The Gold Rush is Over, Now We Sell Shovels

JAN 27, 2026 • PAID

Abstract

The 2027 Medicare Advantage and Part D Advance Notice, released by the Cent Medicare & Medicaid Services (CMS) on January 26, 2026, signals a fundamental in the Medicare Advantage landscape. While the headline number is a modest 0. net payment increase, the underlying policy changes represent a significant regu pivot away from retrospective chart reviews and toward encounter based risk adjustment. This essay analyzes the key provisions of the Advance Notice and th impact on health tech investors and entrepreneurs. The main takeaways are:

- The exclusion of unlinked Chart Review Records (CRRs) from risk score calcul is the most significant change, creating a -1.53% payment headwind and a massiv opportunity for companies that can facilitate compliant, encounter based documentation.

- The similar exclusion of diagnoses from audio only telehealth visits will accele the shift to video enabled and integrated virtual care platforms.

- Recalibration of the Part C and Part D risk adjustment models with more rece data will create new winners and losers among plans, and a need for sophisticate analytics to navigate the changes.

- The overall theme is a flight to quality and accuracy. The era of easy money fro chart mining is ending, and the new era will reward companies that provide the and infrastructure for compliant, efficient, and high quality care delivery and documentation.

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Introduction: The End of the Easy Mon

Every gold rush has its phases. First, there's the wild, chaotic scramble for nugg lying on the ground. Then, as the easy pickings disappear, the real money is mad those who sell the picks, shovels, and Levi's. The 2027 Medicare Advantage and D Advance Notice is CMS's official declaration that the nugget picking phase is [1][2]. The headline number, a paltry 0.09% net payment increase, is a masterclas burying the lede. The real story is in the methodological changes, which collecti represent a tectonic shift in how Medicare Advantage plans are paid. For years, t MA gold rush was fueled by risk adjustment, a system designed to pay plans mo sicker patients. And for years, a cottage industry of chart reviewers and data mi sprung up to help plans find every possible diagnosis, whether it was from a face face visit or a dusty chart found in a basement. That game is now officially endi CMS is turning off the spigot for diagnoses that aren't tied to an actual patient encounter. This is not a subtle tweak. It's a fundamental rewiring of the MA pay system, and it creates a massive opportunity for a new generation of entrepreneu

and investors. The ones who understand that the future isn't about finding more diagnoses, but about documenting the right ones, at the right time, in a way that inextricably linked to the care being delivered. The gold rush is over. It's time to selling shovels.

To understand the magnitude of this shift, you need to understand the context. Medicare Advantage has been on an absolute tear for the past decade. Enrollmen grown to over 33 million beneficiaries, representing more than half of all Medica beneficiaries [3]. This growth has been fueled by a combination of factors, includ generous supplemental benefits, low or zero premiums, and yes, aggressive risk adjustment. The risk adjustment system was supposed to be a level playing field way to ensure that plans that took on sicker patients weren't financially penalize But it became something else entirely. It became a game of who could find and document the most diagnoses, regardless of whether those diagnoses were actua being treated or even relevant to the patient's current health status. The result w coding intensity arms race, with plans spending millions on retrospective chart reviews to squeeze every last dollar out of the system. CMS has been trying to re in for years, with limited success. The 2027 Advance Notice is the most aggressi move yet, and it's a clear signal that the agency is serious about bringing the syst back into balance.

The Big Squeeze: Unlinked Chart Revie and the End of an Era

The single most important, and most disruptive, proposal in the 2027 Advance N is the exclusion of diagnosis information from unlinked Chart Review Records, CRRs, from risk score calculations [2]. This sounds technical and boring, which probably by design. But make no mistake, this is a bombshell. For years, a signif portion of risk adjustment revenue for many plans has come from retrospective reviews. A small army of coders would be dispatched to scour years of medical records, looking for any mention of a risk adjustable condition. If they found on they could submit it, even if it had no connection to a recent doctor's visit. Thes the unlinked CRRs. They were a major source of the coding intensity that CMS

been trying to stamp out for years, the gap between what MA plans say their members' health status is and what the data from Original Medicare shows. Wit one change, CMS is taking a sledgehammer to that business model. The agency estimates this will result in a -1.53% payment impact on average [2]. But the aver misleading. For plans that have built their business on aggressive, retrospective reviews, the impact will be far greater, potentially in the 3-5% range or even higl This is a direct shot across the bow of the chart review industry, and a massive tailwind for companies that can help plans and providers capture and document diagnoses at the point of care.

