Where Smart Money Should Go in Healthcare Technology Right Now

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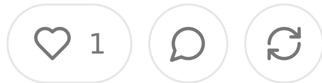

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Abstract

This essay examines current opportunities in healthcare technology through the of recently published compliance guidance from the Office of Inspector General regarding Medicare Advantage programs. The document reveals significant operational gaps, enforcement priorities, and structural weaknesses that represe addressable market opportunities for entrepreneurs and investors. Key themes include:

- Compliance infrastructure represents a $15B+ market opportunity across MA providers, and third parties

- Risk adjustment accuracy remains systematically problematic despite being ce to $400B+ in annual payments

- Prior authorization and utilization management create massive friction costs w generating quality concerns

- Provider network accuracy and directory maintenance remain unsolved at scal

- Third party oversight and FDR management lacks adequate tooling

- Marketing compliance presents both risk and opportunity as regulatory scruti intensifies

The analysis connects regulatory pressure points to product opportunities, with particular focus on software infrastructure, data analytics, and process automati

that can address compliance requirements while improving operational efficienc

Table of Contents

Introduction and Context

The Compliance Infrastructure Opportunity

Risk Adjustment as a Product Category

Prior Authorization and Utilization Management

Network Adequacy and Provider Directory Solutions

Third Party Oversight and Vendor Management

Marketing and Enrollment Compliance Tools

Quality Measurement and Star Ratings Infrastructure

Integrated Platforms vs Point Solutions

Market Sizing and Investment Considerations

Conclusion

Introduction and Context

The OIG just dropped a 42 page document that basically reads like a product roadmap if you know how to interpret it. The Medicare Advantage Industry Compliance Program Guidance updates their 1999 version, which tells you some about how much the landscape has changed. MA enrollment has exploded to cov more than half of Medicare beneficiaries, creating a roughly $450B market that 8 to 10 percent annually. The guidance document is nominally about compliance really it is a detailed catalog of operational problems that MAOs cannot solve wi their current tools and processes.

This matters because regulatory guidance documents reveal where enforcement focus, which means they reveal where companies will spend money to avoid pena More importantly, they reveal systematic operational failures across an industry segment. When OIG publishes 40+ pages detailing specific processes that MAOs should implement, they are essentially admitting that current approaches do not work. Each recommendation represents a potential product.

The key insight is that compliance requirements and operational efficiency are r opposed. The areas where OIG identifies the highest risk tend to be areas where current processes are manual, error prone, and expensive. Building tools that ma compliance easier usually means building tools that make operations better. Companies that can deliver both will capture disproportionate value.

The Compliance Infrastructure Opportunity

Start with the basics. CMS requires MAOs to maintain compliance programs wi specific elements including dedicated officers, committees, training programs, monitoring systems, and corrective action processes. The guidance makes clear t current implementations are inadequate. MAOs operate with compliance teams are too small, lack specialized MA expertise, rely on manual processes, and strug maintain oversight across complex organizational structures.

The market is roughly 500 MAOs ranging from massive national carriers to regi plans with a few thousand members. Below that are several thousand provider organizations acting as FDRs, thousands of TPMOs handling marketing and enrollment, and various vendors providing everything from utilization managem risk adjustment services. Altogether maybe 10,000 organizations need meaningf compliance infrastructure specifically for MA programs.

Most of these organizations build compliance programs using general purpose t spreadsheets, and manual processes. A dedicated compliance platform purpose l for MA requirements could command $50K to $500K annually depending on

organization size. Even at conservative estimates, this is a $500M+ market just fo
core compliance infrastructure.

But the real opportunity is not selling compliance software to compliance officer
is embedding compliance into operational workflows so that doing the right thin
becomes the path of least resistance. Think about how Stripe embedded PCI
compliance into payment processing or how Modern Treasury embedded bankin
compliance into money movement. The companies that win will make complianc
invisible rather than making it a separate workstream.

The guidance document essentially provides a specification. MAOs need systems
maintain policies and procedures, track training completion, manage hotline rep
document investigations, oversee third parties, conduct audits, and generate rep
for boards and regulators. Each of these represents a distinct module within a la
platform.

