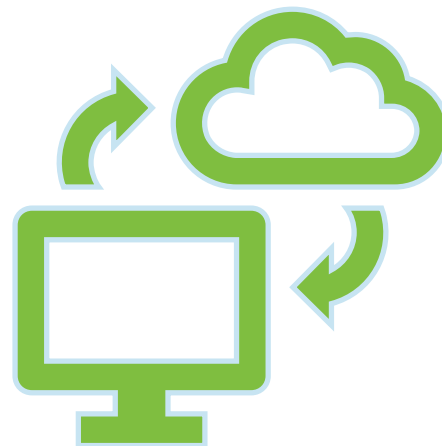


NAACOS Webinar on CY27 Medicare Advantage Final Rule and Rate Announcement



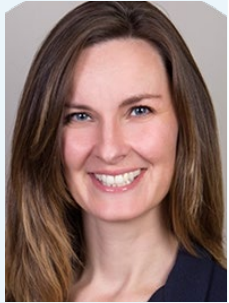
May 2026



Webinar is being recorded

The recording and slides will be available on the [NAACOS website](#) within 48 hours.

Speaker Intros

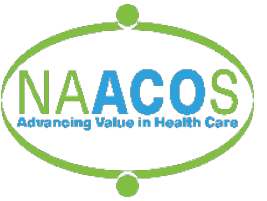


Emily Graham
VP, Regulatory Affairs
Hart Health

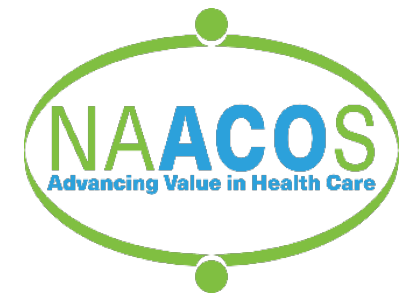


Diwen Chen
Senior Director, Payer
Policy
NAACOS

Overview



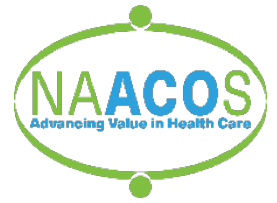
- On April 2, 2026, CMS issued its Contract Year (CY) 2027 Final Rule
- On April 6, 2026, CMS issued its MA Rate Announcement
- Together, the CMS policy documents provide final changes governing MA and Part D plans beginning January 1, 2027
- Finalized changes will also impact the 2027 plan bid process that MA plans will engage in with CMS
- Following presentation provides key highlights from these final policy documents



2027 MAPD Rate Announcement



Final Rates



Year-to-Year Percentage Change From 2026 to 2027

Impact	2027 Advance Notice	2027 Rate Announcement
Effective Growth Rate	4.97%	5.33%
Rebasing/Re-pricing	TBD ¹	-0.17%
Change in Star Ratings ²	-0.03%	-0.03%
MA Coding Pattern Adjustment	0%	0%
Risk Model Revision and Normalization ³	-3.32%	-1.12%
Sources of Diagnoses ⁴	-1.53%	-1.53%
Overall Expected Average Change⁵	0.09%	2.48%

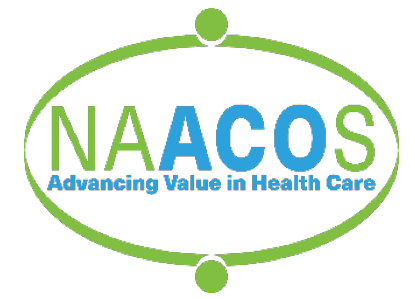
<https://www.cms.gov/newsroom/fact-sheets/2027-medicare-advantage-part-d-rate-announcement>

- **Plan payments expected to be higher than proposed due to the following changes from the Advance Notice:**
 - **Growth Rate:** CMS used updated data which increased the effective growth rate in the final rate announcement.
 - **Risk Model:** CMS delayed updating the V28 model with newer data (i.e., 2023/24 vs. 2018/19) to allow more time for plans to adjust.
- **Keep in mind:** CMS expects the MA risk scores to increase, on average, by 2.50% due to the underlying coding trend.

