drug Payment Policy for Calendar Years 2018-2022 Final Rule, CMS-1793-F, on November 2, 2023.[11] CMS made a one-time lump sum payment to each affected provider that reflects the difference between what covered entities were paid for 340B drugs (generally Average Sales Price (ASP) minus 22.5%) and what they would have been paid had the 340B payment policy not been applied (generally ASP plus 6%) from 2018 through September 27, 2022. CMS is complying with the budget neutralization requirement under sections 1833(t)(2)(E) and 1833(t)(14)(H) of the Act, and, alternatively, under the agency's inherent or common-law recoupment authorities, by reducing non-drug outpatient item and service prospective payments beginning in 2026.

The FFS USPCCs are developed consistent with the Remedy for the 340B-Acquired Drug Payment Policy for CYs 2018-2022 Final Rule (CMS-1793-F) and CY 2026 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center Final Rule (CMS-1834-FC), titled, "Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Quality Reporting Programs; Overall Hospital Quality Star Ratings; and Hospital Price Transparency" (CY 2026 OPPS Final Rule).[12] As we previously described in the CY 2025 and CY 2026 Advance Notices and Rate Announcements, the restatements ("current estimates") of the FFS USPCCs for 2018-2022 reflect the lump sum 340B-acquired drug remedy payments for services rendered from January 1, 2018, through September 27, 2022, for each affected 340B covered entity. The lump sum remedy payments are reflected in the USPCCs of the respective year associated with the service experience. The USPCCs projected for 2026 and later reflect a reduction for all non-drug items and services to all OPPS providers, except any provider that enrolled in Medicare after January 1, 2018, until the entire 340B-acquired drug offset is reached. Accounting for this reduction in the USPCC projections aligns with the fee-for-service projections for each year which, under section

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[11] The final rule appeared in the Federal Register on November 8, 2023, and is available online here: https://www.federalregister.gov/documents/2023/11/08/2023-24407/medicare-program-hospital-outpatient-prospective-payment-system-remedy-for-the-340b-acquired-drug.

[12] CMS notes that section 1854(a)(6)(B)(iii) of the Social Security Act prohibits CMS from requiring an MA organization to contract with a particular hospital, physician, or other entity to furnish items and services, including 340B-acquired drugs, or requiring a particular price structure for payment under such a contract. Section 1852(a)(2) of the Social Security Act mandates that MA organizations reimburse non-contract providers at least the amount they would have received under Medicare FFS. Additional information can be found in the CY 2026 OPPS Final Rule, available online here: https://www.federalregister.gov/documents/2025/11/25/2025-20907/medicare-program-hospital-outpatient-prospective-payment-and-ambulatory-surgical-center-payment

1853(c)(1)(D) of the Act, must be reflected in the FFS per capita costs used for developing the MA ratebook.

The CY 2026 OPPS Final Rule finalized a 0.5 percent budget neutrality adjustment for CY 2026. Consequently, a reduction of 0.5 percent for all non-drug items and services to all OPPS providers, except those that enrolled in Medicare after January 1, 2018, is reflected in the USPCC projections for CY 2026 and thereafter. Because the CY 2026 OPPS Final Rule reduces by 0.5 percent the amount "payable" under Part B for non-drug item and service payments to hospitals enrolled in Medicare before January 2, 2018, we must account for that in the "average per capita amount" as defined in section 1876(a)(4) of the Act. We read section 1876(a)(4) to require the use of actuarial principles to estimate the average per capita amount. In applying those actuarial principles, we determine when an amount is "payable" based on underlying utilization. Therefore, we base our estimate on the amount actually "payable" in 2027 on service utilization in 2027 (and not 2018-2022), as reflected in the 2027 USPCC estimates.

USPCC Estimates[13]

Table I-3. 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	382.79	383.01	460.38	460.66	843.17	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

[13] Growth rates and USPCC estimates reflect impact of proposed changes described in Attachment II, section B2. *Tabulation of Ratebook FFS Experience for 2023 and thereafter.*

	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
2020	403.93	403.94	524.78	524.95	928.71	928.89	1.000
2021	409.46	409.54	573.57	573.62	983.03	983.16	1.000
2022	434.12	434.61	606.84	607.19	1,040.96	1,041.80	0.999
2023	454.85	456.39	663.23	663.87	1,118.08	1,120.26	0.998
2024	463.74	469.10	699.58	702.55	1,163.32	1,171.65	0.993
2025	481.67	484.86	740.65	739.82	1,222.32	1,224.68	0.998
2026	510.34	506.51	782.63	803.20	1,292.97	1,309.71	0.987
2027	544.57	530.86	818.07	857.27	1,362.64	1,388.13	0.982
2028	570.56	555.93	863.70	902.51	1,434.26	1,458.44	0.983
2029	600.51		918.82		1,519.33		

Table I-4. Comparison of Current & Previous Estimates of the Non-ESRD 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	$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	373.61	373.61	450.48	450.48	824.09	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	478.03	478.06	853.76	853.65	1.000
2021	390.07	390.06	559.59	559.39	949.66	949.45	1.000
2022	408.57	409.14	578.22	578.31	986.79	987.45	0.999
2023	419.77	422.14	625.92	626.15	1,045.69	1,048.29	0.998
2024	434.98	442.08	679.03	682.01	1,114.01	1,124.09	0.991
2025	462.25	457.96	740.58	721.97	1,202.83	1,179.93	1.019
2026	475.91	465.49	750.63	765.03	1,226.54	1,230.52	0.997
2027	498.28	487.18	794.95	815.88	1,293.23	1,303.06	0.992
2028	522.47	509.41	840.64	858.14	1,363.11	1,367.55	0.997
2029	549.68		894.33		1,444.01		

Table I-5. Comparison of Current & Previous Estimates of the FFS Dialysis ESRD 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	4,006.26	3,893.89	5,268.88	5,245.62	9,275.14	9,139.51	1.015
2025	4,290.91	4,156.63	5,793.54	5,656.96	10,084.45	9,813.59	1.028
2026	4,596.94	4,441.46	5,888.63	5,931.46	10,485.57	10,372.92	1.011
2027	4,870.05	4,720.20	6,143.25	6,214.25	11,013.30	10,934.45	1.007
2028	5,181.25	5,004.32	6,422.17	6,493.39	11,603.42	11,497.71	1.009
2029	5,516.58		6,759.71		12,276.29		

These estimates are preliminary and could change when the final rates are announced in the CY 2027 Rate Announcement. Further details on the derivation of the national per capita MA growth percentage and the FFS growth percentage will also be presented in the Rate Announcement.

Section D. Proposed changes to tables in Attachment II of CY 2027 Rate Announcement

As part of the ongoing enhancements to materials presented in annual Rate Announcements and supplemental trend exhibits, we are proposing comprehensive changes to the table structure and content within Attachment II of the CY 2027 Rate Announcement.

- Remove from table II-5 Summary of Key Projections: (i) FY Part A total reimbursement incurred, and (ii) total Part B trend. These metrics utilize total non-ESRD enrollment as the denominator, and, therefore, are not useful for analysis of fee-for-service and/or Medicare Advantage trends.
- Combine aged and disabled enrollment in table II-6, Medicare Enrollment Projections. This change would 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.

- Eliminate tables II-7a, Part A Projections for non-ESRD, and II-8a, Part B Projections for non-ESRD. The expenditures and denominator supporting these tables include both FFS and Medicare Advantage. The recently introduced tables II-7b and II-8b reflect comparable measures with consistent FFS and MA expenditures and enrollment. We believe that removing tables II-7a and II-8a will reduce potential for stakeholder confusion while maintaining tables II-7b and II-8b will provide information consistent with established USPCC tables and per capita trend exhibits.

Section E. Loading for Claims Processing Costs

Per section 1853(n)(2)(E) of the Act, the base amount used in setting MA county rates is the amount specified in section 1853(c)(1)(D) for each year that CMS rebases the MA rates. Section 1853(c)(1)(D) provides that the adjusted average per capita cost (AAPCC) for the year involved, which is the basis for the calculation of the USPCC, is determined under section 1876(a)(4). As defined in section 1876(a)(4), the AAPCC (and accordingly the USPCCs) include administrative costs incurred by the Medicare Administrative Contractors (MACs) described in sections 1816 and 1842 of the Act, which are incorporated into the calculation as an adjustment. Consistent with past practice, this "loading" adjustment is developed as the ratio of MAC administrative costs to Medicare benefit payments for the most recent completed fiscal year. Consistent with past years, we will continue to include both FFS and Part C expenditures in the denominator of the loading adjustment calculation for the Total USPCC non-ESRD. In order to better align the costs included in the numerator and denominator, we will continue to include, as adopted for the 2023 rates, only FFS expenditures (as opposed to both FFS and Part C expenditures) in the denominator of the loading adjustment calculation for the non-ESRD FFS USPCC and FFS Dialysis ESRD USPCC. Table I-6 contains the 2027 USPCC loading adjustment for claims processing costs.

Table I-6. USPCC Loading Adjustment for Claims Processing Costs

Expenditure Category	Cash Benefits FY 2025 (000)	MAC Expenses FY 2025 (000)	Claims Processing Loading	USPCC basis
PART A				
FFS	$223,402,298	$218,065	0.000976	FFS USPCC
Part C	$208,904,250	n/a	n/a	n/a
Total	$432,306,548	$218,065	0.000504	Total USPCC
PART B				
FFS	$250,107,316	$600,061	0.002399	FFS USPCC

Expenditure Category	Cash Benefits FY 2025 (000)	MAC Expenses FY 2025 (000)	Claims Processing Loading	USPCC basis
Part C	$318,356,498	n/a	n/a	n/a
Total	$568,463,814	$600,061	0.001056	Total USPCC

Attachment II. Changes in the Payment Methodology for Medicare Advantage and PACE for CY 2027

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

Section 1853(n)(2)(E) of the Act requires that, in determining the specified amount, CMS use as the base amount the amount described in section 1853(c)(1)(D) for a rebasing year or, for years that are not a rebasing year, the base amount from the previous year increased by the national per capita MA growth percentage. Section 1853(c)(1)(D)(ii) requires CMS to rebase the county FFS rates, which form the basis of the specified amount described in Section A2 below, periodically but not less than once every three years. When the rates are rebased, CMS updates its estimate of each county's FFS costs using more current FFS claims information. CMS intends to rebase the county FFS rates for 2027 using FFS claims data from 2020 through 2024. CMS has rebased the rates every year since 2012 and has discussed in previous Rate Announcements that we anticipate rebasing the rates each year. Given that MA rates are based on FFS costs, CMS believes it is important to update the FFS per capita cost estimates using the most current FFS data available. Section 1853(n)(4) requires that the benchmark for an area for a year (including increases for quality bonus percentages) be capped at the level of the applicable amount, as defined at section 1853(k)(1).

PACE payment rates are not developed using the specified amount, per section 1853(n)(5) of the Act, but are developed using the applicable amount, as defined at section 1853(k)(1), as discussed below.

A1. Applicable Amount

The applicable amount is the rate established under section 1853(k)(1) of the Act. As CMS intends to rebase the rates in 2027, the applicable amount for 2027 is the greater of: (1) the county's 2027 FFS cost (that is, the 2027 FFS USPCC adjusted for the county) or (2) the 2026 applicable amount increased by the CY 2027 national per capita MA growth percentage. As discussed in Section A5, section 1853(n)(4) of the Act requires that the benchmark (determined taking into account the application of the quality bonus payment (QBP) percentage) for each county must be capped at the county's applicable amount.

A2. Specified Amount

Under section 1853(n)(2)(A) of the Act, the specified amount is based upon the following formula:

(2027 FFS cost minus (IME phase-out amount and kidney acquisition costs)) × (applicable percentage + applicable percentage quality increase)

Where:

FFS cost is the FFS per capita cost for the area for the year, adjusted to exclude costs attributable to payments under sections 1848(o) and 1886(h) and (n), as described in more detail in Section C and Attachment I;

IME phase-out amount is the amount of indirect costs of medical education that is required to be phased out as specified at section 1853(k)(4) and (n)(2)(A)(i) and (F);

Kidney acquisition costs are the standardized costs for payments for organ acquisitions for kidney transplants that are required to be excluded, beginning 2021, as specified at section 1853(k)(5) and (n)(2)(A)(i) and (G);

Applicable percentage is a statutory percentage applied to the county's base payment amount, as described at section 1853(n)(2)(B); and

Applicable percentage quality increase, referred to in this document as the QBP percentage, is a percentage point increase to the applicable percentage for a county in a qualifying plan's service area as provided in section 1853(o).

Section 1853(n)(2)(B) and (C) of the Act requires CMS to determine applicable percentages for a year based on county FFS rate rankings for the most recent year that was a rebasing year. To determine the CY 2027 applicable percentages for counties in the 50 States and the District of Columbia, CMS ranks counties from highest to lowest based upon their 2026 average per capita FFS rate adjusted to exclude the IME phase out and payments for kidney acquisition for transplant. The 2026 rates are used because 2026 is the most recent rebasing year prior to 2027. CMS then places the rates into four quartiles. For the territories, CMS assigns an applicable percentage to each territory county based on where the territory county rate falls in the quartiles established for the 50 States and the District of Columbia.

CMS is publishing the 2027 applicable percentages by county with the Advance Notice at https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents.html. Each county's applicable percentage is assigned based upon its quartile ranking, as follows:

Table II-1. FFS Quartile Assignment

Quartile	Applicable Percentage
4th (highest)	95%
3rd	100%
2nd	107.5%
1st (lowest)	115%

Section 1853(n)(2)(D) of the Act provides that, beginning in 2013, if there is a change in a county's quartile ranking for a payment year compared to the county's ranking in the previous year, the applicable percentage for the area for the year shall be the average of: (1) the applicable percentage for the previous year and (2) the applicable percentage for the current year. For both years, CMS calculates the applicable percentage that would otherwise apply for the area for the year in the absence of this transitional provision. For example, if a county's ranking changed from the second quartile to the third quartile, the applicable percentage would be 103.75 percent for the year of the change – the average of 107.5 percent and 100 percent (see Table II-1 above).

A3. Quality Bonus Payment Percentage

The Act provides for CMS to make quality bonus payments to MA organizations that meet quality standards measured under a five-star quality rating system. In this document, we refer to this quality bonus as the *QBP percentage* instead of using the statutory term *applicable percentage quality increase*. The QBP percentage is a percentage point increase to the applicable percentage for each county in a qualifying plan's service area, before multiplying the percentage by the FFS rate for the year to determine the specified amount.

Table II-2 shows the QBP percentage for each Star Rating. Plans with fewer than four stars will not receive a QBP percentage increase to the county rates and plans with four or more stars will receive a QBP percentage increase in the calculation of the county rates, as set forth in section 1853(n) and (o) of the Act. See Section A6 for rebate percentages.

Table II-2. Percentage Add-on to Applicable Percentage for Quality Bonus Payments

Star Rating	QBP Percentage
Fewer than 4 stars	0%
4, 4.5, and 5 stars	5%

An MA plan's Star Rating is the rating assigned to its contract applying the 5-star rating system (based on the data collected under section 1852(e) of the Act) specified in 42 CFR §§ 422.160 through 422.166.[14] The contract rating is applied to each plan offered under that contract. MA plans with a Star Rating of four or more stars will bid against their service area benchmarks that include the 5 percentage point QBP add-on to the applicable percentage for the benchmark in each county in the service area, subject to the benchmark cap for the county. MA plans with a Star Rating of fewer than four stars will bid against service area benchmarks that do not include QBP add-ons to the county rates, with the exceptions of new MA plans and low enrollment plans. As discussed below, all benchmarks (determined after application of the QBP percentage) are capped at the section 1853(k)(1) applicable amount per section 1853(n)(4) of the Act.

[14] All regulatory cites are to Title 42 of the Code of Federal Regulations unless otherwise noted.

New MA Plans

New MA plans are treated as qualifying plans that are eligible to receive a QBP percentage increase to the county rates, except that the QBP percentage will be 3.5 percentage points, per section 1853(o)(3)(A)(iii)(I)(cc) of the Act and §§ 422.166(d)(2)(v) and 422.258(d)(7)(v)(C). That is, new MA plans will bid against a service area benchmark that reflects a 3.5 percentage point increase to the applicable percentage used to set the benchmark for each county in the plan's service area. Per section 1853(o)(3)(A)(iii)(II) of the Act and § 422.252, for the purpose of determining a QBP percentage, the term "new MA plan" refers to an MA plan offered by a parent organization that has not had another MA contract in the preceding three-year period.

Per § 422.166(d)(2)(vi), for a parent organization that has had a contract with CMS in the preceding three-year-period, any new MA contract (and MA plans under that contract) under that parent organization will receive an enrollment-weighted average of the Star Ratings earned by the parent organization's existing MA contracts.

Low Enrollment Plans

Low enrollment plans do not receive a quality Star Rating under the 5-star rating system (specified in §§ 422.160 through 422.166) but are treated as qualifying plans for purposes of the QBP. *See* 42 CFR §§ 422.166(d)(2)(v) and 422.258(d)(7)(iv). Section 1853(o)(3)(A)(ii)(II) of the Act, as implemented at § 422.258(d)(7)(iv)(B), provides that for 2013 and subsequent years, CMS shall develop a method for determining whether an MA plan with low enrollment is a qualifying plan for purposes of receiving an increase in payment under section 1853(o). We apply this determination at the contract level and thus determine whether a contract (meaning all plans under that contract) is a qualifying contract. Pursuant to § 422.252, a low enrollment contract is one that could not undertake Healthcare Effectiveness Data and Information Set (HEDIS) and Health Outcome Survey (HOS) data collections because of a lack of a sufficient number of enrollees (that is, fewer than 500 enrollees) to reliably measure the performance of the health plan.

Section 1853(o)(3)(A)(ii) of the Act does not address the amount of the increase for low enrollment contracts. We intend to continue the current policy that low enrollment contracts be included as qualifying contracts that receive the QBP percentage of 3.5 percentage points, similar to the QBP percentage increase applied to new MA plans. We discussed the basis of this policy in detail in the 2018 Advance Notice (pages 12-13) (https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Advance2018.pdf).

Contract Consolidations and QBP

Section 1853(o)(4) of the Act was amended by the Bipartisan Budget Act of 2018 to add subparagraph (D) regarding the determination of Star Ratings for consolidating MA plans, which is implemented for MA plans at § 422.162(b)(3) for contract consolidations approved on or after

January 1, 2019. When two or more contracts for health and/or drug services of the same plan type under the same legal entity are combined into a single contract at the start of a contract year, the rating used to determine QBP status ("QBP rating") for the first year following the consolidation will be the enrollment weighted average of what would have been the QBP ratings of the surviving and consumed contracts, using the contract enrollment in November of the year the Star Ratings were released (§ 422.162(b)(3)(ii)). For the second year after consolidation, CMS will determine QBP status based on the consolidated contract's Star Ratings displayed on Medicare Plan Finder, which will be calculated as provided in § 422.162(b)(3)(iv)(B).

A4. Qualifying County Bonus Payment

Beginning with contract year 2012, pursuant to section 1853(o)(2) of the Act and § 422.258(d)(7)(ii), the QBP percentage is doubled for a qualifying plan located in a "qualifying county." A qualifying county is a county that meets all of the following three criteria:

> (1) has an MA capitation rate that, in 2004, was based on the amount specified in section 1853(c)(1)(B) for a Metropolitan Statistical Area with a population of more than 250,000;
>
> (2) as of December 2009, had at least 25 percent of MA-eligible beneficiaries residing in the county enrolled in a MA plan; and
>
> (3) has per capita FFS County spending for the year (2027) that is less than the national monthly per capita cost for FFS for the year (2027).

See section 1853(o)(3)(B) of the Act and § 422.258(d)(7)(ii).

Example: As described in Section A3, a plan with a rating of 4.5 stars will have 5 QBP percentage points added to the applicable percentage of each county in its service area. For each county that meets the three criteria stated above in that plan's service area, that percentage will be doubled so that an additional 5 percentage points will be added to that county's applicable percentage for a total increase of 10 percentage points. If this qualifying county otherwise has an applicable percentage of 95 percent, this is increased to 105 percent to reflect the quality bonus payment percentage for that county. As discussed in Section A5 below, all benchmarks are capped at the section 1853(k)(1) applicable amount (determined after application of the QBP percentage) per section 1853(n)(4) of the Act.

CMS will publish a complete list of qualifying counties with the final CY 2027 Rate Announcement. The listing will contain all counties that meet all three criteria stated above from section 1853(o)(3)(B) of the Act. Two of the three elements for determining a qualifying county (2004 urban floors (Y/N) for each county, and 2009 MA penetration rates) can be found in the 2026 Rate Calculation Data file (columns AB and AD) on the CMS website at https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Ratebooks-and-Supporting-Data.html. The 2027 FFS rates, which are necessary for the third criterion, are not

available at the time this Advance Notice is published. The FFS rates and the national average FFS spending amount will be published in the final CY 2027 Rate Announcement.

A5. Cap on Benchmarks

Section 1853(n)(4) of the Act requires that the benchmark (determined by taking into account the application of the QBP percentage) for a county must be capped at the level of the county's applicable amount determined under section 1853(k)(1). This provision requires that the QBP increase be included in the benchmark before the comparison is made to determine if the cap is applied. Thus, for all counties, post-QBP percentage rates are capped at the section 1853(k)(1) applicable amount.

A6. Rebate

Under section 1854(b)(1)(C)(v) of the Act, except for Medical Savings Account (MSA) plans, the level of rebate for each plan is based on the plan's Star Rating. Rebates for each plan are calculated as a percentage of the amount by which the risk-adjusted service area benchmark exceeds the risk-adjusted bid. Under § 422.266(b), plans may use rebates to pay for mandatory supplemental benefits (such as reduced cost sharing compared to the cost sharing that is actuarially equivalent to Medicare FFS coverage per section 1852(a)(1)(B) of the Act and additional items and services that are not covered by Medicare Parts A and B) and/or to buy down beneficiary premiums for Part B and/or Part D prescription drug coverage. Pursuant to section 1854(b)(1)(C)(v), which is implemented in § 422.266(a)(2)(ii), the rebate percentages apply based on a plan's Star Rating, as shown in Table II-3.

Table II-3. MA Rebate Percentages

Star Rating	Rebate Percentage
4.5+ Stars	70%
3.5 to < 4.5 stars	65%
< 3.5 stars	50%

Section 1854(b)(1)(C)(vi)(II) of the Act requires that, for purposes of determining the rebate percentage, a new MA contract under a new parent organization will be treated as having a Star Rating of 3.5 stars for 2012 and subsequent years. *See* also § 422.266(a)(2)(iv). The statute is silent on the rebate percentage to assign to low enrollment plans in years after 2012. We view this as a gap in the statute, particularly in light of the direction in section 1853(o)(3)(A)(ii) to treat low enrollment plans as qualifying plans for purposes of the QBP percentage. As we have in prior years beginning with CY 2015, CMS intends to treat low enrollment plans as having a Star Rating of 3.5 stars for purposes of determining the rebate percentage; therefore, rebates for

each low enrollment plan are calculated as 65% of the amount by which the risk-adjusted service area benchmark exceeds the risk-adjusted bid.

Section B. Calculation of Fee-for-Service Cost

B1. Introduction

The FFS per capita cost for each county is the product of (1) the national FFS per capita cost, or USPCC, and (2) a county-level geographic index called the average geographic adjustment (AGA). Each year, CMS strives to improve the development of the AGAs and estimated FFS per capita costs with refinements to how these figures are calculated.

We will continue to incorporate refinements developed and used in prior years to update the claims data used to calculate the AGAs and to continue the repricing of historical data in the AGA calculation to reflect changes in FFS payment rules. CMS will reprice historical hospital inpatient, hospital outpatient, skilled nursing facility, and home health claims to reflect the most currently available wage indices, and CMS will retabulate physician claims with the most currently available Geographic Practice Cost Index (see Sections B3 through B6 for more details). We will also reprice historical claims to account for known legislative and regulatory changes made to uncompensated care payments. Repricing historical claims used for the AGAs, in conjunction with rebasing rates, ensures that the FFS rates for each county reflect the most current FFS fee schedules and payment rules.

We will continue the methodology used in the ratebook development to include Health Professional Shortage Areas (HPSAs) bonus payments. Specifically, we will tabulate the HPSA bonuses by county of residence for years 2020–2024 and add these values to our ratebook FFS expenditures. The HPSA bonuses are disbursed quarterly to providers and are not reflected in the standard claim files.

With this Advance Notice, we are releasing the 2024 FFS cost data by county used in the development of the 2027 ratebook. This data is available on the CMS website at https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/FFS-Data.html. These data do not reflect adjustments for Innovation Center models and demonstrations, the Medicare Shared Savings Program and Advanced Alternative Payment Models, and do not reflect adjustments for claim repricing for the most current available FFS payment final rules and parameters.

Rural Emergency Hospitals (REHs)

The Consolidated Appropriations Act of 2021[15] established REHs to deliver emergency hospital, observation, and other services to Medicare patients on an outpatient basis. To qualify as an REH, facilities must meet specific statutory requirements at section 1861(kkk)(2) of the Act and

[15] Pub. L. No. 116–260, Division CC, Title I, Subtitle B, Section 125.

regulatory requirements at 42 CFR part 485 subpart E. Starting in January 2023, qualifying providers receive two payment enhancements as specified in statute at section 1834(x)(1) and (2) of the Act and further described in regulation in 42 CFR part 419 subpart J.

The first enhancement is that REH facilities receive payment rates that are 5 percent higher than the Hospital OPPS rates for REH services, as defined in 42 CFR § 419.91. The additional REH payment for these services is reflected in the NCH claim records, requiring no explicit adjustment when tabulating ratebook FFS experience.

The second payment enhancement is that starting with CY 2023, REHs are paid an annual additional facility payment in 12 monthly installments. The monthly facility payments are uniform and are established annually through Pub 100-04 Medicare Claims Processing change requests (CR). CR 12820 specifies[16] the 2023 REH monthly facility payment amount of $267,408.68 after sequestration is removed. CR 13457 specifies[17] the 2024 REH monthly facility payment amount of $276,233.58 after sequestration is removed.

Because the REH facility payments are not reflected in the NCH, we are proposing to make an adjustment to the 2023 and 2024 FFS experience used in the development of FFS per capita costs for the 2027 ratebook to include REH additional facility payments. The number of facility monthly payments for each eligible REH will be determined from Medicare Cost Report, Hospital Form 2552-10, supplemented by information from CMS' administrative records. The annual additional facility payment for each REH will be the product of the number of months of eligibility and the facility payment amount after sequestration. The annual REH additional facility payment will be allocated to counties in proportion to county-level outpatient claims for each facility for the calendar year. In aggregate, REH additional facility payments are relatively small, representing about 0.06 percent of 2023 FFS expenditures to non-Core Based Statistical Area, or rural, counties.

With this Advance Notice, we are releasing two files that support the proposed adjustment for REH additional facility payments. The first file contains the proposed 2023 and 2024 REH additional annual facility payments for each provider. The second file includes the proposed 2023 and 2024 REH additional annual facility payments with non-ESRD payments displayed at the county level and ESRD dialysis payments displayed at the state level. These files are available on the "2027 Advance Notice" page of the CMS website at: https://www.cms.gov/medicare/payment/medicare-advantage-rates-statistics/announcements-and-documents.

[16] https://www.cms.gov/files/document/r12369cp.pdf

[17] https://www.cms.gov/files/document/r12373cp.pdf

B2. Tabulation of Ratebook FFS Experience for 2023 and thereafter

In the CY 2026 Advance Notice, we explained that the historical source for FFS enrollment, the Denominator file, had been retired and was last created for CY 2022, and that beginning with 2023 experience, we would replace the data derived from the Denominator file with comparable information from the Common Medicare Environment (CME). For CY 2027, we will continue to apply the following methodology to the tabulation of ratebook FFS experience based on the updated data source based on the monthly status of each field:

1. Use CME dialysis and transplant tables to identify claims for beneficiaries in non-ESRD status.
2. Use the state code and county code from the CME to summarize NCH claim experience by state and county. The state and county code originate with records from the SSA.
3. Exclude claims for beneficiaries with MA coverage.
4. Exclude FFS enrollment and non-hospice claims for FFS beneficiaries in hospice status. As noted previously, payments to hospices are excluded from the development of the USPCCs.

This methodology is applied correspondingly to the non-ESRD FFS USPCCs supporting the CY 2027 growth rates. As noted earlier, this methodology has been reflected in the growth rates and USPCC estimates in Attachment I of this document.