The mechanics of this change are worth understanding in detail. Under the curr system, MA plans can submit diagnoses from a variety of sources, including clai data, encounter data, and chart reviews. Chart reviews come in two flavors: linke unlinked. A linked chart review is one where the diagnosis is tied to a specific p encounter, like a doctor's visit or a hospital stay. An unlinked chart review is on where the diagnosis is just sitting in the chart, with no connection to a specific service or clinical interaction. CMS is now saying that only the linked diagnoses count for risk adjustment [1]. This is a huge change because unlinked chart revie have been a major source of risk adjustment revenue for many plans. The beauty unlinked review, from the plan's perspective, is that it's low friction. You don't to get the provider to document anything new. You just need to find a diagnosis already in the chart, even if it's from years ago, and submit it. This created a per incentive where plans were spending more time looking backward at old charts forward at current care needs. The exclusion of unlinked CRRs is CMS's way of that the risk adjustment system should be about current, active diagnoses that a being managed, not historical diagnoses that are gathering dust in a file cabinet.

The future is not about an army of coders in a back room. It's about a clinician u smart tool that prompts them for the right documentation during a patient visit. about EHRs that are smart enough to link diagnoses to encounters automatically about compliance software that can flag an unlinked CRR before it's even submi This is a forced migration from a retrospective, audit based model to a prospecti encounter based one. And the companies that build the bridges for that migrati

going to be the big winners. Think about the opportunity here. Every MA plan i country is going to need to rethink their risk adjustment strategy. They can't jus on chart reviews anymore. They need to get their providers to document better, time, at the point of care. This creates demand for a whole ecosystem of tools an services. Clinical documentation improvement software that integrates with the and prompts providers for the right documentation. Ambient listening tools tha automatically generate clinical notes and link diagnoses to encounters. Training education programs for providers on proper documentation. Analytics platform can identify gaps in documentation before they become revenue gaps. The list g This is not a niche opportunity. This is a fundamental shift in how the entire M ecosystem operates, and the companies that can help facilitate that shift are goi be in high demand.

The Telehealth Shakeout: Video In, Au Out

In a move that mirrors the crackdown on unlinked CRRs, CMS is also proposing exclude diagnoses from audio only encounters from both Part C and Part D risk adjustment [2]. This is another step in the flight to quality and a clear signal tha views video enabled telehealth as the standard for virtual care. During the pand audio only visits were a lifeline, a quick and easy way to connect with patients. B they were also ripe for abuse, a low friction way to document a diagnosis withou comprehensive clinical evaluation. By excluding these visits from risk adjustme CMS is effectively saying that if a plan wants to get paid for a diagnosis, it needs come from a more robust clinical interaction. This is a huge blow to the standal audio telehealth companies, and a major boost for integrated virtual care platfor that offer video, remote patient monitoring, and other more sophisticated tools.

The telehealth market has been a rollercoaster over the past few years. The pand created a massive surge in demand, and investors poured billions into the sector as the pandemic has receded, the market has cooled considerably. Many of the standalone telehealth companies that raised at sky high valuations are now strug to find product market fit in a post pandemic world. The exclusion of audio only

from risk adjustment is going to accelerate the shakeout. The companies that we built on a model of quick, low friction phone calls are going to have a hard time justifying their value proposition when those calls don't count for risk adjustme anymore. The winners will be the companies that can provide a more compreher integrated virtual care experience. Platforms that offer video visits, remote patie monitoring, asynchronous messaging, and seamless integration with the provide workflow. The key word here is integration. The standalone telehealth model, w patient calls a random doctor they've never met before, is not the future. The fu hybrid care, where virtual and in person care are seamlessly blended, and where virtual care is provided by the patient's regular care team, not a stranger.

