CAPITOL STREET

January 26, 2026

Medicare Preliminary Rates Flattish (+0.09%) for 2027

Lower Growth Rate, V28 Input Update, Chart Review Diagnoses Must Be Linked To Encounter

Relevant Companies

»» Our Take & Next Up

The CMS advance rate notice is lower than we expected, or +0.09%, for 2027 and will likely improve somewhat in the final print (by April 6, 2026). We had said that the bottom line in the Advance Notice would likely fall between 4% and 6%, with skin subs, a winding down of the Part D demo, as well as possible data input updates for V28. We had also said we expected light-touch changes to HRAs or chart reviews, with the latter being addressed for 2027. We did not expect a new risk adjustment model, nor did CMS propose one.

CMS expresses concerns about the use of unlinked chart reviews and their impact on MA risk scores, as found by MedPAC and the OIG. CMS has chosen to clamp down on certain coding pra
ctices and, separately, provided a lower growth rate (+4.97%) than we had expected. When considering estimated risk score trend in MA driven by coding practices and population changes, the expected average change in payments will be +2.54%. We could see improvement in the final rate notice on growth and other policies. ELV and UNH utilize chart reviews more significantly, but we do not envision CMS moderating this proposal drastically in final 2027 rates (due April 6). With most managed care organizations (MCOs) targeting margin improvement, we believe 2027 bids will continue to reduce benefits as the focus will be profitability versus membership.

»» Key Points

The FFS growth rate is 4.97%, which is lower than last year's 9% but not terrible. As a reminder, for CY 2026, the proposed growth rate was 5.93% and the final was 9.04%. The issue here with the proposal is the risk model revision as well normalization. We could see improvement into the final print with updated utilization for Part A & Part B data through the end of 2025.

Under CMS' proposal, medical diagnoses must be linked to actual encounters: This policy does not prohibit diagnoses gleaned from Health Risk Assessments (HRA). We had said that HRA/chart policy is likely to be light touch: linking to an actual encounter could be in the cards.MA plans have been scrutinized for upcoding relative to Medicare, and HRAs and unlinked chart reviews are mechanisms by which plans increase their risk scores. CMS notes that given the maturity of the encounter data and the program integrity concerns at

hand, 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.

No V29 is proposed, per our thinking going in. Recall, CMS had previously indicated in the 2026 advance notice they could have a model that is estimated on MA claims, or encounter data, as soon as 2027.

Policy	Advance 2026	Final 2026	Advance 2027
Effective Growth Rate	5.93%	9.04%	4.97%
Rebasing/ Re-pricing	TBD	-0.28%	TBD
Change in Star Ratings	-0.69%	-0.69%	-0.03%
MA Coding Intensity	0%	0%	0%
Risk Model Revision and Normalization	-3.01%	-3.01%	-3.32%
Sources of Diagnoses	N/A	N/A	-1.53%
Revenue Change	2.23%	5.06%	0.09%

Source: CMS, Capitol Street, 2026

The V28 model is being updated with more recent data (2023 diagnoses to predict 2024 costs), alongside other tweaks. Because V28 was estimated on 2018 diagnoses and 2019 spending, we had said in our preview that it is possible that CMS may choose to update the model with more recent data, which could result in some changes to the coefficients (e.g. some diseases could have higher values and some could have lower values). CMS did, in fact, update the model with this newer data. They also made some small tweaks to the model, including removing constraints on certain kidney diseases.

Part C normalization outlook. CMS makes a technical adjustment to the risk scores such that the average risk score for the payment year is set to 1.0. Because the V28 model is estimated on 2018 diagnoses and 2019 spending, CMS would need to project the fee-for-service risk score growth between 2024 and 2027 in order to estimate this normalization factor. The normalization factor for 2027 is proposed at 1.058. This reflects the expected increase in risk scores from the model denominator year of 2024.

Skin substitutes and other fraudulent billing (urinary catheters) are included in the USPCC. Medicare fraudulent payments and policies indeed provided a downward adjustment as we had projected (we called out skin subs, in particular). The adjustment is intended to prevent suspect billing from distorting CY 2027 payment benchmarks.

Part D policies are minimal.

- **The Part D Demonstration will likely continue to wind down though there is no discussion here.** CMS did not provide details on the Part D demonstration, beyond noting that the demonstration was

introduced for ‘25. We expect that CMS may continue with the demonstration for ‘27. We expect the demonstration would be less generous in terms of the financial support the plans are offered.

- **CMS will continue to have a separate normalization factor for Part D that provides them with an advantage compared to MA-PDs (which we said is likely)**. CMS is also creating separate Part D risk adjustment models for MA-PD and PDP enrollees due to concerns about the overprediction of costs for MA-PD plans and the underprediction of costs for PDPs under the Part D model. CMS has had a separate normalization factor for MA-PD and PDP plans for ‘25 and ‘26.

The agency will introduce new Stars measures on clinical care and medication safety, while removing measures related to care coordination and medication management. In the MA Part D technical rule released Nov 26 (our take here), the agency proposed eliminating 12 administrative measures, shifting the focus toward outcomes and access rather than process measures, per MAHA ideals. This change aims to create a more level playing field for small, regional, non-profit and for-profit health plans.

- There are five new/updated measures (1) colorectal cancer screening (2) care for older adults (3) functional status assessment (4) concurrent use of opioids and benzodiazepines and (5) polypharmacy.
- The agency will eliminate three measures including (1) pain assessment and (2) medication reconciliation post-discharge (3) medication therapy management (MTM) program completion rate
- The agency still seeks feedback on new measures addressing low-value care.

Ipsita Smolinski
Managing Director I Capitol Street
ipsita@capitol-street.com

202.250.3741 I www.capitol-street.com

900 19th St NW 6th Fl
Washington, D.C. 20006

CAPITOL STREET

Copyright 2026 Capitol Street.

This communication, including this broadcast and any attachments hereto, is intended solely for the original recipient(s) and may not be redistributed without the written consent of Capitol Street. This communication is for informational purposes only and is not intended as an offer or solicitation for the purchase or sale of any financial instruments, nor is it intended as advice to purchase or sell such instruments