B2a. Proposed Exclusion of Significant, Anomalous, and Highly Suspect Billing Activity in Calendar Years 2023 and 2024

In early 2023, CMS identified a concerning rise in urinary catheter billings attributed to a small group of 15 Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) supply companies that had recently changed ownership. Through investigative work, CMS determined that beneficiaries did not receive catheters from these DMEPOS suppliers, physicians did not order these supplies, and the supplies were not needed.

On September 27, 2024, to mitigate the impact of significant, anomalous, and highly suspect billing activity for selected intermittent urinary catheter supplies in CY 2023 on Shared Savings Program financial calculations, CMS published the final rule entitled, "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) in which CMS adjusted the benchmark to remove payments for specified catheter codes from the determination of benchmark expenditures. Specifically, CMS excluded all Medicare Parts A and B FFS payment amounts on Medicare DMEPOS claims (claim types 72 and 82) associated with HCPCS codes A4352 (Intermittent urinary catheter; coude (curved) tip, with or without coating (teflon, silicone, silicone elastomeric, or hydrophilic, etc.), each) and A4353 (Intermittent urinary catheter, with insertion supplies) from expenditure and revenue calculations for CY 2023, as a result of CMS's determination that the billing of these codes represents significant, anomalous, and highly suspect billing activity.

For the CY 2027 ratebook, we are proposing to make a corresponding adjustment to the tabulation of 2023 FFS experience used in the development of FFS per capita costs for the 2027 ratebook to exclude all Medicare Parts A and B FFS payment amounts on DMEPOS claims with HCPCS codes A4352 and A4353.

Additionally, as announced in the May 27, 2025 Accountable Care Organization Spotlight newsletter, all Parts A and B payment amounts on Medicare DMEPOS claim types 72 and 82 associated with HCPCS codes A4353 and A5057 and dates of service in CY 2024 are also excluded from Shared Savings Program expenditure and revenue calculations in order to mitigate the impact of significant, anomalous, and highly suspect billing activity.

For the CY 2027 ratebook, we are proposing to make a corresponding adjustment to the tabulation of 2024 FFS experience to exclude all Medicare Parts A and B FFS payment amounts on DMEPOS claims with HCPCS codes A4353 and A5057.

With this Advance Notice, we are releasing the proposed 2023 and 2024 county-level impacts for non-ESRD beneficiaries and state-level impacts for dialysis ESRD beneficiaries of removing significant, anomalous, and highly suspect billing activity, available on the "2027 Advance Notice" page of the CMS website at: https://www.cms.gov/medicare/payment/medicare-advantage-rates-statistics/announcements-and-documents.

B3. AGA Methodology

In the first step of the AGA methodology, CMS will add the 2024 cost and enrollment data to and drop the 2019 cost and enrollment data from, the historical claims experience used to develop new geographic cost indices for each county. As a result, the five-year rolling average will be based on non-hospice FFS claims data from 2020-2024. CMS will then perform a series of adjustments to the historical FFS data to estimate FFS rates per county, explained below as successive steps.

For Puerto Rico, CMS will continue to include five years (2020-2024) of historical claims and enrollment only for beneficiaries with Part A and Part B enrollment at the time of the dates of service for the FFS claim. 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. CMS continues to believe it is appropriate to adjust the FFS rate calculation in Puerto Rico used to determine MA rates so that it is based on beneficiaries who are enrolled in both Part A and Part B in order to produce a more accurate projection of FFS costs per capita in Puerto Rico.

In the second step, CMS will reprice the historical 2020-2024 claims. For inpatient, hospital outpatient, skilled nursing facility, and home health claims this will reflect the most current (i.e., FY 2026) wage indices. For physician claims this will reflect the most current Geographic Practice Cost Indices. For DMEPOS claims this will reflect the applicable methodology under 42

CFR § 414.210(g)(10) during the temporary gap period for the DMEPOS Competitive Bidding Program (CBP), which began on January 1, 2024.[18] The January 2026 fee schedules for repricing DMEPOS claims are accessible on the CMS website at: https://www.cms.gov/medicare/payment/fee-schedules/dmepos/dmepos-fee-schedule.

As noted on page 35 of the CY 2022 Rate Announcement,[19] and consistent with prior years, we do not reprice Part B drugs, and we have not developed the data and systems to support such repricing. Therefore, we do not reprice Part B drugs as part of our adjustments to the AGAs irrespective of the 340B remedy rule provision for lump sum remedy payments for services rendered from January 1, 2018, through September 27, 2022, for each 340B covered entity. On September 28, 2022, the District Court for the District of Columbia vacated the differential payment rates for 340B-acquired drugs going forward. As a result, all CY 2022 claims for 340B-acquired drugs paid on or after September 28, 2022, were paid at the default rate (generally ASP plus 6%). As such, many CY 2022 340B drug claims have been processed, or reprocessed through standard claims processing procedures, at the higher 340B payment rate (generally ASP plus 6%) as described in the Hospital OPPS Remedy for the 340B-Acquired Drug Payment Policy for CYs 2018-2022 Final Rule, CMS-1793-F, (88 FR 77150–94), issued on November 2, 2023. The processing, or reprocessing through standard claims processing procedures, at the higher 340B payment rate (generally ASP plus 6%) for these aforementioned CY 2022 claims will be included in 2022 FFS experience supporting the ratebook AGAs.

We will continue to adjust the uncompensated care payments (UCP) represented in the 2020–2024 claims to reflect the requirements of the most recent final rule (here, the FY 2026 Inpatient Prospective Payment System (IPPS) final rule). The repricing will include the supplemental payment for certain hospitals in Puerto Rico and certain Indian Health Service / Tribal hospitals that was adopted in the FY 2023 IPPS final rule. Repricing for Puerto Rico inpatient claims will continue to reflect the Consolidated Appropriations Act, 2016 (Pub. L. 114-113, Division O, section 601), which amended section 1886(d)(9)(E) of the Act.

We will continue to use, as the source of the county designation of beneficiaries used in the summarization of the risk scores, the county assignment used for the ratebook FFS claims and enrollment. For contract years 2016 and earlier, the county assignment for each FFS beneficiary was based on the ZIP code associated with the beneficiary's mailing address. Beginning with the 2017 ratebook, we used the county of residence sourced from the SSA, which is the same county assignment as the ratebook FFS claims and enrollment. The statutory component of the Regional MA benchmarks for RPPOs will also continue to be based on this county designation of beneficiaries. Under our implementation of section 1858(f)(2) of the Act, the standardized RPPO benchmark for each MA region includes a statutory component consisting of the weighted

[18] For more information on the DMEPOS Competitive Bidding Program Temporary Gap Period, please see: https://www.cms.gov/medicare/payment/fee-schedules/dmepos-competitive-bidding.

[19] https://www.cms.gov/files/document/2022-announcement.pdf

average of the county capitation rates across the region for each appropriate level of Star Rating. The enrollment weights for the statutory component will reflect this county designation of beneficiaries.

As in prior years, (1) CMS will make additional adjustments to the FFS costs described below, and (2) the average of each county's five-year geographic indices, based on the adjusted claims data, will be divided by the county's average five-year risk score in order to develop the AGA for that county. Consistent with the development of prior years' ratebooks, the risk scores used to standardize the non-ESRD and ESRD ratebooks will be based on the risk adjustment model(s) and risk adjustment policies used for the applicable contract year (2027) payment.

B4. Adjustments for Medicare Shared Savings Program and Innovation Center Models and Demonstrations, and Advanced Alternative Payment Models

Medicare Shared Savings Program and Innovation Center Models and Demonstrations

As indicated in Table II-4, we will continue to adjust historical FFS experience to incorporate shared savings and losses or episode savings and losses experienced under the Medicare Shared Savings Program and Innovation Center models and demonstrations. We will update the experience years used for this adjustment as noted on Table II-4. All adjustments of this type apply to only the non-ESRD ratebook except the model(s) noted as ESRD in Table II-4.

Table II-4. The Medicare Shared Savings Program and Innovation Center Models and Demonstrations with Ratebook Adjustments

Program/Models and Demonstrations	Experience Years		Payment Type
	2026 Ratebook	2027 Ratebook	
Medicare Shared Savings Program	2019-2023	2020-2024	Shared savings / shared losses
Comprehensive Care for Joint Replacement (CJR)	2019-2022	2020-2022	Episode savings / episode losses
Next Generation ACO (NGACO)	2019-2021	2020-2021	Shared savings / shared losses
Oncology Care Model (OCM)	2019-2022	2020-2023	Episode savings / episode losses
Enhancing Oncology Model (EOM)	n/a	7/1/2023-12/31/2024	Performance-based payments / recoupments
Bundled Payment for Care Improvement Advanced (BPCI Advanced)	2019-2023	2020-2024	Episode savings / episode losses
Medicare-Medicaid Financial Alignment Initiative Managed FFS Model	2019-2020	2020	Shared savings
Vermont Medicare ACO Initiative	2019-2023	2020-2024	Shared Savings / shared losses

Program/Models and Demonstrations	Experience Years		Payment Type
	2026 Ratebook	2027 Ratebook	
Maryland Primary Care Program	2019-2023	2020-2024	Performance-based Incentive Payment
Million Hearts: Cardiovascular Disease Risk Reduction Model	2019-2021	2020-2021	Incentive payment
Global and Professional Direct Contracting / ACO Realizing Equity, Access, and Community Health (GPDC/ACO REACH)	4/1/2021-2023	4/1/2021-2024	Shared savings / shared losses
Kidney Care Choices / Comprehensive Kidney Care Contracting Option	2022	2022	Shared savings / shared losses
Next Generation ACO (NGACO)	2019-2021	2020-2021	Population-based payment
Vermont Medicare ACO Initiative	2019-2023	2020-2024	Population-based payment
Maryland Primary Care Program	2019-2023	2020-2024	Population-based payment
Making Care Primary	n/a	2024	Population-based payment
Primary Care First	2021-2023	2021-2024	Population-based payment
Primary Care First	2022-2023	2022-2024	Performance-based Incentive Payment
Global and Professional Direct Contracting / ACO Realizing Equity, Access, and Community Health (GPDC/REACH)	4/1/2021-2023	4/1/2021-2024	Population-based payment
Comprehensive Primary Care Plus (CPC+)	2019-2021	2020-2021	Comprehensive Primary Care Payments
Comprehensive Primary Care Plus (CPC+)	2019-2021	2020-2021	Performance-based Incentive Payment
Comprehensive Primary Care Plus (CPC+)	2019-2021	2020-2021	Care Management Fees
Maryland Primary Care Program	2019-2023	2020-2024	Care Management Fees
Maryland Primary Care Program	2022-2023	2022-2024	Health Equity Advancement Resource and Transformation payments
Making Care Primary	n/a	2024	Care Management Fees

Program/Models and Demonstrations	Experience Years		Payment Type
	2026 Ratebook	2027 Ratebook	
Kidney Care Choices / Comprehensive Kidney Care Contracting Option	2022-2023	2022-2024	Population-based payment
ESRD			
Comprehensive ESRD Care (CEC)	2019-3/31/2021	2020-3/31/2021	Shared savings / shared losses
Next Gen ACO (NGACO)	2019-2021	2020-2021	Population-based payment
Vermont Medicare ACO Initiative	2019-2023	2020-2024	Population-based payment
Global and Professional Direct Contracting / ACO Realizing Equity, Access, and Community Health (GPDC/REACH)	4/1/2021-2023	4/1/2021-2024	Population-based payment
Kidney Care Choices / Comprehensive Kidney Care Contracting Option	2022	2022	Shared savings / shared losses

The key aspects of these adjustments are:

- The adjustments reflect an allocation of the savings and losses based on the distribution of the participating entity's aligned beneficiaries by county of residence. The adjustments applied to the non-ESRD ratebook exclude experience for beneficiaries in ESRD status as of July 1 of the experience year. (The adjustments for the model(s) noted as ESRD in Table II-4, which are applied to the ESRD ratebook in a similar manner as the non-ESRD cohort, include experience for beneficiaries in ESRD status.)
- Under the models noted as using "population-based payments" in Table II-4, participants receive a monthly fee that ultimately offsets a percentage reduction in FFS payments to certain providers and suppliers aligned with participants over the same year. For each affected claim, the reduction amount represents the portion of the payment that has effectively been rerouted to the Accountable Care Organization (ACO) or applicable model participant via the population-based payment and is therefore added back to the reduced FFS amount so that the total reimbursement amount is represented.
- Under the CPC+ model, participants received quarterly payments that replaced a percentage of FFS claim amounts for each affected claim. The "comprehensive primary care payments" are included with claim costs to compile the total reimbursement amount.
- In the ratebooks for CYs 2020 and earlier, the allocation of the Medicare Shared Savings Program and Innovation Center model and demonstration payment adjustments between the Part A and Part B Trust Funds was based on the Part A and Part B proportion of the

FFS USPCC for each calendar year. Consistent with model specifications,[20] we intend to continue with the approach of allocating the entire amount of specific payments for all experience years to the Part B Trust Fund. These specific payments are: (i) Oncology Care Model episode savings / losses, (ii) Comprehensive Primary Care Plus comprehensive primary care payments, performance-based incentive payments, and care management fees, (iii) all payments under the Maryland Primary Care Program, (iv) Primary Care First population-based payments and performance-based incentive payments, (v) Kidney Care Choices / Comprehensive Kidney Care Contracting Option population-based payments, and (vi) Making Care Primary population-based payments and care management fees. The remaining Medicare Shared Savings Program and Innovation Center model and demonstration payment adjustments will continue to be allocated in the MA ratebook calculations between the Part A and Part B Trust Funds based on the Part A and Part B proportion of the FFS USPCC for each calendar year.

Further information on the Medicare Shared Savings Program may be found at: https://www.cms.gov/medicare/payment/fee-for-service-providers/shared-savings-program-ssp-acos. Further information on the Innovation Center models and demonstrations may be found at: https://www.cms.gov/priorities/innovation/overview.

Although we considered whether to adjust the FFS claims experience for care management fees, per-beneficiary-per-month fees, and/or advance payment of shared savings paid to providers for other Innovation Center models conducted in 2020-2024 period,[21] we intend to continue prior policy and will not take fees of this type into account in our adjustments to historical FFS experience when such fees or payments were not funded from Medicare Parts A or B Trust Funds.

Advanced Alternative Payment Models

Section 1833(z)(1) of the Act requires payment of an incentive for physicians and other eligible clinicians who become qualifying APM participants (QPs) through sufficient participation in an Advanced Alternative Payment Model (A-APM) for payment years from 2019 through 2026.[22]

A-APMs can include: 1) models under section 1115A of the Act (other than a health care innovation award), 2) certain two-sided models under the Shared Savings Program under section 1899 of the Act, 3) demonstrations under section 1866C of the Act, and 4) demonstrations required by federal law when these alternative payment models meet the criteria specified in § 414.1415, including requiring the use of Certified Electronic Health Record Technology

[20] Information about the various Innovation Center models is available at: https://www.cms.gov/priorities/innovation/models.

[21] Information about the various Innovation Center models is available in the Report to Congress available at: https://innovation.cms.gov/data-and-reports/2021/rtc-2020.

[22] Consolidated Appropriations Act, 2024 (Pub. L. 118-42).

(CEHRT), making payment based on quality measures, and requiring assumption of a more than nominal amount of financial risk. The QP performance period occurs two years prior to payment of the APM incentive. QP determinations are made for each eligible clinician (National Provider Identifier (NPI)) and may be made at either a group or individual eligible clinician level. The first QP performance year was 2017, and the first APM incentive payments were made to QPs in 2019.

APM incentive payments are calculated and paid as specified in § 414.1450. The amount of the APM incentive payment for payment years 2019 through 2024 is equal to 5 percent, for 2025 is equal to 3.5 percent, and for 2026 is equal to 1.88 percent of the QP's estimated aggregate payments for covered professional services as defined in section 1848(k)(3)(A) of the Act furnished during a base year which is the calendar year immediately preceding the payment year. Base year estimated aggregate payments and the corresponding APM incentive payment are calculated for each QP using all of their NPI combinations.

The applicable periods for APM incentive payments made to date are:

Table II-5. Applicable Periods for APM Incentive Payments

QP performance year	2017	2018	2019	2020	2021	2022	2023
Base year	2018	2019	2020	2021	2022	2023	2024
Payment year	2019	2020	2021	2022	2023	2024	2025

We will include with the ratebook historical experience the APM incentive payments disbursed in years 2020 through 2024. The APM incentive payments will be added to ratebook FFS experience for the payment year. For example, the APM incentive payments made in 2020 will be added to 2020 FFS experience. The APM incentive payment adjustment will be allocated based on the distribution of claim expenditures by county of beneficiary residence for the base year expenditures for each NPI. Excluded from the adjustment will be the small proportion, less than 0.50 percent, of incentive payments for providers with no base period experience, given there is no basis for allocation of payments by beneficiary residence for such providers. The adjustment will apply to both non-ESRD and dialysis populations.

Further information on the A-APMs may be found at: https://qpp.cms.gov/apms/advanced-apms.

B5. Additional Adjustment to FFS per Capita Costs in Puerto Rico

For the past ten years, the Secretary has directed the CMS Office of the Actuary to adjust the FFS experience for beneficiaries enrolled in Puerto Rico to reflect the nationwide propensity of beneficiaries with zero claims. For the CY 2017–2026 Rate Announcements, the CMS Office of the Actuary evaluated experience exclusively for beneficiaries who were enrolled in both Parts A and B ("A&B FFS beneficiaries") and were not dually eligible for Veterans Affairs (VA) coverage. The study for setting the CY 2026 rates analyzed experience for calendar years 2019 through 2023 and only considered FFS beneficiaries enrolled mid-year. On average over this

period, 13.8 percent of A&B Puerto Rico FFS beneficiaries were found to have no Medicare Part A or Part B claim reimbursements per year. This compares to a nationwide non-territory proportion of 6.0 percent of A&B FFS beneficiaries found to have no Medicare Part A claim reimbursements and no Medicare Part B claim reimbursements per year over the same period. Based on the Secretary's direction, the Puerto Rico FFS weighting of enrollment and risk scores for the zero-claim cohort was adjusted to reflect the nationwide proportion of zero-claim beneficiaries. The resulting impact was measured as an average increase in the standardized per-capita FFS costs in Puerto Rico of 4.1 percent for 2019 through 2023. Accordingly, a 4.1 percent adjustment was then applied to the pre-standardized Puerto Rico FFS rates supporting the CY 2026 ratebook development.

We are considering whether a similar adjustment should be applied for CY 2027. The CMS Office of the Actuary will perform an analysis that is similar to the prior analysis described in the preceding paragraph but with an updated five years of data: 2020-2024. We welcome comments regarding a similar adjustment to Puerto Rico's experience in the development of the 2027 FFS rates. We will review the results of this study and any comments that we receive, and we will specify in the final Rate Announcement any adjustment that we determine may be necessary based on those results and comments.

As discussed in the CY 2017 Advance Notice, the law requires that MA benchmarks be based on a county's average FFS per-capita cost, 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. As we stated originally in the CY 2017 Rate Announcement and in Rate Announcements for several years since, our actuarial analyses have indicated that the FFS data in Puerto Rico is sufficient for establishing accurate MA benchmarks.

B6. Additional Adjustments after the AGA is Calculated

The following adjustments are made after the AGA is calculated:

- DGME: removed from FFS county costs (as directed by section 1853(c)(1)(D)(i) of the Act), described in more detail in Section C1.
- Credibility: for counties with fewer than 1,000 beneficiaries, blend county experience with that of others in the market area to ensure credibility.
- VA and Department of Defense (DoD): apply an adjustment to FFS per capita costs for beneficiaries dually enrolled in VA and/or the DoD health programs (the Uniformed Services Family Health Plan (USFHP) and/or the Veterans Health Administration (VHA)) pursuant to section 1853(c)(1)(D)(iii) of the Act. The VA/DoD adjustment for the 2027 rates will be based upon an updated study that uses FFS data from calendar years 2019-2023. The methodology for the study and adjustment is described in more detail in the CY 2022 Advance Notice Part II (pages 27-28).

- Organ Acquisition Costs for Kidney Transplants: removed from FFS costs (as directed by section 1853(n)(2)(G) and (k)(5) of the Act), described in more detail in Section C2.
- IME: removed from FFS county costs (as directed by section 1853(n)(2)(F) and (k)(4) of the Act), described in more detail in Section C3.

Note that incentive payments for adoption and meaningful use of certified electronic health record technology (CEHRT) are not included in the claims used to develop the FFS costs and, therefore, no explicit adjustment is needed to exclude these payments from the FFS costs to comply with section 1853(c)(1)(D) of the Act.

B7. Proposed consolidation of files published with the CY 2027 Medicare Advantage Ratebooks

As part of our annual ratebook publication process, we have historically published on this site multiple supporting files in support of the FFS rate development: https://www.cms.gov/medicare/payment/medicare-advantage-rates-statistics.

We propose to consolidate and streamline the adjustments files to improve ease of use for stakeholders:

- Merge the separate impact calculations for DME Competitive Bidding Area (CBA) and DME non-CBA repricing into a single consolidated value for each county and year combination;
- Consolidate the multiple service-level repricing files into a single comprehensive file that includes clear identification fields for service type, experience year, and county;
- Consolidate the multiple innovation model adjustment files into a single comprehensive file that includes clear identification fields for model, adjustment type, experience year, and county;
- Discontinue publication of FFSyyPR.xlsx due to the integration of excluding A-only and B-only Puerto Rico experience into standard NCH record processing effective with 2023 experience; and
- Discontinue publication of FFSyyCC.xlsx due to the integration of cost plan expenditures into standard NCH record processing effective with 2023 experience year.

Section C. Additional Adjustments

As noted in Section B6, additional adjustments are applied after the AGA is calculated. Subsections C1, C2, and C3 below describe the separate adjustment factors developed for DGME, Kidney Acquisition Costs, and IME (respectively) and note where additional information on calculation methodologies can be found.

C1. Direct Graduate Medical Education

See Attachment I Section A regarding medical education expenses in USPCCs.

Section 1853(c)(1)(D)(i) of the Act requires the exclusion of costs attributable to payments under section 1886(h) (payments for DGME) from the FFS per capita costs used for developing the MA ratebooks. Please note that some ratebook files and other CMS data reference "graduate medical expenses," or GME. In the context of the MA ratebooks, DGME and GME refer to the same item and are used interchangeably. The methodology for the calculation of the DGME adjustment is described in more detail in the CY 2026 Advance Notice (page 40).

DGME Carve-out for Maryland Total Cost of Care (TCOC) Model

The Maryland TCOC Model sets a per capita limit on Medicare total cost of care in Maryland and is the first Innovation Center model to hold a state fully at risk for the total cost of care for Medicare beneficiaries. The Maryland TCOC Model builds upon the Innovation Center's Maryland All-Payer Model, which had set a limit on per capita hospital expenditures in the State. Maryland operates an all-payer hospital rate regulation system. This system is made possible, in part, by a Medicare waiver that exempted Maryland from the IPPS and the OPPS and allowed Maryland to set rates for these services. This exemption affects the CMS system data used to develop the DGME, IME, and kidney acquisition cost (KAC) carve-outs, and as such we have worked with the MAC and Maryland's Heath Services Cost Review Commission (HSCRC) to identify data that can be used to develop the DGME, IME, and KAC carve-outs for hospitals participating in the Maryland TCOC Model. The KAC is addressed in more detail in section C2 below, and IME is addressed in more detail in section C3 below.

Consistent with the methodology that began with the CY 2025 rates, we will continue to use the alternative data and methodology used to develop the DGME carveout for hospitals participating in the Maryland TCOC Model. The methodology for the calculation of the DGME carve-out for hospitals participating in the Maryland TCOC Model is described in more detail in the CY 2025 Advance Notice (pages 39-40).

The DGME carve-out factors for the 2027 rates will be published with the CY 2027 Rate Announcement.

On March 12, 2025, CMS announced an earlier termination schedule for several Innovation Center models, aiming to conclude the Maryland TCOC model by December 31, 2025. The geographic adjustments for the five-year historical experience period (2020-2024) used for CY 2027 ratebook development are unaffected by the earlier model termination.

C2. Organ Acquisition Costs for Kidney Transplants

Section 17006(b) of the 21st Century Cures Act amended section 1853(k) and (n) of the Act to exclude CMS's estimate of the standardized costs for payments for organ acquisition for kidney transplants from MA benchmarks starting in 2021. Section 1853(k)(5) of the Act, implemented in § 422.306(d), provides for the exclusion of these costs from the applicable amount and section 1853(n)(2)(A)(i), implemented in § 422.258(d), provides for the exclusion from the base amount

(used to calculate the specified amount). Further, section 17006(c) of the 21st Century Cures Act amended sections 1851(i) and 1852(a)(1)(B); the amendments, implemented[23] in §§ 422.100(c)(1) and 422.322, require FFS coverage of organ acquisition costs for kidney transplants incurred by MA enrollees and exclude coverage of organ acquisitions for kidney transplants from the benefits that MA plans must provide to their enrollees. As discussed in the CY 2021 final rule (CMS-4190-F) (85 FR 33825) and CY 2021 Advance Notice, we apply the carve-out from the FFS costs when developing ESRD MA rates as well.

The 21st Century Cures Act did not require FFS coverage of organ acquisition costs for kidney transplants received by PACE participants. Therefore, as noted in the CY 2021 final rule (85 FR 33824–25), PACE organizations must continue to cover organ acquisition costs for kidney transplants consistent with the requirement in section 1894(b)(1)(A)(i) of the Act that PACE organizations provide all Medicare-covered items and services. Accordingly, CMS will continue to include the costs for kidney acquisitions in PACE payment rates–both the PACE county rates and the PACE ESRD rates–unlike for MA benchmarks.

The methodology for the adjustment for organ acquisition costs for kidney transplants is described in more detail in the CY 2026 Advance Notice (pages 42-43).

Per section 1853(k)(5) and (n)(2)(G) of the Act, the 1881(d) expenditures for coverage of living donor expenses beyond what is reflected in the kidney acquisition cost center and paid on a pass-through basis in the FFS program are required to be included in the carve out of kidney acquisition costs from the benchmark amounts. The methodology for including living donor expenses in the adjustment is described in more detail in the CY 2026 Advance Notice (page 45).

The KAC carve-out factors for the 2027 rates will be published with the CY 2027 Rate Announcement.

KAC Carve-Out for Maryland Total Cost of Care Model

As previously noted, a Medicare waiver that exempted Maryland from the IPPS and OPPS affects the CMS system data used to develop the KAC carve-out. The KAC data provided by the MAC to Maryland's HSCRC is an appropriate data source to calculate the KAC carve-out for Maryland hospitals. Consistent with the methodology that began with the CY 2026 rates, we will continue to use KAC data provided by the MAC to Maryland's HSCRC to develop a KAC carve-out adjustment specifically for Maryland hospitals with a kidney transplant program participating in the Maryland TCOC Model.

[23] See the CY 2021 final rule (CMS-4190-F) (85 FR 33796, 33824–26) titled, "Medicare Program; Contract Year 2021 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program."

See section C1 for more information on the Maryland TCOC Model. The methodology for the calculation of the KAC carve-out for hospitals participating in the Maryland TCOC Model is described in more detail in the CY 2025 Advance Notice (pages 41-42).

The KAC carve-out factors for the 2027 rates will be published with the CY 2027 Rate Announcement.

C3. IME Phase Out

See Attachment I Section A regarding medical education expenses in USPCCs.

Section 161 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) (Pub. L. 110-275) amended section 1853(k)(4) of the Act to require CMS to phase out IME amounts from MA capitation rates. Section 1853(n)(2)(F) applies the same phase-out to FFS costs in the calculation of the specified amount in setting MA rates. Payment to teaching facilities for IME expenses associated with MA plan enrollees will continue to be paid directly by CMS to hospitals. Section 1894(d)(3) provides that the IME payment phase-out does not apply to PACE capitation rates. The methodology for the calculation of the IME adjustment is described in more detail in the CY 2026 Advance Notice (pages 45-46). Under section 1853(k)(4)(B)(ii) of the Act, the maximum reduction for any specific county in 2027 is 10.8 percent of the FFS rate.

Consistent with past practice, in order to help plans identify the impact of the IME reduction, CMS will separately identify the amount of IME for each county rate in the 2027 MA ratebook.

IME Carve-out for Maryland TCOC Model

Consistent with the methodology that began with CY 2025 rates, we will continue to use the alternative data and methodology used to develop the IME carveout for hospitals participating in the Maryland TCOC Model. See section C1 for more information on the Maryland TCOC Model. The methodology for the calculation of the IME carve-out for hospitals participating in the Maryland TCOC Model is described in more detail in the CY 2025 Advance Notice (pages 42-43).