The opportunity here is for companies that can provide a seamless, integrated vi care experience for both patients and providers. Platforms that are embedded in provider's workflow, that make it easy to conduct a video visit, and that automat document the encounter in the EHR. This also creates a tailwind for remote pati monitoring and other connected health technologies. If a plan can't rely on a ph call to document a member's chronic condition, they will be more willing to inv a connected glucometer or blood pressure cuff that can provide a steady stream data and documented encounters. The beauty of remote patient monitoring is th creates a continuous stream of clinical data and encounters, all of which can be for risk adjustment. A patient with diabetes who is using a connected glucomete generating data every day, and that data can be used to document the ongoing management of their condition. This is a much more robust and defensible form documentation than a once a year phone call. The telehealth shakeout is here, a winners will be the companies that can provide a higher fidelity, more integrate more clinically rigorous virtual care experience.

Recalibrating the Compass: The New R Model

Beyond the headline grabbing changes to unlinked CRRs and audio only telehea CMS is also making a number of more subtle but still important updates to the and Part D risk adjustment models. The most significant of these is the recalibr

of the models using more recent data. The new models will be based on 2023 diagnoses and 2024 expenditures, a significant update from the 2018 and 2019 d used previously [2]. This is a big deal because the cost of treating different disea changes over time. A new blockbuster drug can dramatically increase the cost of treating a certain type of cancer, while a new generic can lower the cost of treati common chronic condition. By recalibrating the models, CMS is ensuring that tl risk scores more accurately reflect the current cost of care. This will create a nev of winners and losers among plans. Those that have a high prevalence of membe with conditions that have become more expensive to treat will see a payment boo while those with members whose conditions have become less expensive will see

The risk adjustment model is essentially a giant regression equation that predict much it will cost to care for a beneficiary based on their demographic characteri and their diagnoses. The model is calibrated using historical data from Original Medicare, and the coefficients in the model represent the relative cost of treatin different conditions. When CMS recalibrates the model with more recent data, t coefficients change. Some conditions become more expensive, some become less expensive, and the relative weights shift accordingly. This creates a significant opportunity for analytics companies that can help plans understand the impact o these changes. The winners will be the companies that can not only tell a plan h their revenue will be affected, but also identify which members and which condi are driving the change. This will allow plans to target their care management an clinical programs more effectively.

For example, let's say the recalibration shows that the cost of treating congestive failure has increased significantly over the past few years, perhaps due to new, expensive medications. A plan that has a high prevalence of CHF patients will se revenue boost from the recalibration. But more importantly, they now have a cle signal that they should be investing more in CHF care management programs. T analytics platform that can identify this opportunity, quantify the revenue impac help the plan design an effective intervention is going to be a valuable partner. T recalibration is a reminder that risk adjustment is not a static game. It's a consta evolving system, and the plans and vendors that have the most sophisticated ana

tools will be the ones who can stay ahead of the curve. The other important thing note about the recalibration is that it's using the V28 clinical classification system which was first implemented in 2024 [2]. This is a more granular and clinically p system than the previous versions, and it allows for more accurate risk adjustme But it also adds complexity, and plans need sophisticated tools to navigate it.

The Part D Puzzle: IRA and Population Specific Calibration

The Part D risk adjustment model is also getting a major overhaul, driven by two factors: the implementation of the Inflation Reduction Act (IRA) and a new, mor granular approach to population calibration. The IRA is a game changer for the D program, with its new manufacturer discounts, benefit redesign, and cap on o pocket spending. The 2027 risk model is being updated to reflect these changes, which will create new incentives and new opportunities for plans and PBMs [2]. companies that can help plans optimize their formularies, manage their pharma networks, and navigate the new manufacturer discount program will be in high demand. But perhaps the more interesting change is the proposal to calibrate th D model separately for Medicare Advantage Prescription Drug (MA-PD) plans a standalone Prescription Drug Plans (PDPs) [2]. For years, CMS has used a single model for both populations, even though they have very different demographic a clinical profiles. By calibrating the models separately, CMS is acknowledging th reality and moving toward a more accurate and equitable payment system.