Unlinked Chart Review Records (CRRs)



- CMS finalized its proposal to **exclude diagnosis information from unlinked chart review records (CRRs)** – diagnosis information not associated with a specific beneficiary encounter – **from risk score calculation starting in CY 2027.**
 - **Exception:** Beneficiaries who switch from one MA organization to another (e.g., moved from one MA organization in CY 2026 to another MA organization in CY 2027).
- CMS noted that MA organizations may continue to submit diagnoses using unlinked CRRs, however, those diagnoses would no longer be used for calculating risk scores.



CY 2027 MAPD Policy and Technical Changes

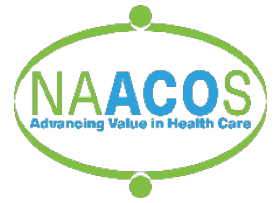


2027 Star Ratings



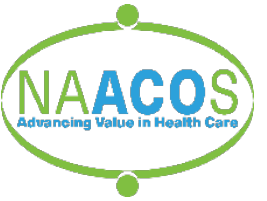
- CMS finalized revisions to the Star Ratings program, including as follows:
 - **Not implementing the Excellent Health Outcomes for All reward** (previously called the Health Equity Index reward) that was developed to incentivize improved performance for a subset of enrollees and **will continue the historical reward factor** that encourages consistently high performance for all enrollees across all quality measures.
 - **Added a new Part C Depression Screening and Follow-Up measure** to address behavioral health gaps starting with the 2027 measurement year and 2029 Star Ratings.
 - **Removed 11 measures; Retained 1 measure proposed for removal**
 - **CMS rationale:** Measures focused on administrative processes and areas where beneficiaries cannot distinguish performance between plans due to high performance and little variation.

Measures Removed, Retained



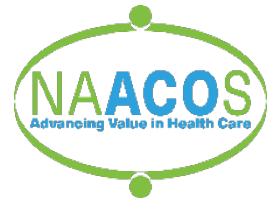
Measure	Program (Part C/D)	Outcome
Plan Makes Timely Decisions about Appeals	Part C	Removed
Reviewing Appeals Decisions	Part C	Removed
Special Needs Plan (SNP) Care Management	Part C	Removed
Call Center – Foreign Language Interpreter and TTY Availability	Part C/D	Removed
Complaints about the Health/Drug Plan	Part C/D	Removed
Medicare Plan Finder (MPF) Price Accuracy	Part D	Removed
Diabetes Care – Eye Exam	Part C	Retained
Statin Therapy for Patients with Cardiovascular Disease	Part C	Removed
Members Choosing to Leave the Plan	Part C/D	Removed
Customer Service	Part C	Removed
Rating of Health Care Quality	Part C	Removed

Reducing Regulatory Burden



- CMS removed “**duplicative and burdensome regulatory requirements** that have limited beneficiary choice, hindered innovation and increased costs,” including as listed below:
 - Rescinded the requirement for MA plans to send **mid-year notices about unused supplemental benefits**.
 - Eliminated the requirement for MA quality improvement programs to include activities that reduce **health disparities**.
 - Eliminated **health equity requirements for MA Utilization Management Committees**, including requiring a health equity expert member, conducting annual health equity analyses, and publicly posting these analyses.

Plan Advertising, Marketing, Enrollment



- CMS finalized its proposals to:
 - Remove **references to State Health Insurance Assistance Programs (SHIPs)**, while maintaining guidance for beneficiaries to contact Medicare.gov or 1-800-MEDICARE for plan advice.
 - Require Third-Party Marketing Organizations (TPMOs) to **provide the TPMO disclaimer during sales calls *before* engaging in discussions about benefits** rather than requiring TPMOs to verbally convey the disclaimer during the first minute of a sales call.
 - Remove the prohibition on using **superlatives** without embedded supporting documentation and to eliminate duplicative regulatory text, emphasizing that plans must still ensure all statements are not misleading and must be able to support superlatives upon request.
- CMS did not finalize its proposal to establish a **special enrollment period (SEP) for provider terminations** but will continue to consider the extent to which it may be appropriate to engage in future rulemaking in this area.