The IME factors for the 2027 rates will be published with the CY 2027 Rate Announcement.

Section D. MA ESRD Rates

Pursuant to section 1853(a)(1)(H) of the Act, CMS establishes “separate rates of payment” with respect to ESRD beneficiaries enrolled in MA plans. As we stated in the CY 2012 Rate Announcement (page 32), it is in keeping with our understanding of the legislative intent to more closely align MA payment rates with FFS costs that the MA ESRD rates are also based on FFS costs. We currently set MA ESRD rates on a state basis (that is, at the state level instead of the

county level), using updated FFS costs each year, and intend to continue that policy and our existing methodology for setting MA ESRD rates.

We will use the 2020-2024 FFS expenditures and enrollment data for beneficiaries in dialysis status for each state to develop the CY 2027 MA ESRD rates. For each year, we compute the FFS dialysis per capita costs (for Part A and Part B items and services for beneficiaries in dialysis status) by state. The geographic indices for each year are calculated by dividing the state per capita cost by the national per capita cost. The five-year weighted average of the geographic indices is standardized by dividing by the five-year average risk scores (calculated using the risk adjustment model for CY 2027 payment). This standardized five-year weighted average is the AGA, which represents the ratio of historical FFS dialysis per capita costs by state to national FFS dialysis per capita costs. We calculated the 2024 FFS Dialysis ESRD USPCC based on the 2024 data described above in Attachment I, Section A, and, using trend factors, develop the prospective 2027 FFS Dialysis ESRD USPCC. The 2027 MA ESRD rates are determined by multiplying the 2027 FFS Dialysis ESRD USPCC by the state AGA.

We will continue to incorporate refinements developed and used in prior years regarding the repricing of historical data in the AGA calculation for the MA ESRD rates. Similar to the non-ESRD rate methodology, we intend to reprice the ESRD historical inpatient, hospital outpatient, skilled nursing facility, and ESRD PPS claims from 2020-2024 to reflect the most current (i.e., FY 2026) wage indices, and re-tabulate physician claims with the most current (i.e., CY 2026) Geographic Practice Cost Indices. We will continue to adjust the UCPs represented in the 2020-2024 claims to reflect the requirements of the most recent final rule. The adjustments will also include shared savings and shared losses performance-based payments made under the CEC model and the Kidney Care Choices / Comprehensive Kidney Care Contracting Option, and population-based payments under the Next Gen ACO, Vermont Medicare ACO Initiative, and GPDC/REACH as described in section B of this document, as well as incentive payments under Advanced Alternative Payment Models. Pursuant to section 1853(k)(5), (n)(2)(A)(i) and (n)(2)(G), MA benchmarks for 2021 and subsequent years exclude organ acquisition costs for kidney transplants (described in detail in Section C above). As noted in the CY 2021 final rule (CMS-4190-F) (85 FR 33796, 33825) and in the CY 2021 Rate Announcement, the exclusion of KACs is also applied to the MA ESRD rates for 2021 and subsequent years. In addition, the 2027 MA ESRD rate is adjusted by removing the GME expenses and the gradual phase-out of IME expenses, consistent with adjustments made for the non-ESRD MA rates that are discussed in Sections B and C of this document.

We will publish a file with the CY 2027 Rate Announcement that includes the key components of the rate development, similar to the rate calculation data supporting the MA non-ESRD county rates.

As stated in Section C, CMS will continue to include organ acquisition costs for kidney transplants in the PACE rates, including PACE ESRD rates, and the IME payment phase-out

does not apply to PACE capitation amounts. Therefore, for 2027, the ESRD rates for PACE organizations will continue to include KACs and IME amounts.

As stated in section 1853(a)(1)(H) of the Act, and as implemented in § 422.304(c)(1)(iv), the seventh sentence of section 1881(b)(7) shall apply to payments under this section covering the provision of renal dialysis treatment. CMS will continue to withhold from the MA ESRD rates an amount equivalent to reducing each composite rate payment 50 cents for the ESRD Network Program.[24] For the CY 2027 ESRD ratebook, we will continue to apply the withhold amount of $6.00 per month, by reducing the monthly payment rate for ESRD beneficiaries by $6.00. The ESRD rates published with the CY 2027 Rate Announcement will be shown both before and after the deduction of the $6.00 Network withhold.

Section E. Location of Network Areas for Private Fee-for-Service (PFFS) Plans in Plan Year 2028

Section 1852(d)(4) of the Act requires MA organizations offering certain non-employer MA PFFS plans in network areas to enter into signed contracts with a sufficient number of providers to meet the access standards applicable to coordinated care plans. Specifically, non-employer MA PFFS plans that are offered in a network area (as defined in section 1852(d)(5)(B)) must meet the access standards described in section 1852(d)(4)(B) through written contracts with providers. These PFFS plans may not meet access standards by establishing payment rates that are at least the rates that apply under FFS and having providers deemed to be contracted as described in § 422.216(f).

Network area is defined in section 1852(d)(5)(B) of the Act, for a given plan year, as an area that the Secretary identifies (in the announcement of the proposed payment rates for the previous plan year under section 1853(b)(1)(B)) as having at least two network-based plans (as defined in section 1852(d)(5)(C)) with enrollment as of the first day of the year in which the Rate Announcement is made. We intend to publish the list of network areas for plan year 2028 with the CY 2027 Rate Announcement. We will make this list available on the CMS website at: https://www.cms.gov/medicare/health-drug-plans/private-fee-for-service-plans/network-requirements.

Section F. MA Employer Group Waiver Plans (EGWP)

We intend to continue to waive the Bid Pricing Tool bidding requirements for all MA employer/union-only group waiver plans (EGWPs) for 2027.[25] As a condition of this waiver of the bidding requirements and the waivers otherwise provided to MA EGWPs, CMS will establish

[24] For more information on the ESRD Network Program, visit https://www.cms.gov/training-education/open-door-forums/end-stage-renal-disease-clinical-laboratories-esrd/network.

[25] As stated in the Medicare Managed Care Manual, Ch. 9, § 10.2, in addition to EGWPs, employer/union group health plan sponsors may choose to enroll their Medicare beneficiaries in individual MA plans. These MA plans do not qualify for the employer/union group health plan waiver of bidding requirements described in this section.

MA EGWP payment amounts using the same methodology for 2027 as was used for 2026. As has been the case since 2017, for 2027, Part C entities offering EGWPs will not be required to submit Part C bid pricing information in the Part C Bid Pricing Tool. CMS has authority under section 1857(i) of the Act to waive or modify requirements that hinder the design of, the offering of, or the enrollment in employment-based Medicare plans offered by employers and unions to their members. Waiving the requirement to submit Part C bid pricing information facilitates the offering of Part C plans for employers and unions seeking to establish high-quality coverage for their Medicare-eligible retirees by avoiding the cost and administrative burden of submitting the complex bids required from non-EGWPs. We refer the reader to the detailed discussion of our rationale and responses to commenters' questions in the CY 2017 Rate Announcement, Attachment III, Section F (pages 27–44) for additional information, and to the responses to questions received by the Office of the Actuary that are available at: https://www.cms.gov/medicare/payment/medicare-advantage-rates-statistics/actuarial-bid-questions.

F1. Bid-to-Benchmark Ratio

In connection with the continuation of this waiver, for 2027, CMS will continue to use the payment methodology for MA EGWPs that was finalized in the CY 2026 Rate Announcement. For 2027, we will use bid-to-benchmark (B2B) ratios based on 2026 bids and weighted by February 2026 enrollment, which is generally consistent with how we have developed these EGWP payments since 2019. With the exception of the 2022 B2B ratios which were weighted by January 2021 enrollment, the B2B ratios for each year since 2019 have been weighted by enrollment figures for February of the preceding year. For 2027, the B2B ratios will be weighted by February 2026 enrollment.

As a result of feedback from the industry on the CY 2022 bid cycle, CY 2023 was the first year that CMS published preliminary B2B ratios for EGWPs in the Advance Notice. MA organizations indicated that having this information early provides valuable information in their negotiations with employer/union groups to create more accurate benefit and premium quotes for their MA EGWP enrollees. However, the preliminary ratios in Table II-6 are based on 2026 bids and weighted by January 2026 enrollment instead of the February 2026 enrollment that we intend to use for the final ratios; therefore, they could differ from the final ratios that are ultimately published in the Rate Announcement, and we recommend that caution be used in reviewing them. The preliminary B2B ratios are as follows:

Table II-6. Preliminary Bid-to-Benchmark Ratios

Applicable Percentage	Bid to Benchmark Ratio
0.95	78.6%
1	77.8%
1.075	77.8%
1.15	77.7%

The payment methodology for MA EGWPs relies on B2B ratios, as described below, that reflect average bid amounts, weighted by plan enrollment. The calculations for the B2B ratios for CY 2027 would therefore be as follows:

> First: [(Weighted Average of the Intra-Service Area Rate Adjustment (ISAR) Adjusted County Bid Amounts for 2026 Individual Market Plan Bids by February 2026 Actual Enrollment)/(Weighted Average of the County Standardized Benchmarks for 2026 Individual Market Plans by February 2026 Actual Enrollment)] = 2026 Individual Market B2B Ratios by Quartile.[26]
>
> Second: The 2026 individual market B2B ratios will be calculated separately for HMO plan types and PPO plan types by quartile.[27] The PPO B2Bs by quartile will be weighted by the total proportion of EGWP PPO plan type enrollment, and the HMO B2Bs by quartile will be weighted by the total proportion of EGWP HMO plan type enrollment to result in the final B2B ratios for 2027 by quartile.

As has been in effect since 2017, for 2027:

- The B2B ratios will be applied to each of the published 5%, 3.5%, and 0% quality bonus percentage county ratebook rates for the payment year to establish Part C base payment amounts for EGWPs based on their Star Rating, for each county.
- In order to calculate a county rebate payment, each county-level EGWP Part C base payment amount will be compared to the corresponding published 5%, 3.5%, and 0% quality bonus percentage county benchmarks for the payment year (2027), which include adjustments for qualifying counties, to determine the amount of savings. The savings amount will be multiplied by the corresponding rebate percentage to determine the Part C EGWP county-level rebate amount.
- The EGWP Part C base payment amount will be added to the Part C EGWP rebate amount to establish the county-level local EGWP total payment amount.
- The total payment amount will be risk adjusted using beneficiary-specific risk scores. Therefore, the formula applied for local EGWP payment on a per-beneficiary basis would be: (Base County Payment Rate + County Rebate) × Beneficiary-Level Risk Score.

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[26] As in prior years, territories will not be included in the weighted average B2B ratios, but they will be assigned the weighted average of the quartile within which their counties fall. To determine the CY 2027 applicable percentages, CMS ranks counties from highest to lowest based on their 2026 average per capita FFS costs and places the rates into four quartiles. When calculating the 2026 B2B ratios, CMS will group counties by the 2026 unblended quartiles and will then apply these B2B ratios to the 2027 unblended quartiles.

[27] Consistent with how we have developed EGWP payments since 2019, HMO and HMOPOS plans have been combined into an "HMO plan type" and LPPO and RPPO plans have been combined into a "PPO plan type." "HMO" Health Maintenance Organization, "HMOPOS" Health Maintenance Organization Point of Service, "PPO" Preferred Provider Organization, "LPPO" Local Preferred Provider Organization, "RPPO" Regional Preferred Provider Organization. "PFFS" Private Fee-for-Service individual market plans are excluded from these calculations.

For RPPO EGWPs, the weighted-average B2B ratios will continue to be calculated as described above. To establish the Part C base RPPO EGWP payment amount, we will then also continue to apply the same methodology as described above.

In order to calculate the RPPO EGWP rebate amounts, these percentages will continue to be applied for each county within a region to the published payment year regional benchmarks to establish the savings amount and rebate amounts by Star Rating and quartile.

The RPPO EGWP Payment Formula continues to be (Base County Payment Rate + Regional Rebate) × Beneficiary-Level Risk Score, where each is calculated as follows:

- Base County Payment Rate = Bid to Benchmark Ratio × 2027 MA Monthly Capitation Rate
- Regional Rebate = (1 − Bid to Benchmark Ratio) × 2027 Regional Rate × Rebate Percentage
- The 2027 Regional rate is based on a blend of the statutory and bid component. As with non-EGWPs, if there is no bid component of the 2027 Regional rate (i.e., no individual bids in a region), then the EGWP rate will be based solely on the statutory component.

As has been the case since 2017, for 2027, there will be no Part C Regional PPO EGWP bids to include in the calculation of the MA regional benchmarks. The statutory components of the regional standardized A/B benchmarks will continue to be published each year as part of the Announcement of MA Payment Rates. CMS will also continue to publish the final MA regional standardized A/B benchmarks in late summer, which will reflect the average bid component of the regional benchmark based on non-EGWP bid submissions.

F2. MA Rebates and Part B Premium Buy-Down

As part of the waiver of the requirement for EGWPs to submit bid pricing information, CMS will continue to waive the requirement that MA EGWPs must specify how they are allocating MA rebate dollars (other than the buy-down of the Part B premium) for 2027. However, the limits set forth in § 422.266 regarding how the MA rebate may be used have not been waived and therefore continue to apply for EGWPs. CMS does not distinguish the amount to be allocated for rebates in calculating payments to MA EGWPs; however, if the MA EGWP elects to treat part of the payment as an MA rebate, how the rebate portion of the payment may be used is subject to the requirements at § 422.266. Thus, an EGWP could designate no part of its payment from CMS as MA rebates, or it could designate a portion of its payment as MA rebates and apply these designated rebate amounts to pay for mandatory supplemental benefits in accordance with § 422.266(b)(1) or to buy down Part B or Part D premiums in accordance with § 422.266(b)(2) and (3). However, the MA EGWP could not use MA rebates to pay for optional supplemental benefits, as this is prohibited by § 422.266(b)(1).

For 2027, we will also continue the existing policy permitting MA EGWPs to buy down Part B premiums for their enrollees using a portion of the Part C payment that the MA EGWP has designated as MA rebates.

As has been the case since 2020, MA EGWPs will be subject to the same maximum Part B buy-down amount as non-EGWPs. That is, EGWPs may only buy down the Part B premium up to the maximum amount displayed in the CY 2027 MA Bid Pricing Tool Worksheet 6. Additionally, as with non-EGWPs, the Part B premium buy-down amount cannot vary among beneficiaries enrolled in an EGWP. The Part B buy-down amount applies to every beneficiary under the plan ID. Therefore, if an EGWP would like to reduce the Part B premium for one employer group under the plan ID by $5 and reduce the Part B premium for another employer group by $10, then the MA organization must establish two separate EGWP plan IDs (i.e., two separate Plan Benefit Packages (PBPs)), each with the specific amount to buy-down the Part B premium. In this example, the PBP for plan 801 would contain a $5 buy-down amount, and the PBP for plan 802 would contain a $10 buy-down amount.

We will continue to collect a Part B premium buy-down amount in the EGWP's PBP submission to CMS. Any MA EGWP that chooses to use a portion of its payment to buy down the Part B premium must apply such Part B premium buy-down amount consistently to every beneficiary enrolled in the EGWP in accordance with uniformity of benefit rules, which are not waived for EGWPs in connection with buy-downs of Part B premiums. Those MA EGWPs that choose to designate a portion of their payment as MA rebates to buy down the Part B premium for their enrollees will have that amount reduced from their capitated payment. For example, if an MA EGWP determines that under its benefit offering there will be a $5 reduction to each enrollee's Part B premium, $5 per member per month will be entered into the requisite field in the PBP, and then $5 will be subtracted from the monthly capitated amount. For local MA EGWPs, this is reflected in the payment formula described above as follows:

Total Payment = (Base County Payment Rate + County Rebate) × Beneficiary Level Risk Score - *Part B Buy Down Amount*.

MA EGWPs will continue to be prohibited from separately refunding Part B premiums for their enrollees outside of this process.

F3. Additional Adjustments

The following rules will continue to apply as they have since 2017 under the EGWP payment methodology:

- MA EGWPs will not receive capitation payments for hospice care. For more information about how an MA enrollee electing hospice affects payments to MA plans, please see § 422.320.
- MA EGWPs will continue to be paid using the ESRD ratebook for their ESRD beneficiaries in Transplant and Dialysis status and the individual market MA ratebook for those beneficiaries in Functioning Graft status, in keeping with the current payment policy for non-EGWP MA organizations.
- Consistent with how CMS pays capitation for Part B-only enrollees in the non-EGWP context, Part B-only MA EGWPs will continue to receive only the Part B portion of the EGWP payment amount, which is determined by multiplying it by the Part B percentage of the MA rate.
- MA EGWP MSA plans will continue not to submit Bid Pricing Tools for 2027, but the 2027 local EGWP payment rates will continue to not be applied to EGWP MSA plans. The monthly prospective payments for EGWP MSAs will be based on the following formula: 2027 MA Monthly Capitation County Rate × beneficiary risk score – 1/12 of the Annual MSA Deposit Amount. The 2027 Annual MSA Deposit Amount must be submitted in the appropriate PBP field. Consistent with individual market MSA plans, MA EGWP MSA plans are not able to use a portion of the Part C payment to buy down the Part B premium.

Notwithstanding the payment policies described above, entities offering MA EGWPs must continue to meet all of the CMS requirements that are not otherwise specifically waived or modified, including, but not limited to, submitting information related to plan service areas, PBPs, and formularies in accordance with the rules for 2027. MA organizations must continue to make a good faith effort in projecting CY 2027 member months for each plan and place the amount in the appropriate section of the CY 2027 PBP submissions to CMS.

Section G. CMS-HCC Risk Adjustment Model

G1. Background on the CMS-HCC Risk Adjustment Model

The Centers for Medicare & Medicaid Services (CMS) Hierarchical Condition Categories (HCC) risk adjustment model is used to adjust capitated payments for Part C benefits offered to aged and disabled beneficiaries by MA plans and PACE organizations so that payments to MA organizations and PACE organizations reflect the varying risk of the beneficiaries they enroll.

The CMS-HCC model uses beneficiary demographic characteristics and diagnosis information from a base year (i.e., data collection year) to predict expected plan spending for medical costs in the following year (i.e., the payment year).

- Demographic information, such as beneficiary age, sex, dual eligibility, and long-term institutional status, is obtained from CMS administrative data.

- Diagnosis information is obtained from FFS claims for FFS beneficiaries. Diagnoses are grouped into CMS-HCCs based on severity and cost.
- Healthcare expenditures are collected from FFS claims.

The CMS-HCC risk adjustment model is used to calculate risk scores that represent a beneficiary's expected medical cost relative to the average expected medical cost of beneficiaries entitled to Part A and enrolled in Part B, excluding those beneficiaries who are in End Stage Renal Disease (ESRD) or hospice status. Risk scores are used to adjust bidding and payments for each beneficiary's expected expenditures relative to the average.

Model Segmentation & Variables

For beneficiaries who are enrolled in a Medicare Advantage plan, and who are not in ESRD status, risk scores are calculated with distinct sets of coefficients depending on a beneficiary's classification into a segment (i.e., a group of beneficiaries). There are separate model segments for new enrollees, continuing community enrollees, and continuing institutionalized enrollees:

- New enrollees. New enrollees are those with less than 12 months of Part B enrollment in the data collection year.
- Continuing community enrollees. Non-institutional continuing enrollees are those with 12 months of Part B enrollment in the data collection year who are residing in the community in the payment month, with six different segments depending on whether they are entitled to Medicare due to age or disability (based on age as of February 1 of the payment year) and depending on whether they are full-benefit dual, partial-benefit dual, or non-dual (based on the payment month).[28]
- Continuing institutionalized enrollees. Institutional continuing enrollees (i.e., with 12 months of Part B enrollment in the data collection year) are those in a long-term institutional stay (based on the payment month). (Short-term institutionalized beneficiaries are included in the community population described above.) Long-term institutionalized (LTI) enrollees are those enrollees residing in an institution for at least 90 days. CMS uses Minimum Data Set (MDS) assessments (e.g., annual, quarterly, significant change assessment, etc.) to identify LTI beneficiaries for each month. Because the goal is to use information that indicates a beneficiary resides in an institution, when identifying a beneficiary as LTI, we consider the various types of assessments done in

[28] Section H. CMS-HCC Risk Adjustment Model for CY 2017 discussed the split segmentation of the model by aged/disabled and dual status: https://www.cms.gov/medicare/health-plans/medicareadvtgspecratestats/downloads/advance2017.pdf (p. 27 – 42)

institutions with a length of stay of 90 or more days.[29] As part of the process to determine which model segment beneficiaries belong to, LTI status is used for each subsequent month assuming the initial quarterly or annual assessment is not the last assessment. A discharge (e.g., discharge with return not anticipated), or more than 150 days from the last assessment will change a beneficiary's segment status from LTI to community. At final reconciliation, which takes place after the payment year, LTI status is assessed on a month-by-month basis, using the MDS assessments as discussed above.

As mentioned above, new enrollee model segments are used for aged and disabled beneficiaries who are new to Medicare or do not otherwise have enough diagnoses to calculate a risk score – operationalized as those who do not have 12 months of Part B in the data collection period. These new enrollee risk scores are based only on demographic factors (i.e., the new enrollee model segments do not use diagnoses to predict costs). For continuing enrollees, the model sample comprises all beneficiaries who have at least one month in FFS in the prediction year (2024) and all twelve months in FFS in the prior year (2023). Community and institutional risk scores are calculated using the same age/sex variables and HCCs, with some differing interaction terms.

G2. Proposed Updates to the CMS-HCC Model

CMS proposes to implement an updated CMS-HCC risk adjustment model for CY 2027 (hereinafter "2027 CMS-HCC model"). This proposed model has the same segmentation structure and uses the same demographic variables and HCCs as the 2024 CMS-HCC risk adjustment model that has been used in payment for CY 2024 through 2026. Specifically, the proposed 2027 CMS-HCC model for CY 2027 would continue to (1) have eight model segments as first implemented for payment for CY 2017,[30] (2) include condition count variables as first implemented for payment for CY 2020,[31] and (3) use version 28 (V28) of the clinical classification of HCCs as first implemented for payment for CY 2024.[32] In addition, disease hierarchies are applied in the same manner as those in the 2024 CMS-HCC model. Disease hierarchies account for multiple levels of severity for a disease that has varying levels of associated costs. In the case of a disease hierarchy, payment is based only on the most severe and costly manifestation of the disease.

The CMS-HCC model has historically included constraints that hold the coefficients of the HCCs being constrained equal to each other such that the constrained HCCs carry the same

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[29] In circumstances where a significant change assessment occurs in lieu of an initial quarterly or annual assessment the beneficiary is identified as being LTI. Refer to the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual: https://www.cms.gov/files/document/final-mds-3-0-rai-manual-v1-20-1-october-2025.pdf

[30] CY 2017 Advance Notice and CY 2017 Rate Announcement.

[31] CY 2020 Advance Notice, Part I and CY 2020 Rate Announcement.

[32] CY 2024 Advance Notice and CY 2024 Rate Announcement.

weight. HCC constraints are applied for reasons that include small sample size to maintain continuity across the model segments, and specified constraints to maintain the integrity of the relative costs associated with some HCCs in the model. For the proposed 2027 CMS-HCC model, CMS would maintain the specified constraints applied in the 2024 CMS-HCC model, except it would remove the constraint applied to HCC 328 Chronic Kidney Disease, Moderate (Stage 3B) and HCC 329 Chronic Kidney Disease, Moderate (Stage 3, Except 3B). The 2024 CMS-HCC model was initially calibrated using 2018 diagnoses and 2019 costs. ICD-10 codes distinguishing between different stages of chronic kidney disease (CKD) (Stage 3A, Stage 3B, and unspecified) were introduced later in 2021. Therefore, a CMS-specified constraint to make the coefficients for HCC 328 and HCC 329 equal was previously used due to insufficient data to distinguish and estimate separate coefficients for new distinct ICD-10 codes.[33]

In the 2024 Rate Announcement, CMS noted its intention to evaluate separate coefficients in the future once there is sufficient data to distinguish, estimate, and evaluate separate coefficients for HCCs 328 and 329. Since the proposed 2027 CMS-HCC model is calibrated using 2023 diagnoses to predict 2024 costs, there is experience (diagnostic coding and costs) with the ICD-10 codes that distinguishes HCC 328 Chronic Kidney Disease, Moderate (Stage 3B) and HCC 329 Chronic Kidney Disease, Moderate (Stage 3, Except 3B); furthermore, empirical data (monotonic sample sizes for the increased CKD severity and distinct clinically aligned costs across the segments) as well as clinician input support removing the specified constraint applied to HCCs 328 and 329. With the removal of the specified constraint, HCCs 328 and 329 in proposed 2027 CMS-HCC model would reflect the distinct relative costs associated with each condition category.

The proposed 2027 CMS-HCC model incorporates the following technical updates:

- more recent data years used for model calibration whereby the underlying FFS data years are updated from 2018 diagnoses predicting 2019 expenditures to 2023 diagnoses predicting 2024 expenditures,
- more recent denominator year used in determining the average per capita predicted expenditures to create relative factors in the model, changing from payment year 2020 to payment year 2024, and
- exclusion of diagnoses from audio-only services to align with MA diagnosis submission policy.

These important technical updates improve the accuracy of the model and, therefore, we propose to use this 2027 CMS-HCC model in Part C payment for aged/disabled beneficiaries enrolled in MA plans beginning with payment year 2027. Beneficiary risk scores or plan average risk scores

[33] Section J. CMS-HCC Risk Adjustment Model for CY 2024 discussed the reconfiguration and constrained applied to the kidney disease HCCs: https://www.cms.gov/files/document/2024-announcement-pdf.pdf (p. 82)

may change depending on each individual beneficiary's combination of diagnoses or the clinical profile of a plan's enrollee population.

Data Year Update

Coefficients are estimated for each segment separately to reflect the unique cost and utilization patterns of beneficiaries within the segment. Model coefficients for HCCs are estimated by regressing the total annualized expenditure for Medicare Parts A and B benefits for each beneficiary onto their demographic factors and HCCs, as indicated by their diagnoses.[34] Expenditures used are annualized for each beneficiary, meaning that for beneficiaries who are in Medicare for less than 12 months in the prediction year, we calculate what expenditures would be for the entire year using their partial year experience.

CMS calibrated the 2024 CMS-HCC risk adjustment model using 2018 diagnoses and 2019 expenditures from FFS claims. The proposed 2027 CMS-HCC risk adjustment model is calibrated using 2023 diagnoses and 2024 expenditures from FFS claims. More recent data captures the most recent trends in FFS coding and treatment and is important for maintaining payment accuracy.

Denominator Year Update

The denominator for a CMS-HCC risk adjustment model is the average per capita predicted expenditure amount for a specified year. The denominator is used to create the relative factors for each demographic variable and HCC in the model. We calculate relative factors by dividing each dollar coefficient by the denominator. The relative factors are used to calculate risk scores for individual beneficiaries. The 2024 CMS-HCC model uses a 2020 denominator. The denominator year for the proposed 2027 CMS-HCC model is 2024. The average expected cost calculated from a 2024 cohort of FFS beneficiaries with 2023 diagnoses is $12,861.67.

Exclusion of Audio-Only Diagnoses

CMS applies a longstanding filtering logic to identify diagnoses eligible for inclusion in the risk adjustment model calibration.[35] Diagnoses from telehealth visits are eligible for inclusion in the calibration when those visits meet all criteria for risk adjustment eligibility, which include being from an allowable inpatient, outpatient, or professional service, and from a face-to-face

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[34] As discussed in the 2020 Advance Notice, 2024 Report to Congress on Medicare Advantage Risk Adjustment, and the Medicare Managed Care Manual, Chapter 7 – Risk Adjustment coefficients are estimated by regressing total FFS costs for each beneficiary in FFS Medicare who is entitled to Part A and enrolled in Part B onto their demographic factors, condition categories (as indicated by diagnoses), interaction terms (combinations of conditions and/or demographic factors), and count variables.

[35] See the final encounter data filtering logic published in December, 2015: https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/FinalEncounterDataDiagnosisFilteringLogic.pdf

encounter.[36] Diagnoses resulting from telehealth services can meet the risk adjustment face-to-face requirement when the services are provided using an interactive audio and video telecommunications system that permits real-time interactive communication.[37]

Effective January 1, 2022, a new modifier "93" was added to the Current Procedural Terminology (CPT®) code set representing a "Synchronous telemedicine service rendered via telephone or other real-time interactive audio-only telecommunications system." In addition, the "FQ" modifier was added in 2022 to indicate telehealth audio-only services for Federally Qualified Health Centers and Rural Clinics. Given that the 2024 CMS-HCC model was calibrated using 2018 diagnoses and 2019 costs, and was phased in over three-years, this is CMS's first opportunity to calibrate the CMS-HCC model to exclude diagnoses from audio-only services that are identified using modifiers. As previously stated, diagnoses from an acceptable source (i.e., inpatient, outpatient, and professional) and resulting from a face-to-face visit are considered for risk adjustment including a telehealth visit using interactive audio and video telecommunications system that permits real-time interactive communication. Records that only include lines with audio-only modifiers indicate that no services were provided in a face-to-face manner. Therefore, the proposed 2027 CMS-HCC model excludes diagnoses associated with modifiers that identify audio-only services. Specifically, if a line included on a FFS claim has the "93" or "FQ" modifier, then the diagnoses would be excluded from the model calibration as long as no other line on the claim is risk adjustment eligible.

