The CY 2027 MA Rate Announcement an Entrepreneur’s Prospectus

APR 07, 2026

Abstract

The CMS CY 2027 Medicare Advantage and Part D Rate Announcement droppe April 6, 2026. It finalizes a net average payment increase of 2.48 percent, or roug billion dollars in additional MA payments. But the real story for health tech bui and investors is not the topline number. It is the collection of new operational mandates, data architecture changes, and program integrity crackdowns that wil force payers to either build or buy entirely new capabilities over the next 12 to 2 months. This essay reads the Rate Announcement through the lens of a venture incubator asking one question: what companies need to exist because of what CI just did?

Key themes:

Unlinked chart review record exclusion creates a massive encounter data remedi market

Audio-only diagnosis exclusion forces telehealth workflow retooling

Separate PDP and MA-PD normalization opens a wedge for Part D analytics sta

Star Ratings measure set overhaul, including new depression screening, creates HEDIS/quality reporting buildout demand

Skin substitute repricing aftermath continues to scramble risk adjustment econ

The BALANCE Model and GLP-1 utilization create pharmacy benefit uncertain that favors risk analytics tooling

ESRD payment adequacy concerns open a door for kidney care cost management platforms

Puerto Rico-specific adjustments signal a niche but real market for territory-foc plan services

Table of Contents

The Topline Numbers and Why They Lie

CMS finalized a 2.48 percent net average increase in MA plan payments for CY 2 That is about 13 billion dollars more than 2026. When the Advance Notice came in January projecting a 0.09 percent increase, the industry basically had a collect

panic attack, so 2.48 percent feels like a relief. But relief is not the same as gene
When you add in the estimated 2.50 percent risk score trend from underlying co
changes and population shifts, the effective growth is closer to 4.98 percent. Sou
decent until you factor in what the plans themselves say they are seeing in utiliz
trend. Nearly every large MA organization commented that inpatient utilization
B drug spending, post-acute volumes, and behavioral health costs are all running
hotter than what CMS projects. The commenters are not subtle about this. The
comment section of the Rate Announcement reads like a 50-page group therapy
session for actuaries who feel gaslit by the Office of the Actuary.

What matters for builders is that 2.48 percent is a number designed to keep the
on for plans, not to let them print money. The margin environment stays compre
Plans that cannot operationally adapt to the new risk adjustment rules, the new
quality measures, and the new encounter data requirements will be the ones who
markets or cut benefits. And the ones who can adapt will need vendors to help t
do it, because the operational changes CMS is requiring are not trivial.

Unlinked Chart Reviews: The Biggest Startup Catalyst in the Document

This is the single most consequential policy change in the Rate Announcement f
health tech entrepreneurs, and it barely got any press. CMS is finalizing the excl
of diagnoses from unlinked chart review records from risk score calculation star
in CY 2027. The only exception is for beneficiaries who switch from one MA
organization to another.

To understand why this matters, you need to understand how chart reviews worl
the MA risk adjustment ecosystem. MA plans submit encounter data records, wh
are basically electronic claims documenting the services provided to enrollees.
Separately, plans can submit chart review records, which add diagnoses found du
retrospective medical record reviews. When a chart review record is “linked,” it
to a specific encounter data record and says “we found an additional diagnosis in

chart from this visit." When it is "unlinked," it floats free with no connection to documented service encounter.

CMS found that roughly 85 percent of the 88.8 million unlinked chart review re submitted in 2023 for 2024 payment could not be matched to any encounter data record even when they tried matching on beneficiary, billing provider, and dates service within three days. That is a staggering number. CMS is essentially saying you cannot tie a diagnosis to a real clinical encounter, it does not count for paym

The average payment impact of this exclusion is negative 1.24 percent. Without switcher exception, it would be negative 1.78 percent. But the average masks enormous variation. Plans that have relied heavily on in-home health risk assessı third-party chart review vendors, and retrospective coding operations to generat unlinked chart review records are going to get hit much harder. Some of the larg national MA plans have built entire revenue lines around this practice.

So what needs to be built? First, encounter data remediation platforms. Every M plan in America now needs to audit its encounter data submission infrastructure figure out how to make sure every diagnosis that matters is either submitted on encounter data record or on a chart review record that links to one. That is a wo and data engineering problem. The plans that have been lazy about encounter da submissions (and many have, because unlinked chart reviews were an easy workaround) need to fix their pipelines fast. Second, prospective risk adjustmen that capture diagnoses at the point of care rather than retrospectively through cl review. CMS has been pushing this direction for years, and the unlinked chart re exclusion is the final shove. Tools that integrate with EHR workflows to ensure accurate, complete diagnosis capture during clinical visits are now table stakes, nice-to-haves. Third, chart review linking services. For plans that still do retrospective chart review (and many will, it is not going away), the ability to reli link chart review findings to existing encounter data records becomes a critical compliance function. This is a data matching and reconciliation problem that sc for a purpose-built SaaS product.

The market here is not small. Risk adjustment revenue for the MA program is hundreds of billions of dollars. A 1 to 2 percent payment impact across 34 millic enrollees translates to billions of dollars at risk. Even capturing a small slice of t remediation and tooling market around this policy change is a venture-scale opportunity.