Risk Adjustment Data



- CMS finalized its proposal to **remove existing restrictions on the use and release of risk adjustment data** to allow more efficient use of public and private sector resources while maintaining protections for beneficiary-identifying information, and to advance the goals of [*Executive Order 14243, Stopping Waste, Fraud, and Abuse by Eliminating Information Silos*](#), by reducing data-sharing barriers, strengthening program oversight, and supporting research to improve health care delivery.

Outlier Prescriber Criteria



- CMS codified provisions from the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act, and specifically:
 - **Defined an outlier prescriber of opioids** as a statistical outlier when compared to their peers based on NPPES taxonomy and state.
 - **Established a threshold to identify persistent outlier prescribers of opioids** as those outlier prescribers who receive three consecutive outlier prescriber notifications from CMS based on the same methodology.
 - Added **additional definitions** for: Outlier prescriber of opioids; Specialty; Geographic area; Persistent outlier prescriber of opioids.

Codifying IRA Guidance



- CMS finalized regulatory amendments to:
 - Codify previously finalized policies **implementing provisions of the IRA that were operationalized through program instructions**, specifically the [*Final CY 2025 Part D Redesign Program Instructions*](#) and [*Final CY 2026 Part D Redesign Program Instructions*](#), and to make various technical corrections.
 - Align with the **elimination of the coverage gap phase** under the IRA, sunsetting the Coverage Gap Discount Program and terminating all associated agreements effective January 1, 2025, while preserving all statutory responsibilities for applicable drugs dispensed before that date.
 - Implement and codify the **Medicare Part D Manufacturer Discount Program** established under the IRA, including provisions previously operationalized through program guidance and related implementation instructions, specifically the [*Manufacturer Discount Program Final Guidance*](#), and to make various technical corrections.

Future Directions in MA



- CMS issued and received comment on RFIs specific to the following topics:
 - Risk Adjustment
 - Quality Bonus Payments (QBP) in Medicare Advantage
 - Well-Being and Nutrition
 - Dually Eligible Individual Enrollment Growth in C-SNPs, I-SNPs
- CMS is considering all of the feedback for future rulemaking.



NAACOS

Rush Health

Aditi Kumar, MPP

Nikhil Bansal, MD, MS-HSM



- **About Rush Health**
- **VBC Experience**
- **MA Strategy**

Bios

Aditi Kumar, MPP

Director, Value-Based Payer Contracting
Rush Health

- Over 20 years experience working with providers and payers on policy, managed care, and value-based care programs in alignment with payer strategy, and provider finance and incentives.
- Manages value-based care contracting and implementation efforts at Rush Health.
- Holds a Masters in Public Policy from the University of Chicago Harris School and Bachelors in Economics from Loyola University Chicago.

Nikhil Bansal, MD, MS-HSM

Payer Contracting Manager, Value Based Care
Rush Health

- Drives value-based contracting and strategy across Medicare Advantage, Medicaid, and commercial populations.
- Holds an MS in Health Systems Management from Rush University and an MD from the American University of the Caribbean.

Rush Health - Clinically Integrated Network



Rush Copley Medical Center (RCMC)