The discussion of the risk adjustment model updates in this Advance Notice includes the relative factors for the proposed 2027 CMS-HCC model (Attachment VI, Tables VI-1, VI-2, and VI-3). CMS also regularly provides additional plan-specific information outside the Advance Notice discussion to supplement plan review of risk adjustment model revisions. Refer to Attachment II, Section L for more information about sources of diagnoses proposed for use in risk score calculation for CY 2027.

G3. CMS-HCC Risk Adjustment Models for PACE Organizations

As noted in previous Advance Notices and Rate Announcements, CMS intends to transition PACE organizations to fully submitting risk adjustment data to the encounter data system (EDS) (i.e., encounter data), and to align with the model used to pay organizations other than PACE as soon as practicable.[38] In January of 2024, CMS released technical instructions to PACE organizations on the submission of risk adjustment data to the EDS for PACE center services for

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[36] See the Medicare Managed Care Manual, Chapter 7 – Risk Adjustment

[37] Applicability of diagnoses from telehealth services for risk adjustment: https://www.cms.gov/files/document/applicability-diagnoses-telehealth-services-risk-adjustment-4102020.pdf

[38] 2025 Rate Announcement, 2026 Advance Notice, and 2026 Rate Announcement.

which a claim is not generated.[39] With the release of these technical instructions, CMS expects that PACE organizations are submitting fulsome diagnosis data to the EDS.

For CY 2026, CMS finalized the application of a blend of the 2017 CMS-HCC model (90 percent) and the 2024 CMS-HCC model (10 percent) to calculate risk scores. For CY 2027 payments to PACE organizations, CMS proposes to continue calculating risk scores using a risk score blend. For CY 2027 CMS proposes to calculate risk scores using the 2017 CMS-HCC model, which we began using for CY 2020 payments to PACE organizations, and the risk scores calculated using the proposed 2027 CMS-HCC model discussed in this Advance Notice.

Specifically, CMS proposes to calculate blended risk scores for CY 2027 for PACE organizations using the sum of:

- 50 percent of the risk score calculated with the 2017 CMS-HCC model and diagnoses from the risk adjustment processing system (RAPS), encounter data, and FFS claims; and
- 50 percent of the risk score calculated with the proposed 2027 CMS-HCC model and diagnoses from encounter data and FFS claims only.

As previously stated, CMS intends to fully transition PACE organizations to the CMS-HCC model used for organizations other than PACE and to calculate risk scores only using diagnoses from encounter data and FFS claims. In making this transition it is imperative to continue to align with the most current version of the CMS-HCC model being used for the rest of the industry to ensure PACE organization risk scores reflect recent updates and risk adjustment model improvements. Refer to Attachment II, Section L1 for more information about sources of diagnoses proposed for use for PACE risk score calculation.

Section H. End Stage Renal Disease (ESRD) CMS-HCC Risk Adjustment Models

CMS uses separate models to calculate the risk scores applied in payment for the Part A and Part B benefits provided to beneficiaries in ESRD status when enrolled in MA organizations or PACE organizations.

For CY 2027, for organizations other than PACE, CMS will continue to use the 2023 ESRD CMS-HCC models, which are described in the CY 2023 Advance Notice,[40] to calculate risk scores for beneficiaries in dialysis, transplant, and post-graft status. Refer to Attachment II, Section L for more information about sources of diagnoses proposed for use in risk score calculation of beneficiaries in ESRD status for CY 2027.

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[39] Refer to the January 2024 CMS memorandum titled, "PACE Organization Risk Adjustment Submissions to the Encounter Data System."

[40] CY 2023 Advance Notice (section H): https://www.cms.gov/files/document/2023-advance-notice.pdf.

H1. ESRD CMS-HCC Risk Adjustment Models for PACE Organizations

For CY 2027, in alignment with the proposal to blend risk scores from CMS-HCC models for PACE organizations, discussed in Attachment II, Section G3, CMS is also proposing to use a blend of ESRD risk adjustment models to calculate ESRD risk scores for PACE organizations.

Specifically, CMS proposes to calculate blended risk scores for CY 2027 for PACE organizations using the sum of:

- 50 percent of the risk score calculated with the 2019 ESRD CMS-HCC models and diagnoses from RAPS, encounter data, and FFS claims; and
- 50 percent of the risk score calculated with the 2023 ESRD CMS-HCC models and diagnoses from encounter data and FFS claims only.

CMS intends to fully transition PACE organizations to the ESRD risk adjustment models used for organizations other than PACE and to calculate risk scores only using diagnoses from encounter data and FFS claims. Refer to Attachment II, Section L1 for more information about sources of diagnoses used for PACE risk score calculation.

Section I. Frailty Adjustment for FIDE SNPs and PACE Organizations

While the CMS-HCC model predicts future Medicare expenditures of individuals based on their demographic and clinical characteristics, the model may not explain all of the variation in expenditures for frail community populations. The purpose of the frailty adjustment is to predict the Medicare expenditures of community populations with functional impairments that are unexplained by the diagnoses in the CMS-HCC model.

Section 1894(d)(2) of the Act requires CMS to take into account the frailty of the PACE population when establishing the capitated payment amounts for PACE organizations. In addition, section 1853(a)(1)(B)(iv) of the Act allows CMS to make an additional payment adjustment that takes into account the frailty of beneficiaries enrolled in Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs), if the average level of frailty in the FIDE SNP is similar to that in the PACE program. For PACE organizations and eligible FIDE SNPs, CMS makes this adjustment by adding a frailty score to a beneficiary's risk score.

CMS calibrates the frailty factors by regressing the residual, or unexplained, costs from the CMS-HCC risk adjustment model onto counts of activities of daily living (ADLs). Residual costs are unique to each version of the CMS-HCC model, and consequently, so are the frailty factors. For this reason, CMS must update the frailty factors whenever the CMS-HCC model changes. The frailty factors are calibrated to align with the CMS-HCC risk adjustment model using data regarding limitations on ADLs from the FFS Consumer Assessment of Health Providers & Systems (CAHPS) survey. There are six ADLs: 1) bathing and showering, 2) dressing, 3) eating, 4) getting in or out of bed or chairs, 5) walking, and 6) using the toilet.

By using the FFS CAHPS results to calibrate the frailty factors, CMS uses methodologically-similar surveys to estimate the frailty factors and to calculate annual frailty scores. CMS calculates frailty scores using the number of functional limitations represented by the ADL scale from the Health Outcomes Survey (HOS) and the Health Outcomes Survey – Modified (HOS-M) to determine the relative frailty of those in the community who are 55 years of age and older.

FIDE SNPs

For CY 2027, CMS is proposing to update the frailty factors used to calculate frailty scores for beneficiaries enrolled in FIDE SNPs, consistent with the proposed update to the CMS-HCC model (see Section G). The proposed frailty factors are calibrated using the proposed 2027 CMS-HCC model that is based on 2023 diagnoses and 2024 expenditures from FFS claims and ADL data from the 2023 Medicare FFS Consumer Assessment of Health Providers & Systems (CAHPS) survey, which is an update from the previous frailty factors that were based on ADL data from the 2018 CAHPS survey. The proposed frailty factors have constraints applied for instances where frailty factors are negative or nonmonotonic. Specifically, to account for negative frailty factors that resulted for the Partial Medicaid group, the frailty factors for the Partial Medicaid group have been constrained to the frailty factors for the Non-Medicaid group, making the frailty factors for the Non-Medicaid and Partial Medicaid groups equal to each other. Additionally, for the Full-Medicaid group, the frailty factors for ADL groups 3-4 and 5-6 were constrained to be equal to one another due to nonmonotonicity.

As required by the CY 2023 final rule (CMS-4192-F, 87 FR 27741) titled "Medicare Program; Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs; Policy and Regulatory Revisions in Response to the COVID–19 Public Health Emergency; Additional Policy and Regulatory Revisions in Response to the COVID–19 Public Health Emergency," FIDE SNPs must have "exclusively aligned enrollment" beginning for contract year 2025, which means that enrollment in FIDE SNPs is limited to full-benefit dually eligible individuals beginning January 1, 2025.[41] We anticipate that all 2026 enrollees considered for survey collection used for ADL assessment for calculating CY 2027 frailty scores will be reported as full-benefit dually eligible individuals in compliance with 42 CFR § 422.2. Consequently, for CY 2027, CMS will continue to rely on the data as submitted on the MMA State files, the Point of Sale data, and the Commonwealth of Puerto Rico monthly Medicaid file to determine the dual status of a beneficiary for frailty score calculation as has been done historically.

The proposed 2027 CMS-HCC model frailty factors are in Table II-7.

Table II-7. Frailty Factors Associated with the Proposed 2027 CMS-HCC Model

ADL	Non-Medicaid	Partial Medicaid	Full Medicaid
0	-0.055	-0.055	-0.070

[41] See definition of "Fully integrated dual eligible special needs plan" at 42 CFR § 422.2, paragraphs 5 and 6.

ADL	Non-Medicaid	Partial Medicaid	Full Medicaid
1-2	0.141	0.141	0.126
3-4	0.168	0.168	0.407
5-6	0.186	0.186	0.407

MA organizations that are planning to sponsor a FIDE SNP and wish to be considered for frailty payments in CY 2027 must contract with a CMS-approved survey vendor to field the 2026 HOS or HOS-M at the PBP level so that the necessary information to calculate a frailty adjustment for the FIDE SNP's risk scores is available. For FIDE SNPs, CMS uses plan-level ADL information obtained from the HOS or HOS-M in one year to calculate frailty scores for the following year by applying the frailty factors that correspond to the ADL information gathered from the HOS or HOS-M data.

Consistent with prior years, CMS will continue to calculate frailty scores in accordance with longstanding practice.[42] CMS will estimate the PACE minimum frailty score used as the threshold to establish whether a FIDE SNP qualifies to receive a frailty adjustment in CY 2027 in the same manner that is being proposed to calculate FIDE SNP frailty scores for CY 2027 (i.e., using the MMA State files, the Point of Sale data, and the Commonwealth of Puerto Rico monthly Medicaid file to determine the dual status of a beneficiary). New FIDE SNPs (those that are not eligible to participate in the HOS/HOS-M due to the length of time the plan was in operation), FIDE SNPs with 30 or fewer respondents to the HOS/HOS-M, and FIDE SNPs that do not meet the PACE minimum frailty score threshold are not eligible to receive a frailty adjustment.[43]

PACE Organizations

As discussed in Attachment II, section G3, for CY 2027, CMS proposes calculating risk scores using a blend of 50% of the risk scores calculated using the 2017 CMS-HCC model and 50% of the risk scores calculated using the proposed 2027 CMS-HCC model. Consequently, CMS is also proposing a corresponding blend of the frailty factors associated with the 2017 CMS-HCC model and the proposed 2027 CMS-HCC model to calculate frailty scores for PACE organizations for CY 2027 payment.

Specifically, CMS proposes that for CY 2027, PACE organization frailty scores will be calculated as the sum of:

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[42] Refer to Medicare Managed Care Manual, Chapter 7, section 80 – Frailty Adjuster: https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/mc86c07.pdf.

[43] Refer to the criteria included in the annually released, "Participation in 2024 HOS/HOS-M for MA Organizations Planning to Sponsor FIDE SNPs in 2025" and "2025 Frailty Scores and 2024 Health Outcomes Survey (HOS) or Health Outcomes Survey Modified (HOS-M) Activities of Daily Living (ADLs) Results" memos: https://www.cms.gov/about-cms/information-systems/hpms/hpms-memos-archive-weekly/hpms-memos-wk-2-february-5-9 (February 7, 2024) and https://www.cms.gov/about-cms/information-systems/hpms/hpms-memos-archive-weekly/hpms-memos-wk-2-june-9-13 (June 10, 2025).

- 50 percent of the frailty score calculated with the 2017 CMS-HCC model frailty factors and
- 50 percent of the frailty score calculated with the proposed 2027 CMS-HCC model frailty factors.

CMS intends to fully transition PACE organizations to the frailty factors associated with the CMS-HCC model used for organizations other than PACE as described in Attachment II, Section G3.

The 2017 and proposed 2027 CMS-HCC model frailty factors are in Table II-8 and Table II-7, respectively.

Table II-8. Frailty Factors Associated with the 2017 CMS-HCC Model
(Previously published and finalized in the 2017 Rate Announcement[44])

ADL	Non-Medicaid	Medicaid
0	-0.083	-0.093
1-2	0.124	0.105
3-4	0.248	0.243
5-6	0.248	0.420

Section J. Medicare Advantage Coding Pattern Difference Adjustment

For CY 2027, CMS will continue to apply the statutory minimum MA coding pattern difference adjustment factor of 5.90 percent.

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

The CMS-HCC risk adjustment models are calibrated with diagnostic and cost information from a past period for beneficiaries enrolled in FFS. The risk adjustment models are prospective in that they use health status in a base year (i.e., data collection year) to estimate incremental costs for a variety of beneficiary characteristics (e.g., age and sex) and health conditions in the following year (i.e., the payment year). To create relative factors, each model variable's incremental cost estimate, referred to as a dollar coefficient, is divided by the predicted average per capita expenditure for beneficiaries in the FFS program in a given year (i.e., the denominator year). Risk scores are the sum of relative factors assigned to each beneficiary based on their demographic characteristics and health status from the prior year. The average risk score is 1.0 among FFS beneficiaries in the denominator year.

The average FFS risk score changes each year due to an underlying trend that reflects changes in the health status and demographic characteristics of the population, and coding practices compared to the denominator year. Therefore, when a risk adjustment model predicts expenditures in years other than the denominator year, the average FFS risk score may no longer

[44] CY 2017 Rate Announcement, Section J.

be 1.0, as it was in the denominator year. Accordingly, an adjustment must be applied to account for the FFS risk score trend between the denominator year and payment year. For example, the proposed 2027 CMS-HCC model (non-ESRD) has a denominator year of 2024. CMS applies a normalization factor to risk scores in the payment year to account for this trend in the average FFS risk score between the denominator year and the payment year. The normalization factor is a projection of the average FFS risk score based on the trend, and we apply it by dividing each individual risk score in the payment year by the normalization factor. Doing so effectively keeps the average FFS risk score at 1.0 in the payment year.[45] For the normalization factor to work as intended, CMS must predict an average FFS risk score that is a reasonably accurate projection of the future payment year's average FFS risk score, given the historical FFS information available at the time the normalization factor is calculated.

Proposed CY 2027 Normalization Methodology for CMS-HCC Risk Adjustment Models

For CY 2027, CMS will continue to use a multiple linear regression methodology using the most recent five years of FFS risk scores available to calculate all FFS normalization factors for CMS-HCC models, which is the same approach used to calculate CY 2025 and CY 2026 normalization factors. This methodology incorporates historical FFS risk scores from the most recent five years of average FFS risk scores (2021-2025 for CY 2027) and includes a flag that identifies whether an average FFS risk score is based on dates of service before or after the onset of the COVID-19 pandemic. For CY 2025 and CY 2026, we considered FFS risk scores prior to 2021 (dates of service before 2020) as the "pre-COVID-19" period, and FFS risk scores from 2021 onward (dates of service starting in 2020) as the "post-COVID-19" period. For CY 2027, the most recent five years are all in the "post-COVID-19" period. The value of the coefficient for the flag is therefore zero since there is no longer a difference in pre- and post-COVID-19 pandemic trend that needs to be adjusted for.

For a more detailed review and explanation of the multiple linear regression methodology that we will continue using to calculate CY 2027 normalization factors for the CMS-HCC models, please refer to pages 62 and 63 of the CY 2025 Advance Notice and pages 91 to 101 of the CY 2025 Rate Announcement.[46]

The multiple linear regression equation is:

$$Y = \beta_0 + \beta_1 x_1 + \beta_2 x_2$$

[45] See section 1853(a)(1)(C)(i) of the Act, which authorizes use of additional adjustment factors to improve the determination of actuarial equivalence, and section 1853(a)(1)(C)(ii)(I) of the Act, which requires that the risk adjustment used in MA payment reflects changes in treatment and coding practices in the fee-for-service sector.

[46] 2025 Advance Notice and Rate Announcement.

The variables in the multiple linear regression equation for the CY 2027 normalization factors are:

Y = Predicted FFS risk score for a given year (i.e., Normalization Factor)

β_0 = Intercept

β_1 = Regression coefficient for the average annual change in FFS risk scores

x_1 = The specific year to be predicted

β_2 = Regression coefficient for the impact of the COVID-19 pandemic on FFS risk scores

x_2 = COVID-19 flag (0 for years before CY 2021, 1 for CY 2021 and onwards)

The proposed CY 2027 normalization factors calculated using the multiple linear regression methodology and the multiple linear regression coefficients for each of the CMS-HCC risk adjustment models are in subsections K1 through K3.

K1. CMS-HCC Model Normalization Factors

The FFS risk scores for the trend using the 2017 CMS-HCC model and the FFS risk scores for the trend using the proposed 2027 CMS-HCC model are calculated using FFS beneficiaries who are entitled to Part A, enrolled in Part B, who do not have ESRD, and are not in hospice status. The CMS-HCC model normalization factors are applied to the community non-dual aged, community non-dual disabled, community full benefit dual aged, community full benefit dual disabled, community partial benefit dual aged, community partial benefit dual disabled, institutional, new enrollee, and C-SNP new enrollee risk scores.

Table II-9 shows the average FFS risk scores calculated for years 2021 through 2025 using the proposed 2027 CMS-HCC model and the 2017 CMS-HCC model (PACE only)). Average FFS risk scores using the 2024 CMS-HCC model are provided for informational purposes. Table II-10 shows the regression coefficients that were used to calculate the proposed CY 2027 normalization factors for both CMS-HCC models.

Proposed 2027 CMS-HCC Model: The proposed CY 2027 normalization factor calculated using the multiple linear regression method and 2021-2025 average FFS risk scores for the proposed 2027 CMS-HCC model is 1.058.

2017 CMS-HCC Model: The proposed CY 2027 normalization factor calculated using the multiple linear regression method and 2021-2025 average FFS risk scores for the 2017 CMS-HCC model used for PACE organizations is 1.207.

Table II-9. Average FFS Risk Scores for CMS-HCC Models

Year	Proposed 2027 CMS-HCC Model	2017 CMS-HCC Model	2024 CMS-HCC Model
2021	0.942	1.053	0.968
2022	0.967	1.084	0.992
2023	0.984	1.108	1.009
2024	1.000	1.131	1.025
2025	1.020	1.155	1.045

Table II-10. CMS-HCC Model Normalization Factor Regression Coefficients

Coefficient	Proposed 2027 CMS-HCC Model	2017 CMS-HCC Model
Intercept (β_0)	-37.2521	-49.6711
Average Change in FFS Risk Scores (β_1)	0.0189	0.0251
COVID-19 Flag (β_2)	0	0

K2. Normalization Factors for the ESRD Dialysis CMS-HCC Models

The trends for the ESRD Dialysis CMS-HCC models are calculated using FFS beneficiaries who are entitled to Part A, enrolled in Part B, are not in hospice status, and are receiving dialysis treatment. The normalization factors for the ESRD Dialysis CMS-HCC models are applied to the risk scores for enrollees in the dialysis, dialysis new enrollee, and transplant segments.

Table II-11 shows the average FFS risk scores calculated for years 2021 through 2025 using the 2023 ESRD Dialysis CMS-HCC model and the 2019 ESRD Dialysis CMS-HCC model (PACE only) and Table II-12 shows the regression coefficients that were used to calculate the proposed CY 2027 normalization factors for both ESRD Dialysis CMS-HCC models.

2023 ESRD Dialysis CMS-HCC Model: The proposed 2027 normalization factor calculated using the multiple linear regression method and 2021-2025 average FFS risk scores for the 2023 ESRD Dialysis CMS-HCC model is 1.070.

2019 ESRD Dialysis CMS-HCC Model: The proposed 2027 normalization factor calculated using the multiple linear regression method and 2021-2025 average FFS risk scores for the 2019 ESRD Dialysis CMS-HCC model used for PACE organizations is 1.144.

Table II-11. Average FFS Risk Scores for ESRD Dialysis CMS-HCC Models

Year	2023 ESRD Dialysis CMS-HCC Model	2019 ESRD Dialysis CMS-HCC Model
2021	0.997	1.047
2022	1.006	1.060
2023	1.022	1.080
2024	1.032	1.095
2025	1.046	1.111

Table II-12. ESRD Dialysis CMS-HCC Model Normalization Factor Regression Coefficients

Coefficient	2023 ESRD Dialysis CMS-HCC Model	2019 ESRD Dialysis CMS-HCC Model
Intercept (β_0)	-24.0646	-31.8963
Average Change in FFS Risk Scores (β_1)	0.0124	0.0163
COVID-19 Flag (β_2)	0	0

K3. Normalization Factors for the ESRD Functioning Graft CMS-HCC Models

The trends for the ESRD Functioning Graft CMS-HCC models are calculated using FFS beneficiaries who are entitled to Part A, enrolled in Part B, do not have ESRD, and are not in hospice status. The normalization factors for the ESRD Functioning Graft CMS-HCC models are applied to the risk scores for enrollees in the functioning graft community, functioning graft institutional, and functioning graft new enrollee segments.

Table II-13 shows the average FFS risk scores calculated for years 2021 through 2025 using the 2023 ESRD Functioning Graft CMS-HCC model and the 2019 ESRD Functioning Graft CMS-HCC model (PACE only) and Table II-14 shows the regression coefficients that were used to calculate the proposed CY 2027 normalization factors for both ESRD Functioning Graft CMS-HCC models.

2023 ESRD Functioning Graft CMS-HCC Model: The proposed 2027 normalization factor calculated using the multiple linear regression method and 2021-2025 average FFS risk scores for the 2023 ESRD Functioning Graft CMS-HCC model is 1.124.

2019 ESRD Functioning Graft CMS-HCC Model: The proposed 2027 normalization factor calculated using the multiple linear regression method and 2021-2025 average FFS risk scores for the 2019 ESRD Functioning Graft CMS-HCC model used for PACE organizations is 1.213

Table II-13. Average FFS Risk Scores for ESRD Functioning Graft CMS-HCC Models

Year	2023 ESRD Functioning Graft CMS-HCC Model	2019 ESRD Functioning Graft CMS-HCC Model
2021	0.975	1.054
2022	1.006	1.086
2023	1.029	1.110
2024	1.051	1.135
2025	1.074	1.160

Table II-14. ESRD Functioning Graft CMS-HCC Model Normalization Factor Regression Coefficients

Coefficient	2023 ESRD Functioning Graft CMS-HCC Model	2019 ESRD Functioning Graft CMS-HCC Model
Intercept (β_0)	-48.1319	-51.6913
Average Change in FFS Risk Scores (β_1)	0.0243	0.0261
COVID-19 Flag (β_2)	0	0

For information on the Part D RxHCC model normalization factors, please see Attachment III, Section G.

Section L. Sources of Diagnoses for Risk Score Calculation

For CY 2027, for organizations other than PACE, CMS will continue the policy first adopted in the CY 2022 Rate Announcement to calculate risk scores for payment using only risk adjustment-eligible diagnoses from encounter data and FFS claims. In addition, we are proposing that diagnoses from audio-only services and diagnoses from unlinked chart review records are excluded from the calculation of risk scores for Part C beneficiaries, including those in ESRD status.

Excluding Diagnoses from Audio-Only Services from Risk Score Calculation

MA organizations (and other organizations, such as PACE organizations and Cost plans[47]) must report all items and services they provide to enrollees to the Encounter Data System (EDS) under 42 CFR § 422.310. Since MA organizations submit the full breadth of information regarding services furnished to a beneficiary, including all diagnoses, CMS applies the longstanding filtering logic used in model calibration to identify diagnoses eligible for inclusion in the risk

[47] *See* 42 CFR §§ 460.180(b)(3) and 417.486(a) requiring that risk adjustment data that PACE organizations and Cost plans submit to CMS be in accordance with risk adjustment data submission requirements in § 422.310.

score for payment.[48] In April 2020, CMS stated that MA organizations and other organizations that submit diagnoses for risk adjusted payment are able to submit diagnoses for risk adjustment that are from telehealth visits when those visits meet all criteria for risk adjustment eligibility, which include being from an allowable inpatient, outpatient, or professional service, and from a face-to-face encounter.[49] In May 2022, CMS instructed MA organizations, Cost plans, PACE organizations, and Demonstrations to report encounter data records (EDRs) and chart review records (CRRs) for audio-only services (for dates of service on or after January 1, 2022) to the EDS, using modifier "93." MA organizations are instructed to continue using modifier "93" or "FQ" (where applicable) for services provided via audio only.

Consistent with the model calibration, beginning in CY 2027, CMS is proposing 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.

Excluding Diagnoses from Unlinked Chart Review Records from Risk Score Calculation

For CY 2027, for organizations other than PACE, CMS will continue the policy first adopted in the CY 2022 Rate Announcement to calculate risk scores for payment using only risk adjustment-eligible diagnoses from encounter data and FFS claims. In addition, beginning in CY 2027, CMS proposes to exclude all diagnoses submitted on unlinked chart review records (CRRs) from risk score calculation.

As noted previously, MA organizations must report all items and services they provide to enrollees to the EDS under 42 CFR § 422.310. MA organizations report items and services on an encounter data record (EDR). In addition, CMS allows risk adjustment data to be submitted to the EDS as a CRR. A CRR is distinct from an EDR. A CRR allows MA organizations to add risk adjustment eligible diagnoses or delete diagnosis codes previously reported for plan enrollees. There are two ways to submit a CRR: linked to an EDR or unlinked. Linking a CRR to a previously accepted EDR allows an MA organization to associate risk adjustment-eligible diagnoses with specific items or services provided to a beneficiary. For unlinked CRRs, MA organizations do not identify a previously submitted EDR that the submitted diagnoses should be associated with nor do they have to include information about which items and services were provided to the enrollee on the unlinked CRR. MA organizations are expected to submit diagnoses that meet CMS filtering and risk adjustment criteria.[50] The HHS Office of the

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[48] The final encounter data filtering logic published in December, 2015: https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/FinalEncounterDataDiagnosisFilteringLogic.pdf

[49] Applicability of diagnoses from telehealth services for risk adjustment: https://www.cms.gov/files/document/applicability-diagnoses-telehealth-services-risk-adjustment-4102020.pdf

[50] https://www.csscoperations.com/internet/csscw3_files.nsf/F2/ED_Submission_Processing_Guide_20221130_v5.2.0.pdf/$FILE/ED_Submission_Processing_Guide_20221130_v5.2.0.pdf

Inspector General (OIG) and CMS's analysis have found that although limited to a small number of beneficiaries, half or more of MA contracts enrolled beneficiaries with an unlinked CRR and no EDR.[51] This raises data integrity concerns as some MA organizations may be continuing to submit unlinked CRRs in lieu of EDRs for some service records despite the ability to submit EDRs.

Table II-15. Number and Percentage of Contracts and Enrolled Beneficiaries with Final Accepted CRRs but No Final Accepted EDRs, Service Years 2018-2022

Service Year	2018	2019	2020	2021	2022
Number of contracts	287	316	362	381	442
Percentage of contracts	52.66%	54.77%	55.18%	52.55%	57.55%
Number of enrolled beneficiaries	7,677	8,766	10,205	12,668	13,181
Percentage of enrolled beneficiaries	0.04%	0.04%	0.05%	0.05%	0.05%

Note: The table excludes Cost plans and PACE contracts in each year.

Since 2012, when encounter data was first collected, CMS has issued guidance to improve submissions to EDS and more specifically, with regard to CRRs, to ensure MA organizations are utilizing CRRs appropriately.[52] CMS guidance requires that items or services provided to an enrollee under the 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. Furthermore, CRRs (linked and unlinked) are subject to the same risk adjustment filtering logic applied to EDRs to identify risk adjustment eligible diagnoses. However, because unlinked CRRs are not directly associated with an EDR, it is unclear which service(s) generated the diagnoses.