The IRA has fundamentally changed the economics of Part D. The new manufac discount program, the redesigned benefit structure, and the cap on out of pocke spending all create new dynamics that plans need to navigate. The 2027 risk mo being updated to reflect these changes, which means that the relative weights of different conditions will shift to account for the new cost structure. This creates need for sophisticated analytics that can help plans understand how the IRA is affecting their costs and their revenue. For example, the IRA includes a provisio increases the manufacturer discount for certain small manufacturers over time. will affect the cost of treating conditions that are managed with drugs from thes

manufacturers, and the risk model needs to account for that. The companies tha help plans navigate these complexities, optimize their formularies, and manage t pharmacy networks in the new IRA world will be in high demand.

But the more structurally interesting change is the separate calibration for MA- and standalone PDPs. This is a recognition that these are fundamentally differer populations with different cost profiles. MA-PD enrollees are, on average, healtl and have lower drug costs than standalone PDP enrollees. This is because MA p tend to attract a healthier population, and because MA plans have more tools to manage drug utilization, like prior authorization and step therapy. By calibratin models separately, CMS is ensuring that MA-PD plans aren't overpaid and stand PDPs aren't underpaid. This is a boon for plans that serve specific populations, dual eligibles, and a tailwind for companies that can provide population specific analytics and care management tools. The Part D puzzle is getting more comple for the companies that can help solve it, the rewards will be significant. The key insight here is that one size does not fit all. The future of Part D risk adjustmen going to be more granular, more population specific, and more tailored to the ur characteristics of different plan types and member populations.

The Quiet Corners: PACE, Puerto Rico, and Star Ratings

While the big news in the Advance Notice is around risk adjustment, there are a other notable changes in the quieter corners of the Medicare Advantage progran the Programs of All Inclusive Care for the Elderly (PACE), CMS is continuing th transition to the new risk adjustment model, with a 50/50 blend of the old and n models for 2027 [2]. This creates a niche opportunity for tech vendors who can h these unique organizations navigate the complexities of a dual model system. In Puerto Rico, a market with incredibly high MA penetration, CMS is proposing t continue the current payment policies, providing a stable and predictable environment for plans and investors [2]. And in the world of Star Ratings, the bi story is the lack of a big story. The impact of Star Ratings changes on 2027 paym is a mere -0.03%, a rounding error in the grand scheme of things [2]. This stabili

good news for the ecosystem of vendors that help plans improve their quality sc
The demand for their services will remain strong, as the financial incentives for
Star Ratings are still very much in place.

PACE organizations are a unique part of the Medicare ecosystem. They provide
comprehensive, integrated care for frail elderly individuals, and they operate un
capitated payment model. The transition to the new risk adjustment model is
particularly challenging for PACE orgs because they have historically submitted
data through the legacy Risk Adjustment Processing System (RAPS), and they're
being required to transition to the Encounter Data System (EDS). The 50/50 bler
2027 is a transitional step, and CMS has indicated that they intend to fully trans
PACE orgs to the new model in future years. This creates a niche but real opport
for tech vendors who can help PACE orgs manage this transition. Tools that can
them submit data to both systems, reconcile the differences between the two mo
and optimize their coding and documentation practices will be in demand. PACE
small market, but it's an underserved one from a tech perspective, and there's rc
for innovation.

Puerto Rico is a fascinating market. MA penetration is over 80%, far higher than
state or territory [4]. The market has unique characteristics, including a differen
structure and a different regulatory environment. CMS has historically applied s
payment adjustments to Puerto Rico to account for these differences, and the 20
Advance Notice proposes to continue those policies. This stability is good news
plans operating in Puerto Rico and for investors looking at the market. The high
penetration and the stable payment environment make it an attractive market fo
innovation, particularly in areas like bilingual care management and culturally
tailored member engagement. The Star Ratings story is one of stability. The -0.0
impact from Star Ratings changes is negligible, and the overall Star Ratings
methodology is relatively unchanged from prior years. This is good news for the
ecosystem of vendors that help plans improve their quality scores. The financial
incentives for high Star Ratings are still very much in place, with quality bonus
payments providing a significant revenue boost for high performing plans. The

demand for Star Ratings improvement programs, quality measure performance platforms, and member engagement tools will remain strong.

