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CMS CY2027 ADVANCE NOTICE

Demystifying Population /HCC Changes & Impacts A Health Plan Playbook

The CMS CY2027 Advance Notice introduces a broad recalibration of CMS-HCC coefficients. While overall payment impacts appear modest, the distribution of changes across populations and HCCs is substantial.

It is mission critical for Medicare Advantage (MA) plans to understand these shifts and quickly operationalize a playbook, enabling business continuity, revenue integrity and complete coding accuracy.

CMS is not just recalibrating coefficients — **it is recalibrating behavior.**

CY2027 shifts risk adjustment from volume of HCC capture to quality of confirmation, linkage, and longitudinal evidence.

The downside of relying on unlinked chart reviews in Medicare Advantage (MA) plans is significant, especially for Dual and Institutional populations.

The question is no longer, “what did you find?”, it’s, “what can you prove, link to, and sustain”.

The CMS CY2027 Advance Notice introduces a broad recalibration of CMS-HCC coefficients.

While the headline payment impact may appear modest, the distribution of changes across populations and conditions is anything but. **This is not simply a coefficient update.**



CMS is signaling a structural shift:

For Medicare Advantage plans, this moment is mission-critical. The plans that operationalize quickly will protect revenue integrity, reduce audit exposure, and maintain coding continuity.

Those that continue to rely on unlinked chart review and retrospective volume will feel outsized downside — especially in Dual and Institutional populations.

In this assessment, we quantify CY2027 impacts by population and HCC category, and outline a clear operational playbook for what plans must do now.

The CY2027 Signal: CMS Is Repricing Execution Quality

CMS is implicitly rewarding:

- Encounter-linked diagnoses
- Specialty-confirmed complexity
- Visit depth and chronic persistence
- Documentation defensibility across time

Unlinked diagnosis submission is no longer a strategy — it's a liability.

Stable	Community Non-Dual Aged (NA)	Low	Modest reweighting, balanced repricing	PCP-led closure + clean encounter linkage
Quality Gap Detection	Non-Dual Disabled (ND), Dual Aged (FBA/PBA)	Medium	Disability and chronic complexity increasingly weighted	PCP + selective specialty follow-up
High-Risk	Dual Disabled (FBD/PBD), Institutional	Very High	Severe conditions sharply repriced, evidence depth required	Specialty-first + longitudinal proof chain

Quantifying HCC Repricing by Model

Across models, CMS-HCC repricing is widespread:

- Dual and Institutional models show more HCC increases than decreases
- Non-Dual Aged remains the most stable and balanced
- Institutional populations carry the highest coefficient of volatility

Large Shifts Matter Most (>25% Change)

Model	HCCs with > +/- 25% Change	Volatility Signal
Community Non-Dual Aged	~ 40%	Low Volatility
Community Disabled / Dual Aged	~ 44-52%	Medium volatility
Dual Disabled	~63%	High volatility
Institutional	~75%	Very High volatility

CMS is concentrating financial sensitivity in the sickest populations.

Largest Upside Conditions (Complexity Rewarded)

These conditions gained substantial RAF weight – but require specialty-driven confirmation and longitudinal evidence:

- Advanced CKD Stage 5 (~32% increase)
- Pressure ulcers (~45–60% increase)
- Chronic skin ulcers (non-pressure) (~38% increase)
- Quadriplegia / paraplegia (~40% increase)
- Respirator dependence / tracheostomy (~34% increase)
- Rare metabolic and hematologic disorders (up to ~65% increase)

Pattern: High-severity, chronic, specialty-confirmed, multi-visit conditions.

Largest Downside Conditions (Commodity Chronic Compression)

Several common conditions saw coefficient compression:

- Diabetes tiers (~6–9% decrease)
- COPD / chronic lung disease (~19% decrease)
- Heart failure categories (~11% decrease)
- Morbid obesity (~19% decrease)
- Moderate CKD (Stage 3A) (~50% decrease)
- Depression and substance use tiers down materially

Pattern: High-frequency conditions with historical audit sensitivity and limited longitudinal differentiation.

CMS'S NEW EXECUTION HIERARCHY

The Playbook Plans Need

CY2027 makes one thing clear: Identification alone is insufficient. Plans must operationalize a closed-loop execution system:

The New Risk Adjustment Ladder

1. **Suspect** (Care Gap Collect ASM data / Prospective NLP Charts for Evidence)
2. **Confirm** (Encounter + visit depth evidence)
3. **Escalate** (Specialty involvement for high-delta HCCs)
4. **Sustain** (Chronic validation across time)
5. **Defend** (Audit-ready evidence chain)

ASM (Alternate Supplemental Medical Records) from providers should prioritize missed Diagnosis and root cause of not submitting through claim submissions — not submit.

AWV can surface gaps — but cannot close complexity alone.

Specialty follow-up becomes mandatory for high risk and high impact HCCs across models.

Three Operational Redesigns for CY2027 Readiness

1. Supplemental Records /ASM data → Encounter Linkage Pipeline

Suspects must convert into encounter-linked evidence, not remain unlinked chart review output.

2. Speciality Escalation for High-Delta HCCs

AWV and PCP visits alone will not close severe conditions in Dual Disabled populations.

3. Audit Defense as a Built-In Layer

Longitudinal proof and documentation of defensibility are no longer optional.

INVENT HEALTH PERSPECTIVE: Risk Adjustment Becomes an Execution System

At Invent Health, we view CY2027 as the moment risk adjustment becomes operational infrastructure — not a coding exercise.

The winners will integrate:

- Suspecting
- EMR linkage
- Specialty confirmation
- Encounter attribution
- Audit defense

...into one connected workflow.

Medicare Advantage is entering its operational maturity phase.

RAF will increasingly reward disciplined evidence chains — not retrospective volume.

The Market Is Tightening

The “gold rush” era of risk adjustment is fading. The next phase belongs to plans that are:

- **75% faster** quality measure computation and validation.
- **Up to 40% reduction** in manual chart review effort.
- **Comprehensive measure coverage:** HEDIS®, Stars®, QRS, and client-specific measures.
- **Cross-LOB support:** ACA, Medicaid, and Medicare Advantage.
- **Improved audit readiness** through evidence traceability and compliance logging.

The question for every MA organization is now simple:

Is your program built for coefficient capture – or evidence execution?

Plans that modernize now will protect RAF, reduce audit exposure, and outperform in the CY2027 environment.

What’s next? MA plans must make operational improvements to account for these changes to ensure revenue integrity and audit confidence.

Given the breadth of updates coming in PY2027, proactive plans are already well on their way to weathering the coming storm. How prepared is your plan?



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Let’s talk! Contact us here to schedule your demo and discover what Invent Health can do for you and your plan.



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