As noted previously, stakeholders have raised concerns about CMS accepting diagnoses for risk score calculation that are not linked to the provision of a healthcare item or service. In addition to the OIG, the Medicare Payment Advisory Commission (MedPAC) found that for 2020 through 2023 about half of the differential coding they measured in MA could result from use of diagnoses from chart reviews and health risk assessments and that these two mechanisms are primary factors driving coding differences among MA plans. Based on these findings, excluding unlinked CRRs from risk adjustment may reduce differences in payment resulting from differences in differential coding across MA organizations.[53] Given the maturity of the encounter data and the program integrity concerns at hand, 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. Therefore, CMS proposes to exclude diagnoses from unlinked CRRs from risk score calculation starting in CY 2027. Importantly, the exclusion of unlinked CRRs

[51] An analysis conducted by the OIG found similar results: https://oig.hhs.gov/documents/evaluation/2792/OEI-03-17-00470-Complete%20Report.pdf

[52] HPMS memos Guidance for Chart Review Record (CRR) Submissions and Additional Guidance for Chart Review Record (CRR) Submissions provide information about the appropriate use of CRRs for submission to the EDS.

[53] https://www.medpac.gov/wp-content/uploads/2025/03/Mar25_Ch11_MedPAC_Report_To_Congress_SEC.pdf

from the risk score calculation does not prohibit MA organizations from submitting unlinked CRRs to the EDS.

L1. Sources of Diagnoses for Risk Score Calculation for PACE Organizations

Risk Score Blend

In January of 2024, CMS released technical instructions to PACE organizations on the submission of risk adjustment data to the EDS for PACE center services for which a claim is not generated.[54] With the release of these technical instructions, CMS expects that PACE organizations are submitting fulsome diagnosis data to the EDS.[55]

For CY 2026, CMS finalized a proposal to calculate risk scores for PACE organizations in a manner that will begin to transition risk score calculation for PACE organizations from the 2017 CMS-HCC model calibrated to calculate risk scores using diagnoses submitted to the legacy Risk Adjustment Processing System (RAPS) to the updated risk adjustment models used for MA organizations calibrated to calculate risk scores using encounter data.[56] More specifically for 2026, the risk score for PACE participants will be calculated using 10 percent of the risk score produced by the 2017 CMS-HCC model and 90 percent of the risk score produced by the 2024 CMS-HCC model.

For CY 2027, CMS is proposing to continue to calculate risk scores for PACE participants using a blended model approach but increasing reliance on the CMS-HCC model used for organizations other than PACE in order to continue improving payment accuracy, as described in the CMS-HCC risk adjustment models section (Attachment II, Section G3). We propose to calculate a blended risk score for PACE participants by deriving 50 percent of the risk score from the 2017 CMS-HCC model and 50 percent of the risk score from the proposed 2027 CMS-HCC model. CMS is also proposing to blend ESRD risk scores for PACE organizations in CY 2027 using 50 percent of the risk score from the 2023 ESRD CMS-HCC models and 50 percent of the risk score from the 2019 ESRD CMS-HCC models, as described in the ESRD risk adjustment models section (Attachment II, Section H1). PACE organizations have now had two years of experience submitting encounter data for circumstances in which they do not have claims, and CMS continues to support PACE organizations by providing technical assistance and addressing technical questions. This blend acceleration balances providing support for PACE

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[54] Refer to the January 2024 CMS memorandum titled, "PACE Organization Risk Adjustment Submissions to the Encounter Data System."

[55] CMS collects EDRs and CRRs using the X12 837 Version 5010 industry standard electronic health care claims transmission format. Due to the structure of PACE center services PACE organizations do not always have claims to use to populate the 837. Therefore, historically (since 2013) PACE organizations have only been required to submit encounter data in circumstances in which they have claims.

[56] Attachment II, Section G1. of the CMS-HCC risk adjustment models for PACE organization discusses the technical instructions to PACE organizations for submission to the EDS: https://www.cms.gov/files/document/2026-advance-notice.pdf.

operational submission progress with utilization of the updated models being used in the rest of the program.

CMS intends to fully transition PACE organizations to the CMS-HCC model and ESRD risk adjustment models used for organizations other than PACE over time. As such, for CY 2027, CMS proposes to calculate risk scores for PACE organizations by summing 50 percent of the risk score calculated with encounter data and FFS diagnoses using the CMS-HCC models used for organizations other than PACE (i.e., the proposed 2027 CMS-HCC model and the 2023 ESRD CMS-HCC models) with 50 percent of the risk score calculated with pooled diagnoses from RAPS, encounter data, and FFS 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 remains committed to working closely with PACE organizations to support their transition to EDS submissions and the full implementation of the risk adjustment models used for organizations other than PACE.

Unlinked CRRs

We note, the exclusion of diagnoses from unlinked CRRs for risk score calculation discussed above does not apply to PACE organizations for CY 2027. In the technical submission instructions released in January 2024, PACE organizations were instructed to submit diagnoses for services for which they do not collect a claim via an encounter data record or an unlinked chart review record.[57] PACE organizations are to continue submitting to the EDS in accordance with the technical instructions provided in January 2024. For the portion of the risk scores that are based on the proposed 2027 CMS-HCC model, and hence on encounter data submitted by PACE organizations, CMS will continue to use EDRs, linked CRRs, and unlinked CRRs to calculate risk scores applicable to PACE organizations.

[57] Refer to the January 2024 CMS memorandum titled, "PACE Organization Risk Adjustment Submissions to the Encounter Data System."

Attachment III. Benefit Parameters for the Defined Standard Benefit and Changes in the Payment Methodology for Medicare Part D for CY 2027

Attachment III provides updates to the Part D benefit parameters for CY 2027 and proposes revisions to the RxHCC risk adjustment models. CMS annually updates the Part D benefit parameters, and we provide the CY 2027 updates to these parameters in Sections A though E. We discuss proposed updates to the RxHCC risk adjustment model and related factors and information sources in Sections F through H.

Each year in the Advance Notice, CMS updates the statutory parameters for the defined standard Part D drug benefit and provides information on any changes to the payment methodology for the Part D benefit.

In order to ensure that the actuarial value of the Part D drug benefit remains consistent with changes in Part D drug expenses, certain parameters are updated using one of two indexing methods: the annual percentage increase in average expenditures for Part D drugs per eligible beneficiary (API) or the annual percentage increase in the Consumer Price Index (CPI) (all items, U.S. city average).

In Section A1, CMS provides the API and CPI for 2027, identifies those parameters updated or eliminated by statute, and provides tables outlining the benefit parameters for the standard benefit as well as for low-income subsidy (LIS) beneficiaries. In Section A2, CMS explains the calculation methodologies for the API and CPI. In Section A3, CMS describes the benefit parameters updated in this notice and provides additional tables with information on the updated parameters for both LIS and non-LIS beneficiaries.[58]

In Sections B through E, CMS describes other updates relevant to the Part D benefit parameters for 2027, including Part D premium stabilization, the prospective reinsurance amount for CY EGWPs, retiree drug subsidy amounts, and Part D risk sharing.

In addition, CMS provides information on proposed updates to the RxHCC risk adjustment model used to adjust direct subsidy payments for Part D benefits offered by standalone prescription drug plans (PDPs) and Medicare Advantage-Prescription Drug (MA-PD) plans in

[58] Historically, CMS has used the term "applicable beneficiary," as defined in section 1860D-14A(g)(1) of the Act and § 423.100, to refer to a non-LIS beneficiary enrolled in a stand-alone PDP or MA-PD plan and who is not enrolled in a retiree prescription drug plan, and the term "non-applicable beneficiary" to refer to an LIS beneficiary. The Coverage Gap Discount Program sunset effective January 1, 2025, and was replaced by the new Manufacturer Discount Program, as established in section 1860D-14C of the Act. Both LIS and non-LIS beneficiaries are included in the definition of applicable beneficiary under the Manufacturer Discount Program. Therefore, the terms "applicable beneficiary" and "non-applicable beneficiary" are no longer useful for describing how the benefit parameters discussed in the Advance Notice apply to LIS and non-LIS beneficiaries and will no longer be used to distinguish between LIS and non-LIS beneficiaries.

Section F, the normalization factors for the proposed RxHCC models in Section G, and information on the sources of diagnoses for the Part D risk score calculation in Section H.

Section A. Annual Adjustments to Medicare Part D Benefit Parameters in 2027

Certain parameters are updated annually using one of two indexing methods, the API or the CPI, to ensure that the actuarial value of the benefit remains consistent with changes in Part D drug expenditures. Beginning in CY 2023, the IRA exempted from the deductible and eliminated beneficiary cost sharing for adult vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) and exempted from the deductible and required that cost-sharing amount for a one-month supply of each covered insulin product must not exceed the statutorily-defined "applicable copayment amount." For 2023, 2024, and 2025, the applicable copayment amount for covered insulin products was $35. Beginning in CY 2026, the applicable copayment amount for covered insulin products is the lesser of $35, an amount equal to 25 percent of the maximum fair price (MFP) established for the covered insulin product under the Medicare Drug Price Negotiation Program, or an amount equal to 25 percent of the negotiated price of the covered insulin product under the PDP or MA-PD plan. Beginning in CY 2024, beneficiary cost sharing in the catastrophic phase of the benefit was eliminated. Beginning in CY 2025, the IRA eliminated the coverage gap phase. For additional information about Part D policies related to the Inflation Reduction Act of 2022 (IRA) (Pub. L. 117-169) for 2027, see the CY 2027 proposed rule (CMS-4212-P, 90 FR 54894) titled, "Contract Year 2027 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program," which appeared in the Federal Register on November 28, 2025.

Given these changes, defined standard Part D prescription drug coverage in CY 2027 will consist of a three-phase benefit as follows:

- **Annual deductible:** Beneficiaries will be responsible for all of their Part D prescription drug costs until they reach the defined standard deductible limit, with the exception that the deductible will continue to not apply to any Part D covered insulin product and any ACIP-recommended adult vaccine. The defined standard Part D deductible will be updated using the API for 2027.
- **Initial coverage phase:** In the initial coverage phase, the beneficiary pays 25% coinsurance for most covered Part D drugs.[59] Because the coverage gap phase was eliminated beginning in CY 2025, there will not be an initial coverage limit, and, thus, that parameter will no longer be updated. The initial coverage phase will extend to the maximum annual out-of-

[59] The exceptions include ACIP-recommended adult vaccines, for which beneficiaries pay $0, and covered insulin products, for which the cost sharing is capped. For CY 2026 and each subsequent year, the applicable copayment amount for a month's supply of each covered insulin product is the lesser of: (1) $35, (2) an amount equal to 25 percent of the MFP established for the covered insulin product under the Medicare Drug Price Negotiation Program, or (3) an amount equal to 25 percent of the negotiated price of the covered insulin product under the PDP or MA-PD plan.

pocket (OOP) threshold. The annual OOP threshold will be updated using the API for CY 2027.

- **Catastrophic coverage phase:** Beneficiaries will continue to pay no cost sharing for covered Part D drugs in the catastrophic coverage phase. Therefore, beneficiary cost sharing above the annual OOP threshold will no longer be updated.

A1. Updating the Medicare Part D Benefit Parameters

Part D of Title XVIII of the Act directs CMS to update the statutory parameters for the defined standard Part D drug benefit each year. These annual adjustments ensure that the actuarial value of the drug benefit remains consistent with changes in Part D drug expenses. This section provides the methodologies used to update the statutory parameters for CY 2027.

Historically, the statutory parameters have included the defined standard benefit deductible, initial coverage limit, and annual OOP threshold. In addition, CMS is required by statute to update the parameters for the LIS benefit. Given the changes enacted by the IRA, for CY 2027 the defined standard benefit deductible, annual OOP threshold, and LIS benefit parameters will be updated per the methodology provided by the Act.

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

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." As noted above, the defined standard benefit deductible and annual OOP threshold will be updated using the API in CY 2027. The only LIS cost-sharing parameter that is updated using the API is the maximum copayment below the annual OOP threshold for low-income, full-subsidy-eligible beneficiaries with incomes between 100 and 150 percent of the federal poverty level (FPL).

The CY 2026 annual percentage trend in the API can be found in Table III-1 below. The percent increase in the benefit parameters indexed to the API for CY 2027 is 13.65 percent. This increase reflects the CY 2026 annual percentage trend of 9.37 percent in the API as well as a multiplicative update of 3.92 percent for prior year revisions. See Section A2 for additional information on the calculation of the API.

Annual Percentage Increase in Consumer Price Index, 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 2027. CMS uses an estimate of the September 2026 CPI based on projections from the President's FY 2027 Budget for this purpose.

The CY 2026 annual percentage trend in the CPI can be found in Table III-1 below. The percent increase in the maximum copayments indexed to the CPI for CY 2027 is 3.00 percent. The CY 2027 increase reflects the CY 2026 annual percentage trend in the CPI of 2.31 percent as well as a multiplicative update of 0.67 percent for prior year revisions.

See Section A2 for additional information on the calculation of the annual percentage increase in the CPI.

Table III-1. Updated API and CPI for CY 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 III-2 below summarizes the Part D benefit parameters discussed in this notice, including those that are required by statute to be updated with either the API or CPI each year. The 2026 column shows the CY 2026 values for the Part D benefit parameters. The 2027 column shows the updated parameters for CY 2027. The CY 2027 values will be updated using either the 2027 API of 13.65% percent or CPI of 3.00% percent, as applicable.

We also provide the Part D benefit parameters that remain constant from year-to-year.

For completeness, Table III-2 also includes estimates of the cost threshold and cost limit for the Retiree Drug Subsidy program (discussed in more detail in Section F).

Table III-2. Updated Part D Benefit Parameters for Defined Standard Benefit, Low-Income Subsidy, and Retiree Drug Subsidy

	2026	2027[60]
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

[60] 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[60]
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
Full Subsidy-Non-FBDE Beneficiaries (1)		
Applied or eligible for QMB/SLMB/QI or SSI, income at or below 150% FPL for 2026 and resources ≤ $16,590 (individuals, 2026) or ≤ $33,100 (couples, 2026) [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	$ 14,400

(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 Health Plan Management System (HPMS) memo 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.

A2. Calculation methodologies for the Annual Percentage Increase (API) and Consumer Price Index (CPI)

As noted above, the API and CPI are indexing methods used to update certain Part D benefit parameters. This section describes in detail the calculation methodologies used to determine the API and CPI for 2027.

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

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 prescription drug event (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 annual percentage trend in Table III-3 is based on updated NHE prescription drug per capita costs and PDE data. The years in this table refer to the trend observed in the period of the August of the prior year to July of that year relative to the same interval in preceding years. For example, year 2021 represents the trend observed in August 2020 to July 2021 relative to August 2019 to July 2020.

Table III-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%

Year	Prior Estimates of Annual Percentage Trend	Revised Annual Percentage Trend
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%
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 will reflect the CY 2026 annual percentage trend and a multiplicative update for prior year revisions. The CY 2026 annual percentage trend can be found in Table III-4. The 2026 API is updated by 13.65 percent.

Table III-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) Calculation Methodology

To ensure that Part D 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 FY 2027 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 FY 2027 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 III-5 below.

Table III-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.

A3. Annual Adjustments for Part D Benefit Parameters in CY 2027

Defined Standard Part D Prescription Drug Benefit Parameters

In accordance with section 1860D-2(b) of the Act, CMS updates the statutory parameters for the defined standard Part D prescription drug benefit each year. As mentioned previously, these annual adjustments ensure that the actuarial value of the drug benefit remains consistent with changes in Part D drug expenses. The IRA made several amendments and additions to the Act that affect the structure of the defined standard Part D prescription drug benefit in CY 2027, which are reflected in the discussion below.

As described in section 1860D-2(b) of the Act, as amended by section 11201 of the IRA, the defined standard Part D prescription drug benefit is composed of three sequential coverage phases: deductible, initial coverage, and catastrophic coverage phases. Under section 1860D-2(b) and (c) of the Act, as amended by section 11201 of the IRA, the coverage gap phase was eliminated in CY 2025, meaning a beneficiary will leave the initial coverage phase and enter the catastrophic phase once they incur enough TrOOP-eligible costs to meet the annual OOP threshold, which is $2,400 in CY 2027. TrOOP is spending on covered Part D drugs by the beneficiary or on their behalf by certain third parties. The categories of payments that count toward TrOOP changed in CY 2025. Specifically, TrOOP includes previously excluded supplemental benefits and excludes Manufacturer Discount Program payments (see section 1860D-2(b)(4)(C)(iii) and (F) of the Act).

Cost sharing for beneficiaries varies by coverage phase, by LIS status, and whether the drug is a covered insulin product or ACIP-recommended adult vaccine. See Table III-6 below for non-LIS beneficiary cost sharing and the next section for discussion of cost-sharing requirements for LIS beneficiaries.

For CY 2027, under section 1860D-2(b)(1) of the Act, the defined standard benefit deductible amount is updated by multiplying the CY 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 III-6 below summarizes the defined standard benefit parameters and provides the CY 2026 parameter values. The updated parameter values for CY 2027 are obtained by applying the 2027 API and rounding to a specified amount and are summarized in Table III-6.

Table III-6. Part D Benefit Parameters for Defined Standard Benefit for CY 2026 and CY 2027 for Non-LIS Beneficiaries[61]

	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	

Annual Adjustments for Low-Income Subsidy (LIS) Beneficiary Cost-Sharing Parameters

The LIS benefit provides Part D cost-sharing assistance to certain low-income Medicare Part D beneficiaries across the same coverage phases described above. Medicare Part D beneficiaries who are eligible for full Medicaid benefits, recipients of Supplemental Security Income (SSI) benefits (*see* § 423.773(c)(1)(ii)), or eligible for a Medicare Savings Programs as a Qualified Medicare Beneficiary (QMB), Specified Low-income Medicare Beneficiary (SLMB), or Qualifying Individual under a State's Medicaid plan (*see* § 423.773(c)(1)(iii)) are deemed automatically eligible for the full subsidy and do not have to separately apply for the LIS benefit. Other Medicare Part D beneficiaries must apply for the LIS benefit and may receive the full

[61] 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.

subsidy if they meet certain income and asset requirements, as described in section 1860D-14(a)(3)(E) of the Act.

The cost-sharing benefits for LIS beneficiaries are described in section 1860D-14(a)(1) of the Act. Full subsidy FBDE individuals who are institutionalized or receiving certain home and community-based services, as defined in § 423.772, have a $0 deductible and $0 copayments for all covered Part D drugs, regardless of the defined standard benefit phase. Other full subsidy (both FBDE and non-FBDE) beneficiaries also have a $0 deductible but pay nominal copayments for all covered Part D drugs below the annual OOP threshold as described in section 1860D-14(a)(1)(D)(ii) and (iii).

The following LIS cost-sharing parameters are updated each year by multiplying the prior year's value by the API and rounding as specified by the statute:

Maximum Copayments up to the Annual OOP Threshold for Certain Low-Income Full Subsidy Eligible Beneficiaries: From $5.10 per generic, preferred drug that is a multi-source drug, or biosimilar and $12.65 for all other drugs in CY 2026, rounded to the nearest multiple of $0.05.

Maximum Copayment Amounts up to the Annual OOP Threshold for Full Benefit Dual Eligible Beneficiaries with Incomes Not Exceeding 100 Percent of the Federal Poverty Level: 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.[62]

Please see Table III-7 below for complete information on the different LIS benefit categories and cost-sharing parameters for CY 2026, as well as the LIS cost-sharing parameters updated for CY 2027 by either using the 2027 API or CPI.

Table III-7. Updated Part D Low-income Cost-Sharing Parameters for CY 2027[63]

	2026	2027
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]		

[62] Per section 1860D-14(a)(4)(A) of the Act, the copayments are increased from the unrounded 2024 values of $1.55 for multi-source generic or preferred drugs, and $4.65 for all other drugs.

[63] 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
Up to Out-of-Pocket Threshold		
Generic/Preferred Multi-Source Drug (3)	$1.60	$1.65
Other (3)	$4.90	$5.00
Between 100% and 150% of FPL		
Up to Out-of-Pocket Threshold		
Generic/Preferred Multi-Source Drug	$5.10	$5.80
Other	$12.65	$14.40
Full Subsidy-Non-FBDE Beneficiaries (1)		
Applied or eligible for QMB/SLMB/QI or SSI, income at or below 150% FPL for 2026 and resources $16,590 (individuals, 2026) or ≤ $33,100 (couple, 2026) [category code 1] (4)		
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

(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 percent of FPL who meet the statutory resource requirements, and full-subsidy-non-FBDE beneficiaries.
- Category Code 2 – Non-institutionalized FBDE beneficiaries with incomes up to 100 percent of the FPL and who meet the statutory resource requirements.
- 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 individual (or couple) would have been institutionalized.

(3) Increases to the maximum copayments for non-institutionalized FBDE beneficiaries with incomes not greater than 100 percent of the FPL are applied to the unrounded CY 2026 values of $1.67 for generic/preferred multi-source drugs and $5.01 for all other drugs.

(4) The resource limits for CY 2027 will be provided via the annual HPMS memo 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 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). In addition, beneficiaries that would have

been eligible for the partial LIS benefit had the IRA not been enacted are eligible for the full LIS benefit if they meet the resource standard described at section 1860D-14(a)(3)(E) of the Act.

Section B. Part D Premium Stabilization

As described in the CY 2027 proposed rule (CMS-4212-P, 90 FR 54894) titled, "Contract Year 2027 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program," which appeared in the Federal Register on November 28, 2025, under section 1860D-13 of the Act, as added by section 11201 of the IRA, the Base Beneficiary Premium (BBP) for CY 2024 through CY 2029 is equal to the lesser of the prior year's BBP increased by 6 percent, or the BBP as it would have been calculated if the IRA's premium stabilization provision had not been enacted.

Therefore, the BBP for CY 2027 will not be greater than CY 2026 BBP, which was $38.99 (as released in the July 28, 2025, HPMS memorandum) increased by 6%, or $41.33. We will provide more information on the BBP calculation for CY 2027 during the usual timeframe after CY 2027 bids have been submitted. Please note that the BBP is calculated at the national level and that premiums for individual plans may increase by more than 6%.[64]

It is important to note that the Part D premium stabilization policy impacts the direct subsidy payments for Part D benefits offered by PDPs and MA-PD plans. CMS provides a capitated direct subsidy payment for each Part D beneficiary equal to the Part D plan's approved standardized bid, risk adjusted for the beneficiary's health status, and reduced by the plan's basic Part D premium, as defined at § 423.329. Consistent with CY 2024, CY 2025, and CY 2026, the direct subsidy amount will change depending on the impact of premium stabilization on the BBP calculation and, thereby, a plan's basic Part D beneficiary premium. As a result, the portion of the plan's bid for basic Part D coverage not funded by basic Part D premiums will continue to be paid through the direct subsidy.

[64] In July 2024, CMS announced a voluntary demonstration program for standalone PDPs for CY 2025 that included elements designed to test whether additional premium stabilization and revised risk corridors increase the efficiency and economy of services under the Medicare Part D program as the benefit improvements and changes to plan liability for beneficiary costs under the IRA go into effect. The demonstration design allowed for CMS to continue the demonstration for subsequent years, with parameters in each subsequent year to be determined based on market conditions. In July 2025, CMS released information regarding the revised parameters of the voluntary demonstration program for CY 2026. Note that the demonstration does not affect the calculation of the BBP under the formula established at section 1860D-13(a)(2) of the Act and the BBP for 2027 will be calculated based on the CY 2026 BBP prior to the application of the demonstration parameters. Please see the July 29, 2024, HPMS memorandum "Annual Release of Part D National Average Monthly Bid Amount and Other Part C & D Bid Information" and the July 28, 2025, HPMS memorandum "Annual Release of Part D National Average Monthly Bid Amount and Other Part C & D Bid Information" for additional information.

Section C. Part D Calendar Year EGWP Prospective Reinsurance Amount

From 2017 through 2024, CMS made prospective reinsurance payments to all Part D Calendar Year EGWP sponsors based on the average per member-per month (PMPM) actual (final) reinsurance amounts paid to Part D Calendar Year EGWP sponsors for the most recently reconciled payment year.

In 2025, given that the reinsurance percentages and methodology changed significantly, as discussed in the Final CY 2025 Part D Redesign Program Instructions,[65] the methodology used to calculate the prospective reinsurance payments to all Part D Calendar Year EGWP sponsors was also updated. For CY 2027, CMS will apply the updated methodology first applied for CY 2025. Specifically for CY 2027, CMS will calculate the prospective reinsurance payments to all Part D Calendar Year EGWP sponsors using the weighted average of PMPM prospective reinsurance amounts submitted by Part D sponsors for enhanced alternative (EA) plans as part of the Part D bid submissions for the payment year in question. The weights will be based on the projected number of enrollees in each EA plan. Specifically, the weight for each EA plan reinsurance amount will be a percentage calculated with the numerator equal to the projected enrollment in the plan bid and the denominator equal to the total projected enrollment in all applicable EA plans' bids. CMS is taking this approach to ensure that Part D Calendar Year EGWPs are paid an appropriate prospective reinsurance payment amount. As in CY 2025 and CY 2026, CMS plans to announce the prospective reinsurance payment amount for Part D Calendar Year EGWPs with the annual release of the Part D National Average Monthly Bid Amount (NAMBA), Part D BBP, and related Part D bid information. For CY 2027, the release of such information will occur in the summer of 2026.

Section D. Part D Risk Sharing

The risk sharing payments provided by CMS limit Part D sponsors' exposure to unexpected drug expenses. Pursuant to 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 beginning in CY 2012. Widening the risk corridor would increase the risk associated with providing the Part D benefit and reduce the risk sharing amounts provided (or recouped) by CMS. While CMS may widen the risk corridors, the statute does not permit CMS to narrow the corridors relative to the CY 2011 thresholds.

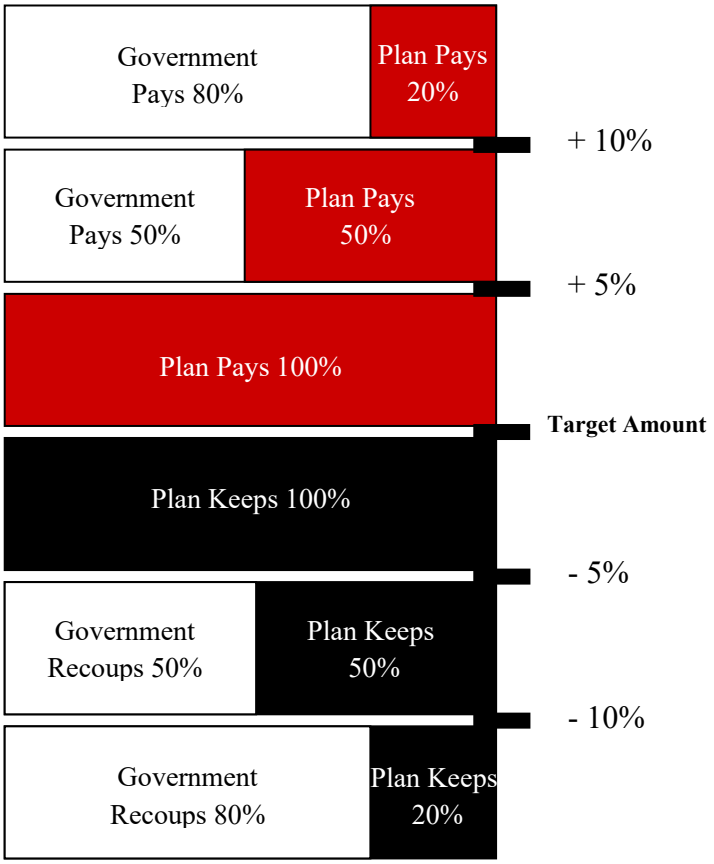
CMS has evaluated the risk sharing amounts for CYs 2008–2023 to assess whether they have decreased or stabilized. A steady decline or stabilization in the Part D risk sharing amounts would suggest that Part D sponsors have significantly improved their ability to predict Part D expenditures. However, CMS has found that risk sharing amounts continue to vary significantly in aggregate from year to year and among Part D sponsors in any given year. We do not believe

[65] 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.

it is appropriate to adjust the parameters in the manner allowed by the statute at this time, and we will apply no changes to the current threshold risk percentages for CY 2027. We will continue to evaluate the risk sharing amounts each year to determine if wider corridors should be applied for Part D risk sharing.

Thus, the risk percentages and payment adjustments for Part D risk sharing are unchanged from CY 2026. The risk percentages for the first and second thresholds remain at +/- 5 percent and +/- 10 percent of the target amount, respectively, for CY 2027.[66] The payment adjustments for the first and second corridors are 50 percent and 80 percent, respectively. Figure III-1 below illustrates the risk corridors for CY 2027.