The Investor's Playbook: Where the Smart Money is Going

So what does this all mean for investors and entrepreneurs? The 2027 Advance N is a clear roadmap for where the smart money should be going in health tech. Th overarching theme is the shift from retrospective data mining to prospective, encounter based care documentation. This creates a number of attractive investı theses. First, and most obviously, is the category of clinical documentation improvement at the point of care. This includes everything from smart EHR tem to ambient listening tools that can automatically generate clinical notes and link diagnoses to encounters. The companies that can make it easy for clinicians to d right thing, without adding to their administrative burden, will be the big winne Second is the next generation of virtual care platforms. The audio only telehealtl market is dead. The future is integrated platforms that offer video, remote patie monitoring, and seamless integration with the provider's workflow. The compan that can provide a truly hybrid care experience, blending the best of virtual and person care, will be in high demand.

Third is the category of advanced risk adjustment analytics. With the recalibrati the risk models and the new population specific calibration in Part D, the need f sophisticated analytics has never been greater. The companies that can help plar understand the financial impact of these changes, identify high risk members, ar target their interventions effectively will be essential partners. Fourth is the compliance and program integrity space. With CMS's increased focus on accura accountability, plans will need to invest in tools that can help them stay on the r side of the regulators. This includes everything from audit preparation software prospective risk adjustment validation tools. The regulatory headwind of increas scrutiny is a massive tailwind for the companies that can help plans navigate it. I is the remote patient monitoring and connected health space. With the exclusion audio only visits from risk adjustment, plans will be looking for other ways to

generate documented encounters for their chronic disease patients. Connected devices that can provide a continuous stream of clinical data and documented encounters will be in high demand.

The bottom line is this: the 2027 Advance Notice is a gift to the health tech community. It is a clear and unambiguous signal from the largest payer in the co about what it values. It values accuracy. It values quality. It values care that is documented at the point of service, not in a back room a year later. The entrepre who build companies that align with these values, and the investors who back th are the ones who will build the next generation of great health tech companies. T market opportunity is massive. With over 33 million MA beneficiaries and over $ billion in annual MA payments, even a small slice of the market represents a significant revenue opportunity [3][5]. And the regulatory tailwind is strong. CM not going to reverse course on this. The trend toward greater accuracy and accountability in risk adjustment is only going to accelerate in future years. The companies that get ahead of this trend now will be the ones that dominate the m in the years to come.

Conclusion: A More Sustainable Future

The 2027 Medicare Advantage and Part D Advance Notice is more than just a se payment policies. It's a vision for a more sustainable and accountable Medicare Advantage program. It's a program where payments are more closely tied to the health of the members, where virtual care is held to a higher standard, and wher focus is on delivering high quality care, not on gaming the system. This transitio not be easy for everyone. There will be plans and vendors who are left behind. Bu the health tech community, it is a massive opportunity. It is a chance to build the and the infrastructure that will power the next era of Medicare Advantage, an er is more efficient, more equitable, and more focused on what really matters: the h of the patient. The gold rush is over. The hard work of building a better system h just begun. And for those who are up to the challenge, the rewards will be far gr than any nugget found lying on the ground.

The three principles that CMS has articulated for the future of MA risk adjustm are worth repeating: simplicity, competition, and accuracy [1]. Simplicity means reducing the administrative burden on plans and providers, making it easier to d right thing. Competition means creating a level playing field where all plans, regardless of size or resources, can compete on the basis of value, not on the bas who has the most sophisticated chart review operation. And accuracy means ens that payments reflect the actual health risk of the members and the actual cost o caring for them. These principles are a North Star for the health tech communit companies that can help the MA ecosystem achieve these goals, that can make th system simpler, more competitive, and more accurate, are the ones that will thriv the years to come. The 2027 Advance Notice is a clear signal that the era of easy money from coding intensity is over. But it's also a signal that the era of buildin better, more sustainable MA program has just begun. And that's an era that shou excite every entrepreneur and investor in health tech.

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