Risk Adjustment as a Product Category

Risk adjustment might be the single largest product opportunity in the documen
CMS uses diagnosis codes submitted by MAOs to calculate risk scores that deter
monthly capitated payments. Higher risk scores mean higher payments. This cre
roughly $400B in annual payment flow that depends entirely on accurate diagno
coding and documentation.

OIG has published multiple reports showing that MAOs systematically overcode
scores, generating billions in excess payments. The guidance document dedicate
substantial space to risk adjustment oversight, essentially saying that MAOs nee
much better systems for ensuring diagnosis code accuracy before submission to
and for auditing codes after submission.

The current approach is mostly manual. MAOs hire armies of coders to review c
They run basic edits looking for obvious errors. They conduct targeted audits of
risk codes. But they lack comprehensive systems for benchmarking provider cod

patterns, identifying outliers, validating clinical documentation, or systematical
correcting errors.

Build the risk adjustment equivalent of fraud detection systems used by paymen
processors. Apply ML to flag suspicious patterns. Identify providers whose codi
diverges from peers treating similar populations. Surface cases where diagnosis
lack supporting documentation. Automate the chart review process using NLP t
extract relevant clinical information. Generate correction submissions back to C
when errors are identified.

The value proposition is straightforward. Help MAOs avoid OIG audits that can
in payment recoupments plus penalties. Avoid DOJ investigations that can resul
False Claims Act settlements. Reduce the manual labor cost of chart reviews anc
coding audits. Improve accuracy of payments which helps both MAOs and CMS.

Market size is substantial. Every MAO needs this. Many provider groups in risk
bearing arrangements need this. The companies doing risk adjustment services t
are mostly doing labor arbitrage, hiring nurses and coders to review charts manu
Software that reduces the per chart cost while improving accuracy captures valu
the labor arbitrage margin while also capturing value from reduced compliance

Pricing could be per member per month, per chart reviewed, or percentage of
payment accuracy improvement. Even conservative assumptions suggest a multi
billion dollar market. Incumbents like Cotiviti and HCTec have pieces of this bu
nobody has built the comprehensive platform that the OIG guidance essentially
requires.

Prior Authorization and Utilization Management

Prior auth is where payer operations meets patient care and the collision creates
massive friction. OIG dedicates substantial space to utilization management con
focusing on inappropriate denials and delays in care. This matters because prior

is one of the biggest pain points in healthcare and also one of the biggest opportunities for automation and improvement.

Current prior auth processes are largely manual. Providers submit requests via f portal, or phone. Payer staff review requests against clinical criteria. Complex ca to medical directors. The whole process takes days to weeks and involves substa back and forth. Denial rates vary wildly. Appeal rates are high. Overturn rates on appeal are also high, suggesting that initial denials were often inappropriate.

The guidance makes clear that MAOs need better oversight of their utilization management programs. They need to track denial rates, analyze appeal outcome audit decisions for consistency with policies, and ensure that medical necessity determinations consider individual patient circumstances rather than applying blanket rules.

This creates opportunity for better prior auth infrastructure. Not just portals fo submitting requests, though that is table stakes. The real opportunity is decision support systems that help payers make faster, more accurate, more consistent decisions. Pull relevant clinical information from multiple sources. Apply evider based guidelines. Flag cases that need medical director review versus cases that auto approved. Generate clear rationales for denials that will withstand appeal.

On the provider side, the opportunity is systems that know payer requirements, validate requests before submission, provide real time feedback on likely approv and automate the appeal process when needed. Essentially turbotax for prior aut

Market size is large because every interaction between every provider and every involves this process. Hundreds of millions of prior auth requests annually. If yo reduce the per request cost by even a few dollars while improving speed and acc you have a billion dollar plus business.

Companies like Cohere Health and Rhyme are attacking pieces of this. But the r is big enough for multiple winners and the incumbent systems are bad enough t there is room for significant disruption. The key is building something that paye

will actually adopt, which means integrating with their existing tech stacks and workflows rather than requiring wholesale replacement.