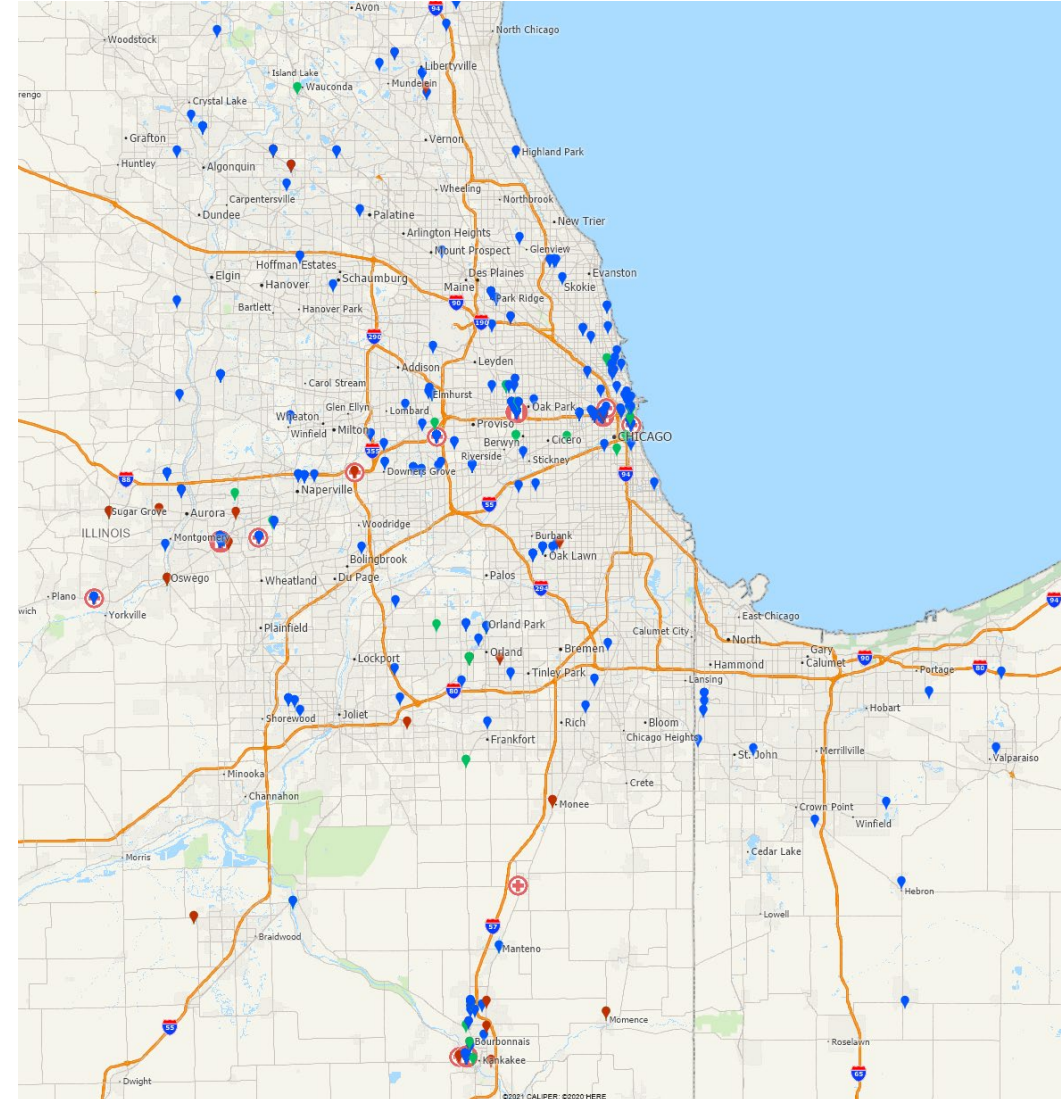
Rush Oak Park Hospital (ROPH)



Riverside Medical Center (RMC)



Rush University Medical Center (RUMC)



Rush Health Providers	Employed	Independent
Total	1,500+	1,100+
PCPs	157	70
Specialists	1413	1047

VBC Experience



Rush Health and Value-Based Care

Rush Health began its VBC journey in 2016 with commercial and Medicare ACOs, and additional Medicare Advantage plans to the portfolio over the last five years.

- **Over 20** value-based care contracts and **200,000** attributed lives.
- Over time, Rush Health has been successful in earning performance-based incentives as operations and resources have been solidified for both value-based care and P4P arrangements.
- Medicare cost savings **+\$50 million** from 2018 to 2024 in MSSP and ACO REACH.

MA Strategy



CMS Star Ratings Program Revisions

Revision: Addition of Depression Screening and Follow-Up measure (2027 MY)

- Rush Health already incorporates a depression screening measure within internal quality program
- Depression screening tools are embedded in EMRs workflows and rooming processes, supporting consistent capture at point of care
- Positive screens trigger a structured follow-up pathway

Previous Revision: Medication Adherence measure specification updates and reduction to single-weight (2026 MY)

- Medication Adherence remains a strategic focus area – these measures revert to triple-weight in 2027, and some payers continue to apply triple-weighting in 2026.
- Rush Health is building internal data infrastructure to enable more timely patient monitoring and flagging of patients, reducing reliance on claims-lagged data from payers.