Figure III-1. Part D Risk Corridors for CY 2027



[66] Per section 1860D-15(e)(3)(B) of the Act, the target amount is the total amount of payments (from both CMS and by or on behalf of enrollees) to a Part D plan for the coverage year based on the standardized bid amount, less the administrative expenses assumed in the standardized bid.

D1. Risk sharing when a plan's adjusted allowable risk corridor costs (AARCC) exceed the target amount

For the portion of a plan's adjusted allowable risk corridor costs (AARCC[67]) that is between the target amount and the first threshold upper limit (105 percent of the target amount), the Part D sponsor pays 100 percent of this amount. For the portion of the plan's AARCC that is between the first threshold upper limit and the second threshold upper limit (110 percent of the target amount), the government pays 50 percent, and the plan pays 50 percent. For the portion of the plan's AARCC that exceeds the second threshold upper limit, the government pays 80 percent, and the plan pays 20 percent.

Example: If a plan's AARCC is $120 and its target amount is $100, the Part D sponsor and the government cover $9.50 and $10.50, respectively, of the $20 in unanticipated costs. The sponsor's responsibility is calculated as follows:

$$100\% \text{ of } (\$105 - \$100) + 50\% \text{ of } (\$110 - \$105) + 20\% \text{ of } (\$120 - \$110).$$

D2. Risk sharing when a plan's adjusted allowable risk corridor costs (AARCC) are below the target amount

If a plan's AARCC is between the target amount and the first threshold lower limit (95 percent of the target amount), the plan keeps 100 percent of the difference between the target amount and the plan's AARCC. If a plan's AARCC is between the first threshold lower limit and the second threshold lower limit (90 percent of the target amount), the government recoups 50 percent of the difference between the first threshold lower limit and the plan's AARCC. The plan would keep 50 percent of the difference between the first threshold lower limit and the plan's AARCC, as well as 100 percent of the difference between the target amount and first threshold lower limit. If a plan's AARCC is less than the second threshold lower limit, the government recoups 80 percent of the difference between the plan's AARCC and the second threshold lower limit, as well as 50 percent of the difference between the first and second threshold lower limits. In this case, the plan would keep 20 percent of the difference between the plan's AARCC and the second threshold lower limit, 50 percent of the difference between the first and second threshold lower limits, and 100 percent of the difference between the target amount and the first threshold lower limit.

Example: If a plan's AARCC is $80 and its target amount is $100 of the $20 in unexpected savings generated, the Part D sponsor keeps $9.50, and the government recoups $10.50. The sponsor's share is calculated as follows:

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[67] Per § 423.336(a), the "adjusted allowable risk corridor costs" for a Part D plan are the allowable risk corridor costs for a Part D plan for the coverage year, reduced by the sum of the total reinsurance payments and total low-income cost-sharing subsidies paid to the sponsor of the Part D plan for the coverage year.

100% of ($100 − $95) + 50% of ($95 − $90) + 20% of ($90 − $80).

Section E. Retiree Drug Subsidy Amounts

While the IRA significantly redesigned the Part D benefit starting in CY 2025, 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 retiree drug subsidy amounts for retiree drug subsidy plans.[68]

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.[69] 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 III-8.

Table III-8. Updated Retiree Drug Subsidy Amounts in CY 2027

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

Section F. RxHCC Risk Adjustment Model

F1. Background on the RxHCC Risk Adjustment Model

The prescription drug hierarchical condition category (RxHCC) risk adjustment model is used to help ensure that payments to Part D plans reflect the plans' expected drug costs given their enrolled population. The model is used to calculate beneficiary risk scores, which represent the expected plan liability for a specific beneficiary's drug costs relative to the average drug costs for all Part D beneficiaries. If a plan's enrolled population is expected to be more or less costly than average, the risk adjustment model ensures that plan payments account for that difference in risk.

- The RxHCC model uses beneficiary demographic characteristics and diagnosis information from a base year (i.e., data collection year) to predict expected plan spending for drug costs in the following year (i.e., the payment year) under the basic Part D drug

[68] 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.

[69] 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.

benefit. Demographic information, such as beneficiary age, sex, disability status, low income, and long-term institutional status, is obtained from CMS administrative data.

- Diagnosis information is obtained from MA encounter data and FFS claims for MA and FFS beneficiaries enrolled in the Part D program. Diagnoses are grouped into RxHCCs based on severity and cost.
- Gross prescription drug expenditures are collected from prescription drug event (PDE) data.

PDEs used to develop the model are always from years prior to the payment year. Individual PDEs reflect costs paid by plans, beneficiaries, and the government for the benefit structure in place for a given year. However, the RxHCC model is used to predict plan spending in a future year when the benefit may be different because of changes to the benefit, including, for example, changes over time related to when IRA policies take effect. For this reason, each PDE in the model sample needs to have payments reallocated to the standard benefit structure for the applicable payment year. The spending totals used to calibrate the model reflect how much a plan would have spent for a drug if the future payment year's basic benefit structure was in place when the PDE occurred. The model includes costs for which the plan is financially liable; in other words, the model excludes costs paid for entirely by the government (reinsurance and the low-income subsidy) or the beneficiary. It also excludes enhanced benefits provided above and beyond the defined standard benefit structure. For additional details and examples of the PDE re-mapping process, consult the CY 2025 Advance Notice.[70]

The re-mapped PDE expenditures are used to predict plan spending for each model factor (diagnosis groups, or RxHCCs, and demographic characteristics). These values are then divided by the average predicted per capita expenditure – referred to as the denominator – for a given year to generate relative factors for each model factor. The relative factors represent the marginal, or additional, expected plan spending for drug costs for each model factor relative to the average, holding all else the same. Relative factors are used to calculate risk scores for each beneficiary to use for preparing plan bids and for calculating direct subsidy payments.

Model Calibration

The RxHCC model sample comprises all beneficiaries who were in FFS or Medicare Advantage (MA-PD or MA-only) for all 12 months of the base year (the year from which diagnoses were used for model calibration) and were enrolled in a PDP or an MA-PD plan for at least one month in the prediction year (the year from which costs were used for model calibration). CMS regressed the plan liability for the Part D defined standard benefit for each beneficiary onto their demographic factors and condition categories, as indicated by their diagnoses, to estimate dollar

[70] Refer to the CY 2025 Advance Notice, Attachment III, section G1.

coefficients. Resulting dollar coefficients represent the marginal (additional) cost of the condition or demographic factor (for example, age and sex groups).

The RxHCC model consists of different subsets (i.e., segments) of Part D beneficiaries. Beneficiaries are segmented based on factors that include low-income status, disability status, and residence setting (community vs. institutional), and whether they are new enrollees (have less than 12 months of Part B in the data collection period). Age groups are defined for beneficiaries based on their age on February 1 of the prediction year. Beneficiaries who age into Medicare after February 1 of the prediction year are treated as 65 years old in model calibration. LIS and institutional status are determined on a month-by-month basis. Plan liability figures for each beneficiary are annualized and weighted based on the proportion of months beneficiaries are eligible for each model segment in the prediction year.

Since 2011, there have been eight unique beneficiary subsets ("model segments"):

- Five segments are for continuing enrollees, who are defined as beneficiaries who had 12 months of enrollment in Part B in the base year (when diagnosis information is collected) (12 months of Part B is used as a way to identify beneficiaries who have an adequate amount of diagnoses to calculate a risk score.)
    - Community, Non-Low Income, Age 65+
    - Community, Non-Low Income, Age <65
    - Community, Low Income, Age 65+
    - Community, Low Income, Age < 65
    - Institutional
- Three segments are for new enrollees, who are beneficiaries with fewer than 12 months of enrollment in Part B in the base year.
    - Non-Low Income
    - Low-Income
    - Institutional

To create the relative factors used to calculate risk scores for payment, the dollar coefficients are divided by the average predicted plan liability across all model segments (the denominator). Denominators for the recalibrated RxHCC risk adjustment models are calculated using data from 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.

When the RxHCC model is recalibrated to reflect updated data years and/or an updated benefit structure, it can result in changes to coefficients for the factors in the model. Changes in the relative (denominated) factors can occur when the marginal cost attributable to a demographic factor or an RxHCC changes differently than the average beneficiary cost. Recalibration of the RxHCC model can result in changes in risk scores for individual beneficiaries and for plan average risk scores, depending on each individual beneficiary's combination of diagnoses.

For CY 2027, CMS is proposing model updates (described in section F2). Relative factors for the proposed RxHCC models for CY 2027 are presented in Attachment VI.

F2. Proposed Updates to the RxHCC Models

The IRA made substantial changes to the Part D benefit and significantly increased gross plan liability. For CYs 2025 and 2026, CMS recalibrated the RxHCC models (both the model for MA-PD plans and PDPs, and the model used solely for PACE organizations) to account for changes made to the Part D benefit structure for those years, thereby improving the model's accuracy under the revised standard benefit.[71] CMS is proposing further updates to align the RxHCC models with benefit updates for CY 2027.

Proposed IRA-related Updates

First, we are proposing to update the RxHCC models by incorporating the following changes to the Part D benefit related to the IRA:

- Continue to use adjusted annual OOP thresholds for pre-IRA data years to reflect what the threshold would have been in prior years if the IRA were in place at the time, as described in the 2026 Advance Notice[72];
- Increase manufacturer discounts for specified manufacturers and specified small manufacturers to reflect CY 2027 amounts according to the phase-in schedules under section 1860D-14C(g)(4)(B) and (C) of the Act;
- Update the model's list of adult vaccines and covered insulin products with revised cost-sharing under the IRA to reflect the most recent applicable national drug codes (NDCs); and
- Continue to adjust gross drug costs to account for the 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.

Increasing Manufacturer Discounts. The IRA provides for lower applicable discounts for certain manufacturers' applicable drugs marketed as of August 16, 2022, during a multi-year phase-in period, which concludes by 2031. A list of NDC-9 codes eligible for phased-in manufacturer discounts was published in July 2025.[73] This list of eligible drugs is based on ownership information submitted by manufacturers to HPMS and whether the manufacturers entered into a Discount Program agreement by the statutory deadline of March 1, 2024. The phased-in discount percentages in the RxHCC models being proposed for CY 2027 reflect the July 2025 list and the

[71] For more details, see CY 2025 Advance Notice, Attachment III, Section G2 and CY 2026 Advance Notice, Attachment III, Section F2.

[72] See table III-9 in Attachment III, Section F2.

[73] For more information, see https://www.cms.gov/medicare/coverage/prescription-drug-coverage/part-d-information-pharmaceutical-manufacturers.

CY 2027 benefit structure.[74] Specifically, for specified manufacturers, the plan liability proportion of cost-sharing for applicable drugs dispensed to LIS beneficiaries was changed for CY 2027 to 70 percent during the initial coverage phase and 75 percent during the catastrophic phase. For specified manufacturers, no changes were made to the plan liability proportion of cost-sharing for applicable drugs dispensed to non-LIS beneficiaries because these drugs are not eligible for the phased-in manufacturer discount. For specified small manufacturers, the plan liability proportion of cost-sharing for applicable drugs dispensed to all beneficiaries was changed for CY 2027 to 70 percent during the initial coverage phase and 75 percent during the catastrophic phase.

Updating Adult Vaccine and Insulin NDC codes. The RxHCC model proposed for CY 2027 will continue to reflect special cost-sharing rules under the IRA for ACIP-recommended adult vaccines and covered insulin products. The proposed models have an updated list of NDCs used to identify these drugs to reflect codes applicable as of May 2025.

Adjusting Gross Drug Costs for the MFP. For CY 2026, CMS finalized an RxHCC model that adjusted gross drug costs to reflect the agreed-upon MFPs of the selected drugs for which an MFP is in effect for IPAY 2026 as part of the Medicare Drug Price Negotiation Program. The proposed model for CY 2027 will continue to reflect agreed-upon MFPs for these drugs for which an MFP is in effect for IPAY 2026, as adjusted for inflation to the calibration year.[75] CMS is unable to 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. We anticipate incorporating MFPs for the selected drugs for IPAY 2027 in the RxHCC model calibration for future years.

Other Proposed Updates

Next, we are proposing the following updates for CY 2027 (these updates do not apply to the RxHCC model being proposed solely for PACE organizations):

- Update the underlying data used in the model calibration to more recent years, specifically using diagnoses from 2023 FFS claims and MA encounter data records and gross drug costs from 2024 PDEs;
- Update the denominator year from 2023 to 2024;
- Update the model to exclude diagnoses from audio-only services and those submitted on unlinked chart review records (CRRs); and

[74] Due to the timing of the RxHCC model calibration, CMS is not able to incorporate any changes made to the list after July 2025 into the CY 2027 RxHCC model.

[75] For more details about how MFP data was incorporated into the 2026 RxHCC models, refer to Attachment III, Section F2 of the CY 2026 Advance Notice.

- Update the model to use separate continuing enrollee model segments for beneficiaries in MA-PD plans and PDPs.

Data Years and Denominator Year. CMS is proposing an RxHCC model for CY 2027 with updated data years to reflect more recent utilization and cost patterns. Specifically, the diagnosis and cost data are updated from 2022 diagnoses and 2023 costs to 2023 diagnoses and 2024 costs. The denominator for this proposed model is updated from 2023 to 2024.

As noted previously, we did not similarly update the data years and denominator year for the model being proposed solely for PACE organizations. The data years for the 2027 RxHCC model being proposed solely for PACE organizations will continue to be based on 2018 diagnoses predicting 2019 expenditures, which are the most recent available data that both 1) still have MA-PD plans submitting RAPS data and 2) avoid using data that is most affected by the COVID-19 pandemic. For more information, consult Attachment III, Section F2 of the 2026 Advance Notice.[76]

Diagnoses Included for Risk Adjustment. In addition to changes to the data years for calibration, CMS is proposing to make an update to the diagnoses used in the 2023/2024 model calibration to exclude diagnoses obtained from audio-only encounters using modifier "93" or "FQ" and those from chart review records that are not linked to an encounter data record. These two changes are in alignment with the proposals previously described for Part C (see Attachment II, Section L).

The version of the model proposed solely for PACE organizations (the 2018/2019 model calibration) is not being similarly updated because the "93" and "FQ" modifiers were not effective until January 1, 2022. Further, the model is based on RAPS data instead of encounter data and there are no chart review records present in RAPS data.

Model Segmentation. Predicting expenditures accurately for groups of Part D beneficiaries is a fundamental objective of the risk adjustment model. With that goal in mind, the RxHCC model has historically segmented the model to use separate relative factors for subsets of beneficiaries that have distinct cost and utilization patterns. Model segmentation allows the RxHCC model to produce separate risk scores for different subsets of Part D beneficiaries based on factors that include residence (community versus long term institutional), low-income status, aged versus disabled status, and whether beneficiaries are new enrollees. Historically, these model segments (and their corresponding relative factors) have applied to all beneficiaries regardless of whether they are enrolled in an MA-PD plan or a PDP.

In both the CY 2025 and CY 2026 Advance Notices,[77] CMS presented analyses showing that while the RxHCC model does well at predicting across levels of risk, including enrollees in the

[76] See the CY 2026 Advance Notice.

[77] See Attachment III, Section H of the CY 2025 Advance Notice and Attachment III, Section G of the CY 2026 Advance Notice.

highest deciles of predicted risk, MA-PD plan costs tend to be overpredicted, while PDP costs tend to be underpredicted. We find that this pattern would continue for 2027 if not addressed. For MA-PD plans, we found that the average predicted expenditures for continuing enrollees would be $2,911.94, while the average annual expenditures are $2,732.50, resulting in a predictive ratio of 1.066. Conversely, for PDPs, the average predicted expenditures for continuing enrollees would be $2,415.06, while the average annual expenditures are $2,689.97, resulting in a predictive ratio of 0.898. We believe that this differential in predicted costs 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 of PDPs to affect the submission of diagnoses in FFS, and available strategies used to manage Part D costs.

The repeated pattern of overprediction of costs for MA-PD plans and underprediction of costs for PDPs indicates that revising the RxHCC model is warranted to improve the model's predictive performance for both sectors of the Part D market. Therefore, CMS is proposing to include an additional segment for MA-PD versus PDP enrollment. Specifically, for the 2023/2024 model calibration, we propose to use separate continuing enrollee model segments for MA-PD plans and PDPs. Updating the model in this way 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 for MA-PD plans and PDPs compared to a model that uses the same relative factors for both sectors. See section F3 for discussion on the predictive ratios of the proposed model.

Because new enrollee risk scores are only calculated using demographic information, these segments are less impacted by underlying market differences between MA-PD plans and PDPs. As a result, we are not proposing any changes to model segments for new enrollees. Additionally, because we are in the process of transitioning PACE organizations to submitting fulsome encounter data and eventually calculating risk scores entirely using the same Part D model used for MA-PD plans and PDPs, we are not proposing to use separate model segments as part of the 2018/2019 model proposed solely for PACE organizations.

The proposed 2027 RxHCC model calibrations will use the following segments.

Table III-9: Proposed Model Segments for 2027 RxHCC Model Calibrations

2023/2024 calibration	2018/2019 calibration
Ten segments for continuing enrollees:[78] • Community, Non-Low Income, Age 65+ (MA-PD) • Community, Non-Low Income, Age 65+ (PDP)	Five segments for continuing enrollees: • Community, Non-Low Income, Age 65+

[78] Continuing enrollees are defined as beneficiaries who had 12 months of enrollment in Part B in the base year (when diagnosis information is collected). (12 months of Part B is used as a way to identify beneficiaries who have an adequate amount of diagnoses to calculate a risk score.)

2023/2024 calibration	2018/2019 calibration
• Community, Non-Low Income, Age<65 (MA-PD) • Community, Non-Low Income, Age<65 (PDP) • Community, Low Income, Age 65+ (MA-PD) • Community, Low Income, Age 65+ (PDP) • Community, Low Income, Age < 65 (MA-PD) • Community, Low Income, Age < 65 (PDP) • Institutional (MA-PD) • Institutional (PDP) Three segments for new enrollees:[79] • Non-Low Income • Low-Income • Institutional	• Community, Non-Low Income, Age<65 • Community, Low Income, Age 65+ • Community, Low Income, Age < 65 • Institutional Three segments for new enrollees: • Non-Low Income • Low-Income • Institutional

Relative factors for the proposed RxHCC models for CY 2027 are presented in Attachment VI. CMS also regularly provides additional information outside the Advance Notice discussion to supplement plan review of risk adjustment model revisions.

Methodology for Calculating Risk Scores

The 2023/2024 calibration of the RxHCC model is being proposed to calculate risk scores for CY 2027 payment for PDPs and MA-PD plans, and as part of a blended risk score for PACE organizations.

The 2018/2019 calibration of the RxHCC model is being proposed to calculate risk scores for CY 2027 payment as part of a blended risk score for PACE organizations. This proposed version of the model is solely for PACE organizations.

Because RAPS data have long been the primary source of diagnoses for risk scores used to pay PACE organizations, the RxHCC risk adjustment model used for PACE has historically been calibrated using the specialty-based filtering logic that aligns with how PACE organizations determine which risk adjustment-eligible diagnoses to submit to RAPS. The RxHCC models used to calculate risk scores for PACE organizations for CY 2025 and for CY 2026 were calibrated using 2018 diagnoses and 2019 costs. For CY 2027 for PACE organizations, CMS is proposing an RxHCC model calibrated using specialty-based filtering to be used in a Part D risk score blend. This proposed RxHCC model includes the updates previously described above but continues to be based on 2018 diagnoses and 2019 costs (like for CY 2025 and CY 2026). These data years are the most recent available data that both (1) still have MA-PD plans submitting

[79] New enrollees are beneficiaries with fewer than 12 months of enrollment in Part B in the base year.

RAPS data[80] and (2) avoid using data that is most affected by the COVID-19 pandemic. For this reason, CMS is unable to update the data years used to calibrate this model any further.

In alignment with the proposal to blend risk scores from the CMS-HCC and ESRD risk adjustment models for PACE organizations, discussed in Attachment II, Sections G3, CMS is also proposing to use a blend of RxHCC risk scores for PACE organizations.

Specifically, CMS proposes to calculate blended risk scores for CY 2027 for PACE organizations using the sum of:

- 50 percent of the risk score calculated with the proposed RxHCC model for CY 2027 calibrated using 2018/2019 data and diagnoses from RAPS, encounter data, and FFS claims; and

- 50 percent of the risk score calculated with the proposed RxHCC model for CY 2027 calibrated using 2023/2024 data and diagnoses from encounter data and FFS claims only.

As with the CMS-HCC and ESRD risk adjustment models, CMS intends to fully transition PACE organizations to the RxHCC risk adjustment model used for organizations other than PACE and to calculate risk scores only using diagnoses from encounter data and FFS claims.

F3. Predictive Ratios for the Proposed 2027 RxHCC Model (2023/2024 calibration)

The predictive accuracy of the RxHCC model is measured by how accurately it predicts costs over subgroups of beneficiaries. Because the goal of the risk adjustment model is not to predict the costs of individual beneficiaries, but to predict accurately over subgroups of beneficiaries, we rely on subgroup-level measures of predictive accuracy. Specifically, predictive accuracy in the RxHCC models is measured by the predictive ratio – the ratio of predicted cost to actual cost – for a group of beneficiaries. A predictive ratio of 1.0 means that the model perfectly predicts cost on average for a subgroup of beneficiaries. When evaluating the predictive power of the model, a predictive ratio between 0.90 and 1.10 is generally considered accurate.[81]

Table III-10 shows predictive ratios for the 2023/2024 calibration of the RxHCC model being proposed for CY 2027, which has separate segments for MA-PD plans and PDPs, and for comparison purposes, predictive ratios for a 2023/2024 calibration of the RxHCC model that is not segmented by MA-PD plans and PDPs. Predictive ratios are presented separately for MA-PD plans and PDPs by decile of predicted risk for continuing enrollees. These predictive ratios reflect the ratio of gross plan spending predicted by the model for CY 2024 to the actual gross Part D plan expenditures for that year. Actual expenditure amounts are calculated using the

[80] For payment in CY 2022 (2021 dates of service), we did not use RAPS data to calculate risk scores for non-PACE organizations. See the CY 2022 Advance Notice, Part II, Attachment II, Section N for more details.

[81] Report to Congress: Risk Adjustment in Medicare Advantage. December 2021, p. 42.

remapped PDEs that reflect the CY 2027 Part D benefit structure, and that are described in Section F2 above.

By using separate model segments for MA-PD plans and PDPs, the overall average predictive ratio is 1.0 for Part D overall, and for both MA-PD plans and PDPs within and across the continuing enrollee model segments, as shown below in Table III-10. As discussed above, we found that a model without segmentation by MA-PD plans and PDPs results in a predictive ratio of 1.0 for Part D overall but is 1.066 for MA-PD plans and 0.898 for PDPs across the continuing enrollee segments, tending to overpredict costs for MA-PD plans and underpredict costs for PDPs overall and by decile of predicted risk.

Table III-10: Predictive Ratios by Deciles of Predicted Risk (sorted low to high): Across Continuing Enrollee Model Segments, Medicare Advantage Prescription Drug (MA-PD) Plans vs. Standalone Prescription Drug Plans (PDPs), Proposed 2023/2024 Calibration Sample with Separate MA-PD and PDP Model Segments vs. Single Model Segment for Comparison

Deciles	Proposed Separate Segment 2027 Model MA-PD	Single Segment 2027 Model MA-PD (For Comparison)	Proposed Separate Segment 2027 Model PDP	Single Segment 2027 Model PDP (For Comparison)	Change in Predicted Accuracy MA-PD	Change in Predicted Accuracy PDP
Entire sample	1.000	1.066	1.000	0.898	⬆	⬆
First (lowest) decile	0.521	0.719	0.616	0.502	⇩	⬆
Second decile	1.312	1.504	1.224	1.071	⬆	⇩
Third decile	1.095	1.231	1.433	1.175	⬆	⇩
Fourth decile	1.013	1.131	1.032	0.936	⬆	⬆
Fifth decile	1.008	1.119	1.047	0.920	⬆	⬆
Sixth decile	0.979	1.086	1.004	0.865	⬆	⬆
Seventh decile	0.999	1.093	0.950	0.838	⬆	⬆
Eighth decile	1.023	1.104	0.966	0.842	⬆	⬆
Ninth decile	1.005	1.047	1.006	0.891	⬆	⬆
Tenth (highest)	0.993	1.038	0.997	0.919	⬆	⬆

NOTE: These predictive ratios reflect the ratio of model-predicted costs to actual costs based on deciles (of model-predicted costs) across beneficiaries in all continuing enrollee model segments.

We find that the proposed 2023/2024 RxHCC model improves accuracy overall and for most deciles of predicted risk. Under a 2023/2024 RxHCC model that does not use separate model segments for MA-PD plans and PDPs, we find that MA-PD costs are overpredicted across most deciles while PDP costs are underpredicted. After segmenting the model by MA-PD and PDP we find improvements in predictions for most deciles and accurate predictions (between 0.9 and 1.1) for a majority of deciles.

Section G. Normalization Factors for the RxHCC Models

The RxHCC risk adjustment models, as described in Section F of Attachment III, are calibrated with diagnostic and cost information for beneficiaries enrolled in MA-PD plans and PDPs.

The diagnoses that determine health status for beneficiaries enrolled in MA-PD plans are submitted by MA organizations, whereas diagnoses for beneficiaries enrolled in standalone PDPs are reported on FFS claims. (When we calculate risk scores, we take diagnoses from whichever source reported the diagnoses for the beneficiary in the data collection year. If a beneficiary was enrolled in both an MA-PD plan and a PDP during the year, we use risk adjustment-eligible diagnoses submitted by either or both the MA organization(s) and FFS providers.) The average Part D risk score is 1.0 in the denominator year across beneficiaries enrolled in MA-PD plans and PDPs. When a risk adjustment model predicts expenditures in years other than the denominator year, the average risk score may no longer be 1.0 due to an underlying trend that reflects changes, such as those in coding and population characteristics, between the denominator year and other years. We maintain an average 1.0 risk score across the entire Part D program in the payment year through the normalization factor, which we have done since early in the Part D program.[82] The normalization factor is a projection of the underlying risk score trend to the payment year and is applied by dividing each individual risk score in the payment year by the relevant normalization factor.

Since CY 2025, CMS has used separate normalization factors for MA-PD plans and PDPs given the increased prominence of risk adjustment in Part D payment due to the significant change in plan liability under the IRA redesign of the Part D benefit, and a trend of growing divergence in risk scores between MA-PD plans and PDPs. We observe that MA-PD and PDP risk score trends continue to diverge. We calculated the risk score trend separately for MA-PD plans and PDPs using the proposed 2027 RxHCC model and find that the average PDP risk score decreased by 5.7 percent from 2018 to 2024, while the average MA-PD risk score increased by 16.6 percent over that same time period. Separate normalization factors account for the differential trends we observe and help ensure that risk scores more accurately reflect Part D costs in each of these two sectors of the Part D market in the payment year. As a result, in order to "take into account variation in costs for basic prescription drug coverage among prescription drug plans and MA-PD plans based on the differences in actuarial risk of different enrollees being served," as directed by section 1860D-15(c)(1)(A) of the Act, we will continue calculating separate normalization factors for risk scores used to pay MA-PD plans and PDPs. We must maintain an

[82] See section 1853(a)(1)(C)(ii)(I) of the Act, which requires that the risk adjustment used in MA payment reflects changes in treatment and coding practices in the fee-for-service sector. In establishing the factors used to risk adjust Part D payment, section 1860D-15(c)(1)(B) of the Act permits the Secretary to take into account the similar methodologies used under section 1853(a)(3) to adjust payments to MA organizations for benefits under the original Medicare fee-for-service program option.

average 1.0 risk score across the entire Part D program in the payment year, which we achieve by setting the 1.0 within each market sector.

G1. Proposed Normalization Factors for the 2027 RxHCC Risk Adjustment Model (2023/2024 Calibration)

For CY 2026, as finalized in the CY 2026 Rate Announcement, CMS used average MA-PD and PDP risk scores from 2019 to 2023 and the multiple linear regression method to calculate the normalization factor for the 2022/2023 calibration of the 2026 RxHCC model. The multiple linear regression method was first used for CMS-HCC model normalization factors for CY 2025.

The multiple linear regression methodology includes a flag that identifies whether an average risk score is based on dates of service before or after the onset of the COVID-19 pandemic. For the COVID-19 flag used to calculate the proposed CY 2027 normalization factor, we considered risk scores prior to 2021 (dates of service before 2020) as the "pre-COVID-19" period, and risk scores from 2021 onward (dates of service starting in 2020) as the "post-COVID-19" period. As with the Part C normalization factors, this methodology similarly allows CMS to incorporate the most recent average RxHCC risk scores into the calculation, without excluding any years of risk scores, while making reasonable projections of what the actual average MA-PD and PDP risk scores will be in the payment year.