Network Adequacy and Provider Directory Solutions

Provider directories are a surprisingly hard problem that remains mostly unsolv despite being critical to MA plan operations. CMS requires MAOs to maintain accurate directories showing which providers are in network, where they practic whether they are accepting new patients, and other key details. MAOs must veri information at least quarterly. Yet OIG and others consistently find that directo contain high rates of inaccurate information.

The problem is that provider information changes constantly. Doctors move, ret change their patient panel status, add or drop insurance contracts, modify their practice scope. Keeping directories current requires continuous verification, bu MAOs rely on periodic surveys sent to providers or their staff, who may not resp or may provide outdated information.

Inaccurate directories create real problems. Patients try to see providers who are actually in network or not actually available. This leads to surprise bills, patient complaints, and regulatory scrutiny. MAOs can face penalties for inadequate net or inaccurate directories. The guidance makes clear that current approaches are insufficient and that MAOs need much better systems.

Build the provider data platform that maintains accurate real time information through continuous verification from multiple sources. Pull data from claims submissions, appointment scheduling systems, practice websites, state licensing boards, CMS enrollment databases. Use ML to identify inconsistencies. Generat alerts when information appears outdated. Provide APIs that allow directories t current automatically rather than requiring manual updates.

Expand beyond basic directory information to provide deeper provider intellige Coding patterns, quality metrics, patient satisfaction scores, clinical focus areas

appointment availability, referral patterns. Turn provider directories from static into dynamic platforms that help patients find the right provider and help MAO manage their networks more effectively.

Market opportunity includes every MAO plus every provider group that needs to manage its own provider data. Pricing could be per provider per month, per verification, or SaaS model based on plan size. Even modest per provider fees sca hundreds of millions across the industry.

Companies like Ribbon Health and Medallion are working on aspects of this pro The market is big enough for multiple approaches. The key technical challenges data aggregation from disparate sources, entity resolution to match providers ac systems, and continuous verification to maintain accuracy over time.

Third Party Oversight and Vendor Management

MAOs increasingly rely on complex networks of third parties including FDRs, TPMOs, vendors, and providers. The guidance devotes substantial attention to t party oversight, making clear that MAOs need much better systems for vetting vendors, monitoring their performance, ensuring their compliance, and taking corrective action when needed.

Current approaches are mostly manual. Contracts live in document managemen systems. Vendor performance tracking happens in spreadsheets. Compliance attestations arrive via email. Audits are scheduled in separate systems. There is single source of truth about vendor relationships, obligations, performance, or r

This creates opportunity for vendor management platforms purpose built for healthcare and particularly for MA requirements. Track all vendor relationships Store contracts with key provisions highlighted. Maintain attestations and certifications. Schedule and track audits. Monitor performance metrics. Generat alerts when attestations expire or when performance degrades. Document correc actions. Provide reporting for compliance committees and boards.

Go beyond basic contract and performance management to provide compliance intelligence. Flag vendors with OIG exclusions or other regulatory issues. Bench vendor performance against peers. Identify vendors that represent concentrated because they serve critical functions or handle sensitive data. Provide playbooks vendor oversight tailored to different vendor types.

Market includes every MAO plus large provider organizations and other healthc entities with complex vendor networks. Pricing could be per vendor, per user, or based on contract value under management. Even conservative penetration sugg market opportunity in the hundreds of millions.

The technical challenge is integrating with diverse vendor systems to pull performance data automatically rather than relying on manual reporting. The bu challenge is selling to procurement, legal, compliance, and operations groups th have a stake in vendor management but may not coordinate well.

Marketing and Enrollment Compliance Tools

Marketing and enrollment represent high risk areas that are getting increased scrutiny from OIG, CMS, and DOJ. The guidance highlights concerns about imp financial incentives, deceptive marketing practices, and inadequate oversight of agents and brokers. Recent enforcement actions have resulted in substantial settlements related to marketing violations.

MAOs spend billions annually on marketing and enrollment, much of it flowing thousands of independent agents and brokers. Tracking these payments, ensurin compliance with compensation limits, monitoring for inappropriate steering, an investigating complaints is largely manual today. Spreadsheets, email, phone cal

Build the Stripe or Ramp equivalent for managing marketing spend. Payment infrastructure that enforces compliance rules automatically. Agent and broker onboarding that includes required training and background checks. Compensati structures that comply with CMS limits and avoid prohibited incentives. Trackin

reporting of all marketing activities. Investigation workflows for complaints. Integration with CRM and enrollment systems.