Impact: Rush Health is well-positioned amid recent CMS Star Ratings revisions. No fundamental shifts to existing quality infrastructure and clinical workflows required.

MA Stars and Utilization Management

Ongoing Initiative: Improve MA Stars quality performance amidst rapid plan expansion, network growth, and evolving payer programs

- Consolidated MA Stars dashboard tracking performance across multiple levels – overall, plan, provider group, measure level – to enable target intervention
- Monthly utilization reviews for high-risk patients conducted with physician leaders and senior medical directors
- Leveraging population health tools to generate payer-agnostic, actionable gap lists to drive focused quality improvement
- Standardizing data ingestion and processing across a multi-EMR environment to support consistent, scalable reporting

Impact: Greater physician and clinical engagement; improved MA Stars quality performance; 0.5-star plan-level increase year-over-year

What's Ahead for Rush Health in MA

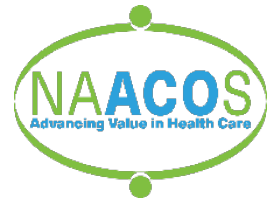
Key Highlights

- Since 2020, Rush Health's Medicare Advantage lives have tripled.
- Greater variation in the quality parameters per contract including targets and weights.
- With concentrated efforts, Rush Health continues to improve its average Star Ratings each year and continues to see step by step progression in this area.
- As the volume of MA patients grow over time, Rush Health has developed strategies to prioritize new patients, annual wellness visits, chronic conditions such as diabetes, and medication adherence.

Thank you!



NAACOS Upcoming Events



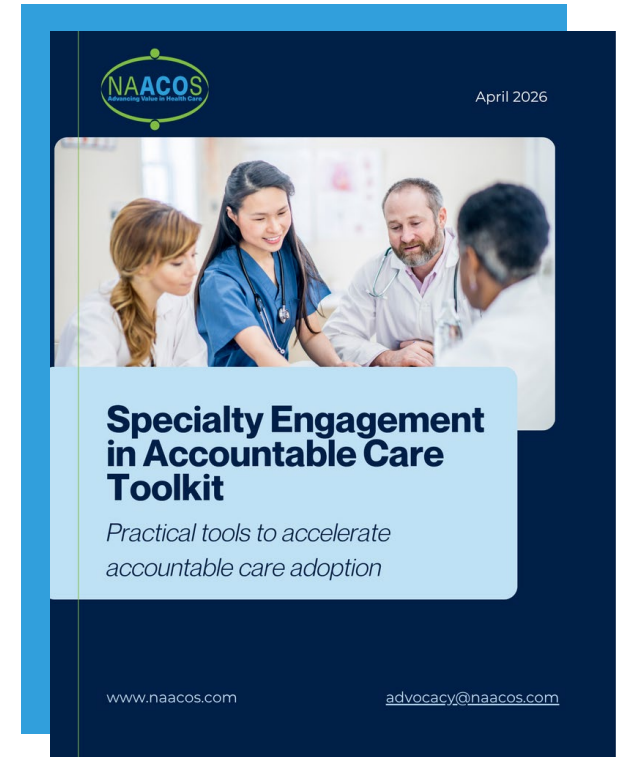
Title	Date(s) and Times	Location	More information
MA Deep Dive Roundtable Series (next meeting 5/20)	3rd Tuesday, bimonthly: 1pm ET	Virtual	<ul style="list-style-type: none"> • Register • Other Roundtables
Monthly ACO REACH/LEAD Roundtable Meeting Series <ul style="list-style-type: none"> • Pre-recorded Webinar: Provides a detailed overview of the model. • ACO Comparison Chart: Outlines and compares MSSP, ACO REACH, and LEAD across several domains. • LEAD Model Detailed Slides: Presents comprehensive model details 	4 th Thursday each month: noon ET	Virtual	Register
NAACOS Specialty Engagement in Accountable Care Toolkit Webinar	May 11: 3pm ET	Virtual	Register
Innovation Spotlight – AI Series with Ursa Health	May 12: 2pm ET	Virtual	Register
Upcoming and Past Webinars	Schedules Vary	Virtual	Link

Specialty Engagement in Accountable Care Toolkit



NAACOS released the *Specialty Engagement in Accountable Care Toolkit* to support meaningful specialty engagement across the continuum of care.