The multiple linear regression methodology with a COVID-19 indicator allows CMS to take into account the different slopes and risk score levels that exist before and after the onset of COVID-19, capturing the impact of the pandemic on Part D risk scores in our projection without requiring any exclusion of risk scores. The inclusion of a COVID-19 indicator and performing a multiple linear regression will ensure our projections align more closely with the trend observed in the five most recent average risk scores available, which for CY 2027 are average Part D risk scores from 2020 to 2024.

The multiple linear regression equation is:

$$Y = \beta_0 + \beta_1 x_1 + \beta_2 x_2$$

The variables in the multiple linear regression equation for the CY 2027 normalization factor are:

Y = Predicted risk score for a given year (i.e., Normalization Factor)

β_0 = Intercept

β_1 = Regression coefficient for the average annual change in risk scores

x_1 = The specific year to be predicted

β_2 = Regression coefficient for the impact of the COVID-19 pandemic on risk scores

x_2 = COVID-19 flag (0 for years before CY 2021, 1 for CY 2021 and onwards)

Using the historical average risk scores from 2020-2024 and the corresponding flag for years before and after the onset of the COVID-19 pandemic, CMS used multiple linear regression to calculate regression coefficients for β_0 (intercept), β_1 (average annual change in risk scores), and β_2 (impact of the COVID-19 pandemic on risk scores), which are the outputs of the multiple linear regression model. The regression coefficients are model specific and are constants. CMS used the model-specific regression coefficients, rounded to the fourth decimal place, to calculate the CY 2027 normalization factor for the RxHCC risk adjustment model. For an example of how to calculate the normalization factor using the regression coefficients, refer to Section K of the CY 2025 Advance Notice.[83]

The proposed normalization factor for the proposed 2027 RxHCC model (2023/2024 calibration) using the multiple linear regression methodology and average risk scores for MA-PD plans and PDPs from 2020 to 2024 are 1.109 for MA-PD plans and 1.005 for PDPs. CMS's proposal for calculating normalization factors for the 2027 RxHCC model (2023/2024) better reflects the historical MA-PD and PDP risk score trends by incorporating the most recent data and accounting for the impact of the pandemic on the normalization factor projection.

Table III-11 shows the historical average MA-PD and PDP risk scores, and Table III-12 shows the regression coefficients that were used to calculate the proposed CY 2027 normalization factors for the proposed RxHCC model (2023/2024 calibration). We have also included the overall Part D historical risk scores and regression coefficients for informational purposes.

Table III-11. Average Risk Scores for the Proposed 2027 RxHCC Model (2023/2024 Calibration)

Year	Proposed 2027 RxHCC Model (2023/2024) calibration) MA-PD	Proposed 2027 RxHCC Model (2023/2024) calibration) PDP	Proposed 2027 RxHCC Model (2023/2024) calibration) Overall
2020	0.932	1.036	0.987
2021	0.912	0.973	0.942
2022	0.958	0.989	0.972
2023	0.982	0.991	0.986
2024	1.010	0.987	1.000

[83] Refer to the CY 2025 Advance Notice.

Table III-12. Proposed 2027 RxHCC Model (2023/2024 Calibration) Normalization Factor Regression Coefficients

Coefficient	Proposed 2027 RxHCC Model (2023/2024) calibration) MA-PD	Proposed 2027 RxHCC Model (2023/2024) calibration) PDP	Proposed 2027 RxHCC Model (2023/2024) calibration) Overall
Intercept (β_0)	-63.3040	-7.8520	-36.9890
Average Change in FFS Risk Scores (β_1)	0.0318	0.0044	0.0188
COVID-19 Flag (β_2)	-0.0460	-0.0620	-0.0590

G2. Proposed Normalization Factors for the 2027 RxHCC Risk Adjustment Model (2018/2019 Calibration) used for PACE Organizations

The risk score trends used to calculate the normalization factors for the RxHCC models are based on the MA population, and the 2027 RxHCC model (2018/2019) being proposed for PACE organizations is calibrated using diagnoses from RAPS and FFS. CMS fully transitioned to using diagnoses solely from encounter data for CY 2022 payment for organizations other than PACE, so there was no longer a requirement for MA plans to submit data to the RAPS system.[84] For this reason, we must exclude average risk score from 2022 forward from the risk score trend because including them in the normalization factor calculation for the 2027 RxHCC model (2018/2019 calibration) would grossly underestimate what the average Part D risk score is likely to be in CY 2027. Because 2021 risk scores (based on 2020 dates of service) were impacted by decreased utilization during the pandemic, CMS has not included average 2021 risk scores in the calculation of normalization factors using the linear slope methodology. The average 2021 risk score is being used to calculate the proposed normalization factor for the 2027 RxHCC model (2023/2024 calibration) using the multiple linear regression methodology because the particular methodology we are using allows us to take into account pre- and post-pandemic trends. With the average 2021 risk score (based on 2020 dates of service) being the most recent risk score CMS can use to calculate a normalization factor for the 2018/2019 calibration of the 2027 RxHCC model, and being the only risk score available from after the onset of the COVID-19 pandemic, we continue to believe that the multiple linear regression approach is not prudent.

Therefore, for CY 2027, CMS will continue using the historical linear slope methodology to calculate normalization factors for the 2018/2019 calibration of the 2027 RxHCC model being proposed for use solely by PACE organizations, continuing to use average risk scores from 2016 to 2020, as we have done in payment since CY 2023. To calculate the normalization factor using this method, we first calculate the slope from the five-year trend of historical risk scores after

[84] Refer to the CY 2022 Rate Announcement.

which we apply the equation (1+X)^n – where X is the slope, and the exponent, n, is the number of years between the denominator year and the payment year. The 2027 RxHCC model being proposed for PACE organizations has a 2020 denominator and there are seven years of trend between the denominator year and the payment year.

The proposed MA-PD normalization factor using the historical linear slope methodology and historical average risk scores from 2016 to 2020 for the 2027 RxHCC model (2018/2019 calibration) being proposed for PACE organizations is 1.237. We are proposing to use the normalization factor that would be used to calculate risk scores for MA-PD plans under this proposed model for purposes of calculating risk scores for PACE organizations, since they function more similarly to MA-PD plans, compared with PDPs.

Table III-13 shows the historical average MA-PD risk scores for the proposed RxHCC model (2018/2019 calibration) for PACE organizations for CY 2027. We have also included the PDP and overall Part D historical risk scores, for informational purposes. As described previously, normalization factors for the RxHCC model proposed for PACE organizations must exclude average risk scores for 2022 and beyond, in addition to excluding the 2021 risk score due to the impact of the COVID-19 pandemic. This is because CMS fully transitioned to using diagnoses solely from encounter data for CY 2022 payment for organizations other than PACE, so these scores would not be representative of the actual average risk score, but rather a reflection of decreased submission of data to the RAPS system.[85]

Table III-13. Average Risk Scores for the Proposed 2027 RxHCC Model (2018/2019 Calibration)

Year	Proposed 2027 RxHCC Model (2018/2019) calibration) MA-PD	Proposed 2027 RxHCC Model (2018/2019) calibration) PDP	Proposed 2027 RxHCC Model (2018/2019) calibration) Overall
2016	0.921	0.988	0.961
2017	0.943	0.984	0.967
2018	0.978	0.982	0.980
2019	1.014	0.975	0.993
2020	1.040	0.964	1.000

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

For organizations other than PACE, for CY 2027, CMS will continue to calculate Part D risk scores using only risk adjustment-eligible diagnoses from encounter data and FFS claims (refer to Attachment II, Section L).

[85] For more information, see Attachment III, Section H of the CY 2025 Advance Notice.

For PACE organizations, for CY 2027, CMS is proposing to continue to calculate risk scores for PACE participants as a blend of risk scores calculated with two different RxHCC models. This proposal is a continuation of the transition of PACE organizations to the RxHCC risk adjustment model used for organizations other than PACE and to the calculation of risk scores using only diagnoses from encounter data and FFS claims, as discussed in Attachment II, Section G3.

For CY 2027, CMS proposes to calculate risk scores for PACE organizations using the sum of:

- 50 percent of the risk score calculated with the proposed 2018/2019 RxHCC model for CY 2027 using pooled RAPS, encounter data, and FFS claims; and
- 50 percent of the risk score calculated with the proposed 2023/2024 RxHCC model for CY 2027 (the MA-PD model segment) using encounter data and FFS claims.

Like for Part C, we note that the exclusion of diagnoses from unlinked CRRs for risk score calculation does not apply to PACE organizations for CY 2027. As per previous guidance,[86] for the transition to the EDS, PACE organizations should submit an unlinked CRR to report risk adjustment eligible diagnoses from services provided in the PACE center for which a claim is not generated, unless the PACE organization can submit this data on an EDR. Consequently, for the portion of the risk scores that are based on the proposed 2023/2024 RxHCC model, and hence on encounter data submitted by PACE organizations, CMS will continue to use EDRs, linked CRRs, and unlinked CRRs to calculate risk scores applicable to PACE organizations.

Refer to Attachment II, Section L1 above for additional information about sources of diagnoses for PACE risk scores.

[86] See the January 29, 2024, memo titled "PACE Organization Risk Adjustment Submissions to the Encounter Data System" at https://www.cms.gov/about-cms/information-systems/hpms/hpms-memos-archive-weekly/hpms-memos-wk-5-january-29-31.

Attachment IV. 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 Prescription Drug Plans (PDPs or Part D plans), 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 Advance Notice, we provide 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).

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 memo "Information to Review Data Used for Medicare Part C and D Star Ratings and Display Measures." Sponsors should review the data detailed in this memo 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.

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,[87] for all contracts to request a review of their administrative data used for the Part D Patient Safety Star Ratings measures[88] 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.[89] 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 is announcing 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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[87] 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.

[88] 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.

[89] 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 is announcing a deadline of March 31, 2027, for all contracts to request a review of 2026 CTM data for the 2028 Star Ratings. We are announcing this deadline in advance due to the timing of the publication of the Advance Notice and Rate Announcement.
- CMS is announcing 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:[90]

- 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)

As noted in the Announcement of Calendar Year (CY) 2026 Medicare Advantage (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

[90] 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

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. CMS has proposed to remove this measure from the 2028 Star Ratings.[91] 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 IV-1 with information about the measure type, weight, and measurement year.

Table IV-1. 2027 Star Ratings Measures

Part C or D	Measure	Measure Type	Weight	Measurement Year	Improvement Measure	Included in the 2027 CAI Values	Considered for Inclusion in the 2027 EHO4all[92]
C	Breast Cancer Screening	Process Measure	1	1/1/2025 – 12/31/2025	**Yes**	**Yes**	**Yes**
C	Colorectal Cancer Screening	Process Measure	1	1/1/2025 – 12/31/2025	**No**	**No**	**No**

[91] Medicare Program; Contract Year 2027 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 section V.B.1.g.

[92] In the "Medicare Program; Contract Year 2027 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program" proposed rule, CMS proposed removing the Excellent Health Outcomes for All (EHO4all) reward (also known as the Health Equity Index reward) from the Star Ratings beginning with the 2027 Star Ratings and to continue to implement the historical reward factor. If this proposal is finalized, the 2027 Star Ratings will not include the EHO4all reward.

Part C or D	Measure	Measure Type	Weight	Measurement Year	Improvement Measure	Included in the 2027 CAI Values	Considered for Inclusion in the 2027 EHO4all[92]
C	Annual Flu Vaccine	Process Measure	1	3/2026 – 6/2026	**Yes**	**Yes**	**Yes**
C	Improving or Maintaining Physical Health	Outcome Measure	3	7/2025 – 11/2025	**No**	**No**	**Yes**
C	Improving or Maintaining Mental Health	Outcome Measure	3	7/2025 – 11/2025	**No**	**No**	**Yes**
C	Monitoring Physical Activity	Process Measure	1	7/2025 – 11/2025	**Yes**	**Yes**	**Yes**
C	Special Needs Plan (SNP) Care Management	Process Measure	1	1/1/2025 – 12/31/2025	**Yes**	**No**	**No**
C	Care for Older Adults – Medication Review	Process Measure	1	1/1/2025 – 12/31/2025	**Yes**	**No**	**No**
C	Care for Older Adults – Functional Status Assessment	Process Measure	1	1/1/2025 – 12/31/2025	**No**	**No**	**No**
C	Osteoporosis Management in Women who had a Fracture	Process Measure	1	1/1/2025 – 12/31/2025	**Yes**	**Yes**	**Yes**
C	Diabetes Care – Eye Exam	Process Measure	1	1/1/2025 – 12/31/2025	**Yes**	**Yes**	**Yes**
C	Diabetes Care – Blood Sugar Controlled	Intermediate Outcome Measure	3	1/1/2025 – 12/31/2025	**Yes**	**Yes**	**Yes**
C	Kidney Health Evaluation for Patients with Diabetes	Process Measure	1	1/1/2025 – 12/31/2025	**Yes**	**Yes**	**Yes**
C	Controlling Blood Pressure	Intermediate Outcome Measure	3	1/1/2025 – 12/31/2025	**Yes**	**Yes**	**Yes**
C	Reducing the Risk of Falling	Process Measure	1	7/2025 – 11/2025	**Yes**	**Yes**	**Yes**
C	Improving Bladder Control	Process Measure	1	7/2025 – 11/2025	**Yes**	**Yes**	**Yes**
C	Plan All-Cause Readmissions	Outcome Measure	3	1/1/2025 – 12/31/2025	**Yes**	**Yes**	**Yes**

Part C or D	Measure	Measure Type	Weight	Measurement Year	Improvement Measure	Included in the 2027 CAI Values	Considered for Inclusion in the 2027 EHO4all[92]
C	Statin Therapy for Patients with Cardiovascular Disease	Process Measure	1	1/1/2025 – 12/31/2025	**Yes**	**Yes**	**Yes**
C	Transitions of Care	Process Measure	1	1/1/2025 – 12/31/2025	**Yes**	**Yes**	**Yes**
C	Follow-up after Emergency Room Visit	Process Measure	1	1/1/2025 – 12/31/2025	**Yes**	**Yes**	**Yes**
C	Getting Needed Care	Patients' Experience and Complaints Measure	2	3/2026 – 6/2026	**Yes**	**No**	**Yes**
C	Getting Appointments and Care Quickly	Patients' Experience and Complaints Measure	2	3/2026 – 6/2026	**Yes**	**No**	**Yes**
C	Customer Service	Patients' Experience and Complaints Measure	2	3/2026 – 6/2026	**Yes**	**No**	**Yes**
C	Rating of Health Care Quality	Patients' Experience and Complaints Measure	2	3/2026 – 6/2026	**Yes**	**No**	**Yes**
C	Rating of Health Plan	Patients' Experience and Complaints Measure	2	3/2026 – 6/2026	**Yes**	**No**	**Yes**
C	Care Coordination	Patients' Experience and Complaints Measure	2	3/2026 – 6/2026	**Yes**	**No**	**Yes**
C	Complaints about the Health Plan	Patients' Experience and Complaints Measure	2	1/1/2025 – 12/31/2025	**Yes**	**No**	**No**
C	Members Choosing to Leave the Plan	Patients' Experience and Complaints Measure	2	1/1/2025 – 12/31/2025	**Yes**	**No**	**No**

Part C or D	Measure	Measure Type	Weight	Measurement Year	Improvement Measure	Included in the 2027 CAI Values	Considered for Inclusion in the 2027 EHO4all[92]
C	Health Plan Quality Improvement	Improvement Measure	5	NA	**No**	No	**No**
C	Plan Makes Timely Decisions about Appeals	Measures Capturing Access	2	1/1/2025 – 12/31/2025	**Yes**	**No**	**No**
C	Reviewing Appeals Decisions	Measures Capturing Access	2	1/1/2025 – 12/31/2025	**Yes**	**No**	**No**
C	Call Center – Foreign Language Interpreter and TTY Availability	Measures Capturing Access	2	2/2026 – 5/2026	**Yes**	**No**	**No**
D	Call Center – Foreign Language Interpreter and TTY Availability	Measures Capturing Access	2	2/2026 – 5/2026	**Yes**	**No**	**No**
D	Complaints about the Drug Plan	Patients' Experience and Complaints Measure	2	1/1/2025 – 12/31/2025	**Yes**	**No**	**No**
D	Members Choosing to Leave the Plan	Patients' Experience and Complaints Measure	2	1/1/2025 – 12/31/2025	**Yes**	**No**	**No**
D	Drug Plan Quality Improvement	Improvement Measure	5	NA	**No**	**No**	**No**
D	Rating of Drug Plan	Patients' Experience and Complaints Measure	2	3/2026 – 6/2026	**Yes**	**No**	**Yes**
D	Getting Needed Prescription Drugs	Patients' Experience and Complaints Measure	2	3/2026 – 6/2026	**Yes**	**No**	**Yes**
D	MPF Price Accuracy	Process Measure	1	1/1/2025 – 9/30/2025	**Yes**	**No**	**No**
D	Medication Adherence for Diabetes Medications	Intermediate Outcome Measure	3	1/1/2025 – 12/31/2025	**Yes**	**Yes**	**Yes**

Part C or D	Measure	Measure Type	Weight	Measurement Year	Improvement Measure	Included in the 2027 CAI Values	Considered for Inclusion in the 2027 EHO4all[92]
D	Medication Adherence for Hypertension (RAS antagonists)	Intermediate Outcome Measure	3	1/1/2025 – 12/31/2025	**Yes**	**Yes**	**Yes**
D	Medication Adherence for Cholesterol (Statins)	Intermediate Outcome Measure	3	1/1/2025 – 12/31/2025	**Yes**	**Yes**	**Yes**
D	Statin Use in Persons with Diabetes	Process Measure	1	1/1/2025 – 12/31/2025	**Yes**	**Yes**	**Yes**
D	Concurrent Use of Opioids and Benzodiazepines (COB)	Process Measure	1	1/1/2025 – 12/31/2025	**No**	**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**	**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 IV-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 IV-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 IV-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 IV-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 IV-3 lists the states and territories with Individual Assistance designations from the FEMA major disaster declarations.

Table IV-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.

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.

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.

Statin Use in Persons with Diabetes (SUPD) (Part D). The PQA updated the SUPD measure specifications in the draft 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 claim 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[93] 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 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 claim for a statin medication and with one or more prescription claim for either bempedoic acid or one or more prescription claim 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 claim 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).

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

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 would be 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).

Polypharmacy: Use of Multiple Anticholinergic Medications in Older Adults (Poly-ACH) (Part D). The PQA added clarity in the 2026 draft 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).

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 are soliciting feedback on new measures or measurement concepts that would incentivize plans from providing unnecessary, inappropriate, or low-value care. 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.

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 solicit 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.

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.

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.

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.

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).

Use of Opioids at High Dosage in Persons without Cancer (OHD) (Part D). The PQA updated the OHD measure specifications in the draft 2026 PQA Measure Manual to revise the methodology for daily morphine milligram equivalent (MME) calculation. 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 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.[94]

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.

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).

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.

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

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

(worsening), while the APD-LNTH 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.

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.

Attachment V. Economic Information for the CY 2027 Advance Notice

Below, we provide the economic information for significant provisions in the Advance Notice. 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. We note that the information provided below is likely to change as the rates and underlying assumptions are updated; we will provide revised impact estimates in the Rate Announcement that reflect the payment methodologies being finalized and the latest data available.

Section A. Changes in the Payment Methodology for Medicare Advantage 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 5.10 percent, and the MA growth percentage for the 2027 MA non-ESRD rates is estimated to be 4.04 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 $22.86 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 4.04 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 $140 million. This figure accounts for the portion of the program costs covered by Part B premiums.

If we continue the adjustment to the calculation of county benchmarks in Puerto Rico for the number of beneficiaries with zero claims, then 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 6.17 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 $2.14 billion. This figure accounts for the portion of the program costs covered by Part B premiums.

A3. CMS-HCC Risk Adjustment Model

For CY 2027, CMS is proposing to calculate risk scores for MA organizations entirely with the 2027 CMS-HCC model. The CY 2027 impact on MA risk scores, relative to CY 2026, is projected to be –3.32 percent, which represents a $15.22 billion net savings to the Medicare Trust Funds in CY 2027. The 2024 CMS-HCC model (2020 denominator) and the 2027 CMS-HCC model (2024 denominator) have different denominator years (i.e., number of years of risk score trend). Therefore, the risk score impact is normalized to account for the offsetting impact of the FFS risk score trend. The CY 2027 impact on MA risk scores, relative to CY 2026, of excluding diagnoses from unlinked CRR is projected to be –1.53 percent, which represents a $7.12 billion net savings to the Medicare Trust Funds in CY 2027. When estimating the impact of the proposed 2027 CMS-HCC model and unlinked CRR diagnoses exclusion, 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 proposing to calculate frailty scores for FIDE SNPs using updated frailty factors associated with the proposed 2027 CMS-HCC model. To calculate impacts, CMS utilized the survey results from the 2024 HOS / HOS-M to estimate the frailty scores based on the frailty factors used for CY 2026 (associated with the 2024 CMS-HCC model) and the proposed CY 2027 frailty factors (associated with the proposed 2027 CMS-HCC model). The CY 2027 impact of transitioning to frailty scores calculated using the updated frailty factors, relative to CY 2026, is a change in frailty scores of 4.89% which represents a net impact of $30 million to the Medicare Trust Funds in 2027. This 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.

A6. MA Coding Pattern Difference Adjustment

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

A7. Part C Normalization

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 proposing to calculate the normalization factors using a five-year multiple linear regression methodology and average historical FFS risk scores from 2021-2025. Since normalization is applied to risk scores to maintain the same average risk score year-over-year, the impact of normalization is zero.

Section B. Changes in the Payment Methodology for Medicare Part D for CY 2027

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 Funds is uncertain 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 proposing to implement RxHCC risk adjustment models with updates that include revisions to reflect the statutory changes in the Part D benefit structure for CY 2027. 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, for the RxHCC models, CMS is proposing to calculate normalization factors using the multiple linear regression methodology and average historical risk scores from 2020 through 2024 for the model being proposed for MA (and partially for PACE organizations), and using the historical linear slope methodology and average historical risk scores from 2016 through 2020 for the model proposed for PACE organizations. 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 VI. CMS-HCC and RxHCC Risk Adjustment Factor Tables

CMS-HCC Risk Adjustment Factor Tables

Table VI-1. 2027 CMS-HCC Model Relative Factors for Continuing Enrollees

Variable	Description Label	Community, NonDual, Aged	Community, NonDual, Disabled	Community, FBDual, Aged	Community, FBDual, Disabled	Community, PBDual, Aged	Community, PBDual, Disabled	Institutional
Female								
0-34 Years		-	0.189	-	0.297	-	0.428	0.706
35-44 Years		-	0.249	-	0.300	-	0.368	0.740
45-54 Years		-	0.311	-	0.357	-	0.377	0.842
55-59 Years		-	0.361	-	0.394	-	0.386	0.840
60-64 Years		-	0.416	-	0.453	-	0.401	0.727
65-69 Years		0.318	-	0.382	-	0.315	-	1.166
70-74 Years		0.378	-	0.507	-	0.368	-	1.081
75-79 Years		0.449	-	0.558	-	0.439	-	0.985
80-84 Years		0.506	-	0.648	-	0.485	-	0.845
85-89 Years		0.581	-	0.706	-	0.588	-	0.761
90-94 Years		0.682	-	0.820	-	0.621	-	0.602
95 Years or Over		0.693	-	0.894	-	0.734	-	0.416
Male								
0-34 Years		-	0.107	-	0.134	-	0.270	0.450
35-44 Years		-	0.103	-	0.239	-	0.215	0.931
45-54 Years		-	0.158	-	0.243	-	0.216	0.839
55-59 Years		-	0.235	-	0.353	-	0.286	0.854
60-64 Years		-	0.306	-	0.454	-	0.304	0.761
65-69 Years		0.339	-	0.465	-	0.344	-	1.223
70-74 Years		0.395	-	0.594	-	0.424	-	1.234
75-79 Years		0.463	-	0.718	-	0.460	-	1.109
80-84 Years		0.557	-	0.795	-	0.470	-	1.178
85-89 Years		0.637	-	0.839	-	0.541	-	1.127
90-94 Years		0.729	-	0.928	-	0.541	-	0.961
95 Years or Over		0.819	-	1.040	-	0.526	-	0.742
Medicaid and Originally Disabled Interactions								
Originally Disabled Female		0.213	-	0.142	-	0.124	-	-
Originally Disabled Male		0.099	-	0.121	-	0.077	-	-
Medicaid		-	-	-	-	-	-	0.300
Disease Coefficients								
HCC1	HIV/AIDS	0.297	0.211	0.307	0.145	0.274	0.143	0.549

Variable	Description Label	Community, NonDual, Aged	Community, NonDual, Disabled	Community, FBDual, Aged	Community, FBDual, Disabled	Community, PBDual, Aged	Community, PBDual, Disabled	Institutional
HCC2	Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock	0.578	0.807	0.889	0.993	0.503	0.696	0.814
HCC6	Opportunistic Infections	0.351	1.028	0.614	0.792	0.294	0.719	0.812
HCC17	Cancer Metastatic to Lung, Liver, Brain, and Other Organs; Acute Myeloid Leukemia Except Promyelocytic	4.045	3.709	3.982	4.069	3.932	3.877	1.998
HCC18	Cancer Metastatic to Bone, Other and Unspecified Metastatic Cancer; Acute Leukemia Except Myeloid	2.476	2.629	2.602	2.717	2.339	2.468	1.555
HCC19	Myelodysplastic Syndromes, Multiple Myeloma, and Other Cancers	2.476	2.629	2.336	2.384	2.219	1.933	1.293
HCC20	Lung and Other Severe Cancers	1.084	0.969	1.247	1.053	1.175	0.980	0.676
HCC21	Lymphoma and Other Cancers	0.559	0.554	0.565	0.522	0.583	0.598	0.554
HCC22	Bladder, Colorectal, and Other Cancers	0.407	0.397	0.450	0.488	0.400	0.250	0.356
HCC23	Prostate, Breast, and Other Cancers and Tumors	0.184	0.202	0.206	0.173	0.201	0.136	0.284
HCC35	Pancreas Transplant Status	0.212	-	0.151	0.398	0.151	0.151	0.120
HCC36	Diabetes with Severe Acute Complications	0.155	0.183	0.211	0.213	0.173	0.172	0.343
HCC37	Diabetes with Chronic Complications	0.155	0.183	0.211	0.213	0.173	0.172	0.343
HCC38	Diabetes with No, Glycemic, or Unspecified Complications	0.155	0.183	0.211	0.213	0.173	0.172	0.343
HCC48	Morbid Obesity	0.150	0.131	0.268	0.142	0.109	0.062	0.402
HCC49	Specified Lysosomal Storage Disorders	8.522	12.801	3.335	6.155	8.440	12.553	4.626
HCC50	Amyloidosis, Porphyria, and Other Specified Metabolic Disorders	0.778	0.943	0.594	0.872	0.783	0.959	0.203

Variable	Description Label	Community, NonDual, Aged	Community, NonDual, Disabled	Community, FBDual, Aged	Community, FBDual, Disabled	Community, PBDual, Aged	Community, PBDual, Disabled	Institutional
HCC51	Addison's and Cushing's Diseases, Acromegaly, and Other Specified Endocrine Disorders	0.492	0.493	0.543	0.876	0.445	1.687	1.030
HCC62	Liver Transplant Status/Complications	0.279	0.078	0.261	0.401	0.221	0.256	0.787
HCC63	Chronic Liver Failure/End-Stage Liver Disorders	0.910	0.897	1.284	1.293	1.028	0.927	0.915
HCC64	Cirrhosis of Liver	0.424	0.284	0.456	0.601	0.354	0.142	0.458
HCC65	Chronic Hepatitis	0.124	0.284	0.023	0.601	0.257	0.047	0.458
HCC68	Cholangitis and Obstruction of Bile Duct Without Gallstones	0.424	0.284	0.358	0.381	0.354	0.142	-
HCC77	Intestine Transplant Status/Complications	1.594	5.858	2.897	1.767	2.897	2.897	2.893
HCC78	Intestinal Obstruction/Perforation	0.312	0.445	0.411	0.492	0.306	0.596	0.418
HCC79	Chronic Pancreatitis	0.274	0.438	0.494	0.647	0.327	0.696	0.532
HCC80	Crohn's Disease (Regional Enteritis)	0.472	0.427	0.424	0.595	0.425	0.462	0.242
HCC81	Ulcerative Colitis	0.233	0.261	0.212	0.595	0.196	0.056	0.242
HCC92	Bone/Joint/Muscle/Severe Soft Tissue Infections/Necrosis	0.494	0.375	0.774	1.052	0.460	0.899	0.572
HCC93	Rheumatoid Arthritis and Other Specified Inflammatory Rheumatic Disorders	0.510	0.415	0.365	0.333	0.371	0.207	0.264
HCC94	Systemic Lupus Erythematosus and Other Specified Systemic Connective Tissue Disorders	0.256	0.397	0.111	0.303	0.134	0.182	0.264
HCC107	Sickle Cell Anemia (Hb-SS) and Thalassemia Beta Zero	0.259	1.796	1.343	2.409	0.092	2.376	0.414
HCC108	Sickle Cell Disorders, Except Sickle Cell Anemia (Hb-SS) and Thalassemia Beta Zero; Beta Thalassemia Major	0.225	1.110	0.152	0.463	-	0.268	0.414