Extend beyond payment infrastructure to provide marketing compliance intellig Monitor enrollment patterns to identify suspicious activity like inappropriate switching. Track complaint ratios. Benchmark agent performance. Flag potentia issues before they become enforcement actions. Provide documentation that demonstrates compliance oversight in case of audit.

Market includes MAOs and FMOs plus large broker organizations that need to demonstrate compliance to their carrier partners. Pricing could be per transacti per agent, or percentage of spend under management. Given the scale of market spend in MA, even small take rates represent substantial revenue opportunity.

Key technical challenges include integrating with diverse enrollment systems, processing high volumes of small payments to large numbers of agents, and buil rules engines that can keep up with changing CMS compensation policies. Key business challenge is that current systems are deeply entrenched even though th inadequate.

Quality Measurement and Star Ratings Infrastructure

Star Ratings determine quality bonus payments and influence consumer plan selection. MAOs with 4+ stars receive higher capitated payments and can offer supplemental benefits. Getting from 3.5 stars to 4 stars can be worth tens to hur of millions in additional revenue for large plans. Yet the processes for improvin maintaining star ratings are often ad hoc.

Star ratings depend on dozens of measures spanning clinical quality, patient experience, administrative process, and member complaints. Data comes from multiple sources including HEDIS measures, HOS surveys, member surveys, and reporting. Calculating likely star ratings requires complex methodology that cha periodically.

MAOs need better infrastructure for managing star ratings performance. Track measures in real time rather than waiting for annual scores. Identify members w care gaps that impact specific measures. Generate outreach lists prioritized by i on star ratings. Measure effectiveness of interventions. Model impact of differen improvement strategies on overall ratings. Provide dashboards that let executive current trajectory and make resource allocation decisions.

Go deeper than just tracking to provide actionable intelligence. Which provider patients with the most care gaps. Which interventions have the highest ROI for closing gaps. How do current scores compare to competitors. What is the expect distribution of next year's ratings. Which measures represent the biggest opportunities or threats.

Market includes all MAOs plus large provider groups in risk arrangements whe ratings impact their payments. Pricing could be subscription, per member, or percentage of bonus payments attributable to the platform. The value propositio clear because star ratings impact is directly measurable in dollars.

Companies like Arcadia and Innovaccer have pieces of this as part of broader population health platforms. There may be opportunity for a focused star rating platform that goes deeper on MA specific requirements. The technical challenge integrating diverse data sources and keeping up with methodology changes. The business challenge is that existing population health vendors already have relationships and may expand to cover star ratings even if their current offering not purpose built.

Integrated Platforms vs Point Solution

A key strategic question is whether the opportunity favors integrated platforms cover multiple compliance and operational needs versus point solutions that go deep on specific problems. Arguments exist for both approaches.

The integrated platform argument is that MAOs are tired of stitching together of point solutions that do not talk to each other. They want unified data models,

consistent user experiences, and vendors that take responsibility for end to end workflows rather than just pieces. An integrated compliance and operational pla that covers risk adjustment, utilization management, provider networks, vendor oversight, marketing compliance, and quality measurement could command pre pricing and higher retention because of switching costs.

The point solution argument is that healthcare IT graveyards are full of compan that tried to boil the ocean. Better to dominate a specific category, become the undisputed leader in that space, then expand from strength. Point solutions can move faster, sell more easily, and prove value more clearly. Many of the most successful healthcare IT companies started narrow and expanded over time rath than launching as platforms.

The guidance document arguably supports both approaches. It makes clear that MAOs need solutions across many domains, suggesting opportunity for platform it also highlights specific pain points in each domain that remain unsolved, sugg opportunity for focused solutions.

Likely outcome is that both approaches will find success depending on executio Integrated platforms will work if they genuinely provide better integration than assembling point solutions, not just putting different modules under one brand. solutions will work if they truly excel in their category, not just match parity off from platforms.