- ✓ Voluntary best practices
- ✓ Step-by-step guidance
- ✓ Practical, adaptable tools



Download your free copy of the toolkit and resources now!

NAACOS Regional Map



Northwest

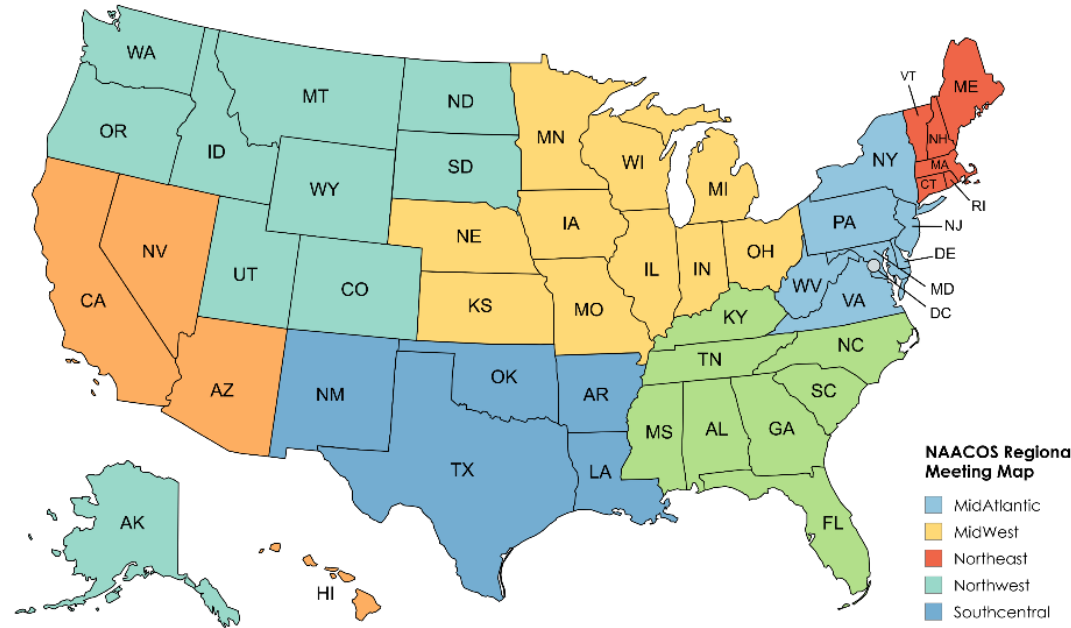
- August 13, 2026 – Boise Idaho
- March 2027 - TBA

Southwest

- November 2026 - TBA
- May 19, 2026 - Virtual

South Central

- January 2027 - TBA
- August 25, 2026 - Virtual



Created with mapchart.net

Northeast

- July 28, 2026 – Providence, RI
- March 2027 - Virtual

Mid-Atlantic

- June - TBA
- December 2, 2026 - Virtual

Midwest

- July 16, 2026 – Milwaukee, WI
- February 2027 - TBA

Southeast

- February 2027- TBA
- September 14, 2026 - Virtual

Boot Camp for Medicare ACOs



Progressive Learning: From Basic to Advanced

The Boot Camp Series is for MSSP and REACH employees at all levels to learn about ACO optimization, innovation, and advancement in data analytics and clinical operations.



Fundamentals

- On-demand videos
- Free to members

Boot Camp 101

- Data/Analytics
- June 2-4, 2026
- 1:00 pm to 5:00 pm EDT
- Registration opening soon!

Boot Camp 201

- Early 2027 - TBA