Variable	Description Label	Community, NonDual, Aged	Community, NonDual, Disabled	Community, FBDual, Aged	Community, FBDual, Disabled	Community, PBDual, Aged	Community, PBDual, Disabled	Institutional
HCC109	Acquired Hemolytic, Aplastic, and Sideroblastic Anemias	1.145	2.001	1.274	1.682	1.125	1.518	0.683
HCC111	Hemophilia, Male	6.547	28.318	18.843	51.820	12.333	47.620	3.779
HCC112	Immune Thrombocytopenia and Specified Coagulation Defects and Hemorrhagic Conditions	0.402	0.614	0.532	0.758	0.479	0.464	0.277
HCC114	Common Variable and Combined Immunodeficiencies	2.608	3.349	2.479	3.075	2.182	2.644	1.239
HCC115	Specified Immunodeficiencies and White Blood Cell Disorders	0.506	0.908	0.528	0.680	0.442	0.715	0.657
HCC125	Dementia, Severe	0.345	0.182	0.440	0.289	0.399	0.224	-
HCC126	Dementia, Moderate	0.345	0.182	0.440	0.289	0.399	0.224	-
HCC127	Dementia, Mild or Unspecified	0.345	0.182	0.440	0.289	0.399	0.224	-
HCC135	Drug Use with Psychotic Complications	0.321	0.727	0.626	1.139	0.676	0.986	0.217
HCC136	Alcohol Use with Psychotic Complications	0.321	0.536	0.557	0.960	0.676	0.792	0.215
HCC137	Drug Use Disorder, Moderate/Severe, or Drug Use with Non-Psychotic Complications	0.321	0.319	0.557	0.501	0.348	0.347	0.215
HCC138	Drug Use Disorder, Mild, Uncomplicated, Except Cannabis	0.226	0.211	0.557	0.469	0.348	0.251	0.215
HCC139	Alcohol Use Disorder, Moderate/Severe, or Alcohol Use with Specified Non-Psychotic Complications	0.176	0.116	0.333	0.152	0.217	0.113	-
HCC151	Schizophrenia	0.466	0.311	0.608	0.398	0.447	0.326	0.585
HCC152	Psychosis, Except Schizophrenia	0.466	0.284	0.608	0.268	0.447	0.243	0.235
HCC153	Personality Disorders; Anorexia/Bulimia Nervosa	0.417	0.284	0.339	0.268	0.438	0.104	0.235

Variable	Description Label	Community, NonDual, Aged	Community, NonDual, Disabled	Community, FBDual, Aged	Community, FBDual, Disabled	Community, PBDual, Aged	Community, PBDual, Disabled	Institutional
HCC154	Bipolar Disorders without Psychosis	0.347	0.162	0.333	0.101	0.322	0.081	0.106
HCC155	Major Depression, Moderate or Severe, without Psychosis	0.258	0.162	0.309	0.101	0.179	0.081	0.090
HCC180	Quadriplegia	1.449	1.120	1.877	1.262	1.634	1.900	1.097
HCC181	Paraplegia	1.105	0.747	1.331	1.262	1.293	0.811	1.074
HCC182	Spinal Cord Disorders/Injuries	0.473	0.343	0.509	0.359	0.511	0.168	0.314
HCC190	Amyotrophic Lateral Sclerosis and Other Motor Neuron Disease, Spinal Muscular Atrophy	0.876	1.556	1.711	2.786	0.660	0.835	1.226
HCC191	Quadriplegic Cerebral Palsy	1.844	0.528	0.129	0.415	0.571	0.963	0.338
HCC192	Cerebral Palsy, Except Quadriplegic	0.385	0.168	-	0.090	0.173	0.006	-
HCC193	Chronic Inflammatory Demyelinating Polyneuritis and Multifocal Motor Neuropathy	2.131	2.202	1.407	2.302	1.260	1.126	0.015
HCC195	Myasthenia Gravis with (Acute) Exacerbation	5.987	6.503	3.366	6.765	1.841	4.056	1.612
HCC196	Myasthenia Gravis without (Acute) Exacerbation and Other Myoneural Disorders	1.150	1.015	0.682	0.521	1.116	0.970	0.286
HCC197	Muscular Dystrophy	0.330	0.422	0.358	0.479	-	0.165	0.253
HCC198	Multiple Sclerosis	0.659	1.033	0.703	1.321	0.569	0.907	0.368
HCC199	Parkinson and Other Degenerative Disease of Basal Ganglia	0.595	0.498	0.691	0.694	0.572	0.394	0.181
HCC200	Friedreich and Other Hereditary Ataxias; Huntington Disease	0.234	0.224	0.134	0.143	0.194	0.142	0.015
HCC201	Seizure Disorders and Convulsions	0.218	0.163	0.259	0.112	0.229	0.229	0.081
HCC202	Coma, Brain Compression/Anoxic Damage	0.564	0.349	0.635	0.185	1.028	0.537	0.133

Variable	Description Label	Community, NonDual, Aged	Community, NonDual, Disabled	Community, FBDual, Aged	Community, FBDual, Disabled	Community, PBDual, Aged	Community, PBDual, Disabled	Institutional
HCC211	Respirator Dependence/Tracheostomy Status/Complications	0.816	0.963	2.570	1.509	1.091	0.621	1.983
HCC212	Respiratory Arrest	0.422	0.645	0.570	0.586	0.467	0.587	0.263
HCC213	Cardio-Respiratory Failure and Shock	0.422	0.645	0.570	0.586	0.467	0.587	0.263
HCC221	Heart Transplant Status/Complications	1.116	1.459	1.745	1.959	1.038	1.363	0.531
HCC222	End Stage Heart Failure	1.791	3.425	1.536	5.355	2.081	4.032	0.262
HCC223	Heart Assist Device/Artificial Heart	1.791	3.425	1.536	5.355	2.081	4.032	0.262
HCC224	Acute on Chronic Heart Failure	0.321	0.371	0.392	0.574	0.290	0.551	0.195
HCC225	Acute Heart Failure (Excludes Acute on Chronic)	0.321	0.371	0.392	0.574	0.290	0.551	0.195
HCC226	Heart Failure, Except End Stage and Acute	0.321	0.371	0.392	0.574	0.290	0.551	0.195
HCC227	Cardiomyopathy/Myocarditis	0.154	0.238	0.192	0.089	0.138	0.075	0.195
HCC228	Acute Myocardial Infarction	0.239	0.307	0.603	0.301	0.405	0.268	0.372
HCC229	Unstable Angina and Other Acute Ischemic Heart Disease	0.219	0.307	0.307	0.233	0.237	0.087	0.372
HCC238	Specified Heart Arrhythmias	0.308	0.276	0.374	0.305	0.310	0.250	0.211
HCC248	Intracranial Hemorrhage	0.242	0.325	0.447	0.425	0.231	0.234	0.119
HCC249	Ischemic or Unspecified Stroke	0.242	0.184	0.400	0.366	0.231	0.234	0.119
HCC253	Hemiplegia/Hemiparesis	0.354	0.278	0.420	0.229	0.528	0.283	-
HCC254	Monoplegia, Other Paralytic Syndromes	0.244	0.122	0.372	0.229	0.006	-	-
HCC263	Atherosclerosis of Arteries of the Extremities with Ulceration or Gangrene	1.246	1.186	1.678	1.310	1.106	1.626	1.245
HCC264	Vascular Disease with Complications	0.467	0.402	0.755	0.536	0.383	0.362	1.232
HCC267	Deep Vein Thrombosis and Pulmonary Embolism	0.305	0.482	0.506	0.811	0.353	0.649	0.340
HCC276	Lung Transplant Status/Complications	2.364	1.562	3.304	2.809	3.841	1.311	0.731
HCC277	Cystic Fibrosis	0.878	1.221	0.945	1.385	2.568	1.705	1.120

Variable	Description Label	Community, NonDual, Aged	Community, NonDual, Disabled	Community, FBDual, Aged	Community, FBDual, Disabled	Community, PBDual, Aged	Community, PBDual, Disabled	Institutional
HCC278	Idiopathic Pulmonary Fibrosis and Lung Involvement in Systemic Sclerosis	0.854	0.918	0.746	1.317	0.651	0.948	1.120
HCC279	Severe Persistent Asthma	0.854	0.705	0.586	0.644	0.651	0.606	1.120
HCC280	Chronic Obstructive Pulmonary Disease, Interstitial Lung Disorders, and Other Chronic Lung Disorders	0.259	0.122	0.318	0.265	0.263	0.169	0.292
HCC282	Aspiration and Specified Bacterial Pneumonias	0.458	0.467	0.604	0.182	0.548	0.052	0.552
HCC283	Empyema, Lung Abscess	0.087	0.122	0.143	-	-	-	-
HCC298	Severe Diabetic Eye Disease, Retinal Vein Occlusion, and Vitreous Hemorrhage	0.338	0.339	0.328	0.416	0.317	0.357	0.441
HCC300	Exudative Macular Degeneration	0.627	0.350	0.458	0.274	0.448	0.520	0.161
HCC326	Chronic Kidney Disease, Stage 5	0.881	1.326	1.233	1.395	1.438	1.353	1.092
HCC327	Chronic Kidney Disease, Severe (Stage 4)	0.489	0.498	0.614	0.441	0.443	0.481	0.469
HCC328	Chronic Kidney Disease, Moderate (Stage 3B)	0.188	0.269	0.130	0.206	0.150	0.309	0.160
HCC329	Chronic Kidney Disease, Moderate (Stage 3, Except 3B)	0.063	0.090	0.051	0.111	0.044	0.018	0.041
HCC379	Pressure Ulcer of Skin with Necrosis Through to Muscle, Tendon, or Bone	3.485	5.328	5.555	6.215	5.693	3.804	2.810
HCC380	Chronic Ulcer of Skin, Except Pressure, Through to Bone or Muscle	1.547	2.213	2.533	2.163	1.726	1.973	1.772
HCC381	Pressure Ulcer of Skin with Full Thickness Skin Loss	1.437	1.798	2.166	1.705	1.636	1.973	0.558
HCC382	Pressure Ulcer of Skin with Partial Thickness Skin Loss	0.963	1.137	1.263	1.062	1.066	1.409	0.460
HCC383	Chronic Ulcer of Skin, Except Pressure, Not	0.798	0.830	1.263	0.790	1.030	0.920	0.460

Variable	Description Label	Community, NonDual, Aged	Community, NonDual, Disabled	Community, FBDual, Aged	Community, FBDual, Disabled	Community, PBDual, Aged	Community, PBDual, Disabled	Institutional
	Specified as Through to Bone or Muscle							
HCC385	Severe Skin Burn	2.031	0.709	4.570	2.367	2.110	1.401	3.399
HCC387	Pemphigus, Pemphigoid, and Other Specified Autoimmune Skin Disorders	0.393	0.411	0.652	0.087	1.963	0.158	1.203
HCC397	Major Head Injury with Loss of Consciousness > 1 Hour	0.186	0.164	0.258	0.230	0.077	0.206	0.006
HCC398	Major Head Injury with Loss of Consciousness < 1 Hour or Unspecified	0.186	0.164	0.258	0.230	0.077	0.206	0.006
HCC399	Major Head Injury without Loss of Consciousness	0.186	0.164	0.258	0.230	0.077	0.206	0.006
HCC401	Vertebral Fractures without Spinal Cord Injury	0.535	0.591	0.622	0.754	0.496	0.472	0.229
HCC402	Hip Fracture/Dislocation	0.455	0.873	0.655	0.397	0.406	1.174	0.066
HCC405	Traumatic Amputations and Complications	0.592	0.531	0.621	0.573	0.760	1.221	0.256
HCC409	Amputation Status, Lower Limb/Amputation Complications	0.561	0.531	0.621	0.573	0.760	0.391	0.256
HCC454	Stem Cell, Including Bone Marrow, Transplant Status/Complications	1.276	0.703	1.970	0.607	0.557	0.496	1.383
HCC463	Artificial Openings for Feeding or Elimination	0.747	0.939	1.112	1.032	0.673	1.164	0.793
Disease Interactions								
DIABETES_HF	Diabetes*Heart Failure	0.079	0.078	0.167	-	0.090	-	0.182
HF_CHR_LUNG	Heart Failure*Chronic Lung Disorder	0.039	0.006	0.149	0.061	0.099	-	0.147
HF_KIDNEY	Heart Failure*Kidney	0.082	0.151	0.066	0.203	0.143	0.100	-
CHR_LUNG_CARD_RESP_FAIL	Chronic Lung Disorder*Cardiorespiratory Failure	0.179	-	0.326	0.210	0.209	0.200	0.386
HF_HCC238	Heart Failure*Specified Heart Arrhythmias	0.056	0.258	0.093	0.257	0.082	0.069	-
gSubUseDisorder_gPsych	Substance Use Disorder*Psychiatric	-	0.048	-	0.115	-	0.123	-
Disabled/Disease Interactions								

Variable	Description Label	Community, NonDual, Aged	Community, NonDual, Disabled	Community, FBDual, Aged	Community, FBDual, Disabled	Community, PBDual, Aged	Community, PBDual, Disabled	Institutional
DISABLED_ HF	Disabled, Heart Failure	-	-	-	-	-	-	0.301
DISABLED_ ULCER	Disabled, Skin Ulcer	-	-	-	-	-	-	0.929
DISABLED_ CANCER	Disabled, Cancer	-	-	-	-	-	-	0.182
DISABLED_ NEURO	Disabled, Neurological	-	-	-	-	-	-	0.065
DISABLED_ CHR_LUNG	Disabled, Chronic Lung Disorder	-	-	-	-	-	-	0.405
Payment HCC Counts								
D1	1 payment HCC	-	-	-	-	-	-	-
D2	2 payment HCCs	-	-	-	-	-	-	-
D3	3 payment HCCs	-	-	-	-	-	-	-
D4	4 payment HCCs	-	-	-	-	-	-	-
D5	5 payment HCCs	0.016	0.016	-	0.065	-	0.139	-
D6	6 payment HCCs	0.069	0.130	-	0.065	-	0.145	-
D7	7 payment HCCs	0.147	0.288	0.064	0.386	0.103	0.195	-
D8	8 payment HCCs	0.247	0.484	0.127	0.497	0.208	0.454	0.002
D9	9 payment HCCs	0.369	0.484	0.174	1.068	0.468	0.939	0.081
D10P	10 or more payment HCCs	0.648	1.291	0.751	1.663	1.288	1.515	0.412

NOTES:

1. The denominator used is $12,861.67.
2. In the "disease interactions" and "disabled interactions," the variables are defined as follows:
   Cancer = HCCs 17-23
   Cardiorespiratory Failure = HCCs 211-213
   Chronic Lung Disorder = HCCs 276-280
   Diabetes = HCCs 35-38
   Heart Failure = HCCs 221-226
   Kidney = HCCs 326-329
   Neurological = HCCs 180-192, 195, 196, 198, 199
   Psychiatric = HCCs 151-155
   Skin Ulcer = HCCs 379-382
   Specified Heart Arrhythmias = HCC 238
   Substance Use = HCCs 135-139

SOURCE: 2023-2024 100% Medicare data.

Table VI-2. 2027 CMS-HCC Model Relative Factors for Aged and Disabled New Enrollees

Variable	Non-Medicaid & Non-Originally Disabled	Medicaid & Non-Originally Disabled	Non-Medicaid & Originally Disabled	Medicaid & Originally Disabled
Female				
0-34 Years	0.762	1.003	-	-
35-44 Years	1.115	1.548	-	-
45-54 Years	1.243	1.677	-	-
55-59 Years	1.233	1.476	-	-
60-64 Years	1.292	1.573	-	-
65 Years	0.524	0.907	1.292	1.742
66 Years	0.542	0.937	1.139	2.090
67 Years	0.573	0.960	1.139	2.090
68 Years	0.604	0.960	1.139	2.090
69 Years	0.629	1.074	1.139	2.090
70-74 Years	0.714	1.153	1.292	2.090
75-79 Years	0.934	1.162	1.292	2.090
80-84 Years	1.097	1.336	1.292	2.090
85-89 Years	1.342	1.538	1.342	2.090
90-94 Years	1.342	1.822	1.342	2.090
95 Years or Over	1.342	1.822	1.342	2.090
Male				
0-34 Years	0.505	0.754	-	-
35-44 Years	0.751	1.201	-	-
45-54 Years	1.102	1.586	-	-
55-59 Years	1.026	1.648	-	-
60-64 Years	1.064	1.619	-	-
65 Years	0.565	1.113	1.064	1.744
66 Years	0.599	1.126	1.311	1.905
67 Years	0.643	1.126	1.311	1.905
68 Years	0.700	1.341	1.311	1.905
69 Years	0.714	1.341	1.311	1.905
70-74 Years	0.851	1.462	1.497	2.134
75-79 Years	1.103	1.680	1.497	2.134
80-84 Years	1.327	1.680	1.497	2.134
85-89 Years	1.568	1.822	1.568	2.134
90-94 Years	1.568	1.822	1.568	2.134
95 Years or Over	1.568	1.822	1.568	2.134

NOTES:

1. The denominator used is $12,861.67.
2. For payment purposes, a new enrollee is a beneficiary who did not have 12 months of Part B eligibility in the data collection year. CMS-HCC new enrollee models are not based on diagnoses, but include factors for different age and sex combinations by Medicaid and the original reason for Medicare entitlement.

SOURCE: 2023-2024 100% Medicare data.

Table VI-3. 2027 CMS-HCC Model Relative Factors for New Enrollees in Chronic Condition Special Needs Plans (C-SNPs)

Variable	Non-Medicaid & Non-Originally Disabled	Medicaid & Non-Originally Disabled	Non-Medicaid & Originally Disabled	Medicaid & Originally Disabled
Female				
0-34 Years	1.562	1.843	-	-
35-44 Years	1.562	1.843	-	-
45-54 Years	1.693	2.008	-	-
55-59 Years	1.693	2.008	-	-
60-64 Years	1.693	2.021	-	-
65 Years	0.930	1.195	1.707	2.060
66 Years	0.930	1.195	1.740	1.993
67 Years	0.962	1.228	1.743	2.037
68 Years	0.988	1.267	1.743	2.037
69 Years	1.036	1.285	1.761	2.093
70-74 Years	1.166	1.478	1.852	2.240
75-79 Years	1.402	1.734	2.023	2.443
80-84 Years	1.605	1.974	2.153	2.636
85-89 Years	1.793	2.199	2.303	2.636
90-94 Years	1.983	2.369	2.303	2.636
95 Years or Over	1.994	2.369	2.303	2.636
Male				
0-34 Years	1.569	1.785	-	-
35-44 Years	1.569	1.785	-	-
45-54 Years	1.707	2.056	-	-
55-59 Years	1.719	2.056	-	-
60-64 Years	1.724	2.080	-	-
65 Years	1.018	1.359	1.724	2.080
66 Years	1.018	1.359	1.675	2.095
67 Years	1.063	1.414	1.714	2.130
68 Years	1.082	1.463	1.714	2.141
69 Years	1.107	1.517	1.719	2.207
70-74 Years	1.240	1.666	1.793	2.259
75-79 Years	1.471	1.888	1.919	2.485

Variable	Non-Medicaid & Non-Originally Disabled	Medicaid & Non-Originally Disabled	Non-Medicaid & Originally Disabled	Medicaid & Originally Disabled
80-84 Years	1.742	2.140	2.160	2.639
85-89 Years	1.936	2.314	2.249	2.639
90-94 Years	2.148	2.440	2.249	2.639
95 Years or Over	2.148	2.440	2.249	2.639

NOTES:

1. The denominator used is $12,861.67.
2. For payment purposes, a new enrollee is a beneficiary who did not have 12 months of Part B eligibility in the data collection year. CMS-HCC new enrollee models are not based on diagnoses, but include factors for different age and sex combinations by Medicaid and the original reason for Medicare entitlement.

SOURCE: 2023-2024 100% Medicare data.

Table VI-4. 2027 V28 CMS-HCC Model with Disease Hierarchies

CMS-HCC	If the Disease Group is listed in this column…	…Then drop the CMS-HCC(s) listed in this column
	CMS-HCC Model Hierarchical Condition Category Label	
17	Cancer Metastatic to Lung, Liver, Brain, and Other Organs; Acute Myeloid Leukemia Except Promyelocytic	18, 19, 20, 21, 22, 23
18	Cancer Metastatic to Bone, Other and Unspecified Metastatic Cancer; Acute Leukemia Except Myeloid	19, 20, 21, 22, 23
19	Myelodysplastic Syndromes, Multiple Myeloma, and Other Cancers	20, 21, 22, 23
20	Lung and Other Severe Cancers	21, 22, 23
21	Lymphoma and Other Cancers	22, 23
22	Bladder, Colorectal, and Other Cancers	23
35	Pancreas Transplant Status	36, 37, 38
36	Diabetes with Severe Acute Complications	37, 38
37	Diabetes with Chronic Complications	38
62	Liver Transplant Status/Complications	63, 64, 65, 68
63	Chronic Liver Failure/End-Stage Liver Disorders	64, 65, 68, 202
64	Cirrhosis of Liver	65, 68
77	Intestine Transplant Status/Complications	78, 80, 81
80	Crohn's Disease (Regional Enteritis)	81
93	Rheumatoid Arthritis and Other Specified Inflammatory Rheumatic Disorders	94
107	Sickle Cell Anemia (Hb-SS) and Thalassemia Beta Zero	108
111	Hemophilia, Male	112
114	Common Variable and Combined Immunodeficiencies	115

CMS-HCC	If the Disease Group is listed in this column…	…Then drop the CMS-HCC(s) listed in this column
	CMS-HCC Model Hierarchical Condition Category Label	
125	Dementia, Severe	126, 127
126	Dementia, Moderate	127
135	Drug Use with Psychotic Complications	136, 137, 138, 139
136	Alcohol Use with Psychotic Complications	137, 138, 139
137	Drug Use Disorder, Moderate/Severe, or Drug Use with Non-Psychotic Complications	138, 139
138	Drug Use Disorder, Mild, Uncomplicated, Except Cannabis	139
151	Schizophrenia	152, 153, 154, 155
152	Psychosis, Except Schizophrenia	153, 154, 155
153	Personality Disorders; Anorexia/Bulimia Nervosa	154, 155
154	Bipolar Disorders without Psychosis	155
180	Quadriplegia	181, 182, 253, 254
181	Paraplegia	182, 254
191	Quadriplegic Cerebral Palsy	180, 181, 182, 192, 253, 254
192	Cerebral Palsy, Except Quadriplegic	180, 181, 182, 253, 254
195	Myasthenia Gravis with (Acute) Exacerbation	196
211	Respirator Dependence/Tracheostomy Status/Complications	212, 213
212	Respiratory Arrest	213
221	Heart Transplant Status/Complications	222, 223, 224, 225, 226, 227
222	End Stage Heart Failure	223, 224, 225, 226, 227
223	Heart Assist Device/Artificial Heart	224, 225, 226, 227
224	Acute on Chronic Heart Failure	225, 226, 227
225	Acute Heart Failure (Excludes Acute on Chronic)	226, 227
226	Heart Failure, Except End Stage and Acute	227
228	Acute Myocardial Infarction	229
248	Intracranial Hemorrhage	249
253	Hemiplegia/Hemiparesis	254
263	Atherosclerosis of Arteries of the Extremities with Ulceration or Gangrene	264, 383, 409
276	Lung Transplant Status/Complications	277, 278, 279, 280
277	Cystic Fibrosis	278, 279, 280
278	Idiopathic Pulmonary Fibrosis and Lung Involvement in Systemic Sclerosis	279, 280

CMS-HCC	If the Disease Group is listed in this column…	…Then drop the CMS-HCC(s) listed in this column
	CMS-HCC Model Hierarchical Condition Category Label	
279	Severe Persistent Asthma	280
282	Aspiration and Specified Bacterial Pneumonias	283
326	Chronic Kidney Disease, Stage 5	327, 328, 329
327	Chronic Kidney Disease, Severe (Stage 4)	328, 329
328	Chronic Kidney Disease, Moderate (Stage 3B)	329
379	Pressure Ulcer of Skin with Necrosis Through to Muscle, Tendon, or Bone	380, 381, 382, 383
380	Chronic Ulcer of Skin, Except Pressure, Through to Bone or Muscle	381, 382, 383
381	Pressure Ulcer of Skin with Full Thickness Skin Loss	382, 383
382	Pressure Ulcer of Skin with Partial Thickness Skin Loss	383
397	Major Head Injury with Loss of Consciousness > 1 Hour	202, 398, 399
398	Major Head Injury with Loss of Consciousness < 1 Hour or Unspecified	202, 399
405	Traumatic Amputations and Complications	409

How Payments are Made with a Disease Hierarchy

EXAMPLE: If a beneficiary triggers HCCs 195 (Myasthenia Gravis with (Acute) Exacerbation) and 196 (Myasthenia Gravis without (Acute) Exacerbation and Other Myoneural Disorders), then HCC 196 will be dropped. In other words, payment will always be associated with the HCC in column 1 if an HCC in column 3 also occurs during the same collection period. Therefore, the organization's payment will be based on HCC 195 rather than HCC 196.

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

Table VI-5. 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

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
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

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
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
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

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
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	-	-

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
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
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	-	-

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
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

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
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 VI-6. 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	-	-
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

Variable	Not Concurrently ESRD, Not Originally Disabled	Concurrently ESRD, Not Originally Disabled	Not Concurrently ESRD, Originally Disabled	Concurrently ESRD, Originally Disabled
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 VI-7. 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

Variable	Not Concurrently ESRD, Not Originally Disabled	Concurrently ESRD, Not Originally Disabled	Not Concurrently ESRD, Originally Disabled	Concurrently ESRD, Originally Disabled
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
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 VI-8. 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

Variable	Not Concurrently ESRD	Concurrently ESRD
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 VI-9. 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

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
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

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
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
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

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
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	1.009	-	0.166	0.068	-

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
	Disability/Developmental Disorder					
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
RXHCC187	Hypertension	0.032	-	0.094	0.106	0.040
RXHCC188	Coronary Artery Disease	0.036	-	0.184	-	-

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
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

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
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 VI-10. 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
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

Variable	Not Concurrently ESRD, Not Originally Disabled	Concurrently ESRD, Not Originally Disabled	Not Concurrently ESRD, Originally Disabled	Concurrently ESRD, Originally Disabled
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 VI-11. 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

Variable	Not Concurrently ESRD, Not Originally Disabled	Concurrently ESRD, Not Originally Disabled	Not Concurrently ESRD, Originally Disabled	Concurrently ESRD, Originally Disabled
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
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 VI-12. 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

Variable	Not Concurrently ESRD	Concurrently ESRD
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 Organizations

Table VI-13. 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						

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
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

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
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

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
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
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

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
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

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
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
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	-	-

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
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

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
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 VI-14. 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	-	-

Variable	Not Concurrently ESRD, Not Originally Disabled	Concurrently ESRD, Not Originally Disabled	Not Concurrently ESRD, Originally Disabled	Concurrently ESRD, Originally Disabled
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
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

Variable	Not Concurrently ESRD, Not Originally Disabled	Concurrently ESRD, Not Originally Disabled	Not Concurrently ESRD, Originally Disabled	Concurrently ESRD, Originally Disabled
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 VI-15. 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

Variable	Not Concurrently ESRD, Not Originally Disabled	Concurrently ESRD, Not Originally Disabled	Not Concurrently ESRD, Originally Disabled	Concurrently ESRD, Originally Disabled
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
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 VI-16. 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

Variable	Not Concurrently ESRD	Concurrently ESRD
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 VI-17. 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
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

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	
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

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	
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.