From an investor perspective, platforms probably require more capital and long timeframes to reach scale but potentially offer higher ultimate outcomes. Point solutions might reach profitability faster with less capital but face strategic risk platform vendors expanding into their space. As usual, the answer is that it depe on the team, the execution, and the specific opportunity.

Market Sizing and Investment Considerations

Aggregate market opportunity across the domains covered in this analysis likely exceeds $10B annually at maturity. Break that down by segment. Core complian infrastructure maybe $500M to $1B. Risk adjustment $2B to $3B. Prior authoriz and UM $2B to $3B. Provider directories and network management $500M to $1 Vendor oversight $300M to $500M. Marketing compliance $500M to $1B. Star r and quality $1B to $2B. Obviously these are rough estimates with wide error bar the order of magnitude is probably right.

Current spend in these categories is already substantial but highly fragmented a labor costs, point solutions, and services firms. The opportunity is to capture sp from all three by delivering software that reduces labor needs, consolidates poin solutions, and replaces services with automation.

TAM is large enough that even companies capturing low single digit market sha build very substantial businesses. SAM is also attractive because MA plans are generally well capitalized, increasingly sophisticated buyers of technology, and f clear regulatory pressure to improve their capabilities in exactly these domains.

Investment considerations depend on stage and approach. Early stage investmen point solutions might require $5M to $20M to reach product market fit and init scale. Platform plays might require $50M to $100M+ to build across multiple m and achieve the integration value proposition. Current market conditions favor focused approaches with clearer paths to profitability rather than massive platfo bets.

Team considerations are critical. Need deep MA domain expertise, not just gene healthcare or insurance knowledge. The regulatory requirements are specific an complex. Also need strong product and engineering talent that can build genuin better software rather than just digitizing existing processes. Finally need enter sales capability because selling to MAOs requires navigating complex organizati with multiple stakeholders and long sales cycles.

Competition exists in most of these categories but is fragmented and generally v Many incumbents are services firms trying to add software or legacy health IT ve

extending existing products. Few companies have been purpose built for MA compliance and operations from the ground up. This creates opportunity for we executed new entrants.

Distribution is a consideration. Direct sales to large MAOs is expensive and slov Partnership channels through consultancies, systems integrators, or other vendc with existing relationships could accelerate adoption. Trade associations and inc groups could provide marketing leverage. Product led growth is hard in enterpr healthcare but might work for certain offerings.

Exit considerations favor M&A over IPO in most cases given current market conditions. Potential buyers include large health IT vendors, payers themselves, firms rolling up healthcare software companies, and possibly EHR vendors expa beyond provider systems. Recent transactions in adjacent spaces have shown hea multiples for companies with strong growth and retention metrics.

Conclusion

The OIG guidance document is ultimately a procurement signal. It tells the indu that current approaches to MA compliance and operations are inadequate and n improve. That translates to budget allocation. CFOs and compliance officers at will read this document and recognize that they need better tools. They will ask vendors for proposals. They will allocate budget.

For entrepreneurs, the opportunity is to build the tools that MAOs need before fully articulate the requirements themselves. Take the guidance document as a specification. Turn each major section into a product thesis. Validate that thesis potential customers. Build the minimum viable product that solves the core prol Get early adopters. Iterate based on feedback. Scale.

For investors, the opportunity is to back teams that combine deep domain exper with strong product and technical capabilities. The market is large, growing, an underserved. The regulatory pressure is clear and increasing. The willingness to exists. The question is execution.

The companies that win this market will be those that make compliance invisibl
embedding it into operational workflows. They will reduce costs while reducing
They will improve patient outcomes while improving financial performance. The
turn regulatory requirements from burdens into competitive advantages.

The timing is right. MA continues to grow rapidly. Regulatory scrutiny is intens
Technology capabilities in ML, NLP, and data infrastructure have matured to th
point where genuinely better solutions are possible. Incumbent systems are agin
inadequate. Buyers are ready.

The shift from fee for service to managed care represents one of the fundamenta
transformations in US healthcare. MA sits at the center of that transformation.
infrastructure supporting MA needs to evolve to match the scale and complexity
the program. That evolution will create enormous value for the companies and
investors who enable it. The OIG guidance document essentially provides a road
Time to build.

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