Audio-Only Telehealth Gets Kneecappe for Risk Adjustment

CMS is finalizing the exclusion of diagnoses from audio-only telehealth encount from risk score calculation. If the only service lines on a claim have audio-only modifiers (modifier 93 or FQ), the diagnoses from that encounter are out for risk adjustment purposes. The average payment impact is zero, which tells you some about how few plans were actually submitting these diagnoses. But the policy sig loud: CMS wants diagnoses tied to face-to-face encounters, period.

For telehealth companies, this is a clarification that has been a long time coming Audio-only visits were never supposed to generate risk-adjustment-eligible diag under existing CMS guidance, but the operational enforcement was spotty. Now explicit. Companies building telehealth platforms for MA plans need to make su their visit type routing clearly distinguishes between audio-video visits (which d support risk adjustment) and audio-only visits (which do not). This is a feature, r product, but it matters for any company selling into the MA risk adjustment workflow. Plans will want reporting dashboards that show what percentage of th telehealth volume is audio-only versus audio-video, broken down by provider an condition, so they can coach their networks accordingly.

Separate Worlds: PDP vs MA-PD Normalization and What It Means for P D Startups

CMS finalized separate normalization factors for standalone prescription drug p and MA prescription drug plans, plus separate continuing enrollee model segme

the RxHCC risk adjustment model. This is a technical change that has big strate implications.

The background: MA-PD plans have historically had higher risk scores than standalone PDPs because MA organizations can affect the submission of diagno through their Part C encounter data. PDPs cannot. The old single normalization factor basically split the difference, which overpaid MA-PD plans and underpaic PDPs. CMS has been moving toward separate normalization for a couple of year the CY 2027 finalization locks it in with a methodology that assumes equal unde risk between the two sectors.

Why does this matter for startups? The PDP market has been under enormous s since the IRA Part D redesign. Plan liability went up, the catastrophic phase cos sharing structure changed, and the premium stabilization demonstration is year year. Several large PDP sponsors commented that they need narrowed risk corri or other stabilization mechanisms to keep offering standalone drug plans. CMS basically punted on all of that, saying it cannot decide whether to continue the premium stabilization demonstration until it sees 2027 bids.

The investment thesis here is that PDPs need better Part D analytics, utilization management, and formulary optimization tools, and they need them from vendo understand the PDP-specific economics, not just the MA-PD economics. The se normalization creates a distinct financial environment for PDPs that is different MA-PDs in terms of how risk is predicted and paid. Any company building Part risk adjustment, bidding support, or pharmacy benefit analytics tools should be building for both segments now and pricing the products accordingly. There is a opening for companies that help PDP sponsors improve their diagnosis data. CM acknowledged that PDPs have a structural disadvantage in diagnosis submission because they do not control the medical encounter. Tools that help PDP sponsor better diagnosis data from FFS claims, or that help them partner with provider organizations for data sharing, could be valuable in this new normalization environment.

Star Ratings Overhaul: Depression Screening, Measure Removals, and Quality Tech

The Star Ratings changes in the CY 2027 Rate Announcement and the companic final rule are the kind of thing that sounds boring until you realize how much m is on the line. MA quality bonus payments are tied to Star Ratings, and a contrac Star Rating determines whether it gets a 5 percentage point benchmark bonus, a point bonus, or nothing. For a large MA contract, the difference between 3.5 sta 4 stars can be hundreds of millions of dollars.

CMS is removing 11 measures from the Star Ratings, adding a Depression Scree and Follow-Up measure starting with the 2027 measurement year (for 2029 Star Ratings), keeping the historical reward factor instead of implementing the Healt Equity Index reward that the prior administration had developed, and adding or updating four measures for the 2027 Star Ratings cycle including Colorectal Can Screening (respecified), Care for Older Adults Functional Status Assessment (returning after spec change), Concurrent Use of Opioids and Benzodiazepines, a Polypharmacy with Multiple Anticholinergic Medications in Older Adults.

The Depression Screening measure is the one to watch from a venture perspecti Behavioral health measurement in MA has been a gap forever. Adding a Part C depression screening measure creates demand for clinical workflow tools, memb engagement platforms, and data capture systems specifically designed to ensure plans can document depression screening at scale across their enrolled populati This is not a small operational lift. Plans need to screen millions of members, document the screening, and ensure follow-up if the screen is positive. That is a coordination problem, a data capture problem, and a member engagement probl wrapped into one quality measure.

The polypharmacy and opioid-benzodiazepine measures create similar demand f medication management platforms. These are clinical pharmacy measures that r plans to have visibility into their members' full medication profiles and the abili

intervene when dangerous combinations are detected. Companies building medi therapy management tools, pharmacist intervention platforms, or prescriber ale systems are well-positioned here.

The removal of 11 measures focused on administrative processes is also worth n CMS is explicitly saying it wants Star Ratings to focus on clinical outcomes and patient experience, not on administrative checkbox compliance. For quality improvement vendors, this means the sales pitch needs to shift from "we help yo check boxes" to "we help you move clinical outcomes." That is a harder product build but a stickier one.

Skin Substitutes, Risk Model Freeze, a the Coding Economy

CMS decided not to finalize the proposed 2027 CMS-HCC risk adjustment mod recalibration and will instead continue using the 2024 model for CY 2027. This the single biggest change from the Advance Notice to the final Rate Announcem and is the main reason the payment increase jumped from 0.09 percent to 2.48 percent. The proposed model would have used 2023 diagnoses and 2024 expendi data, which included the anomalous skin substitute spending that inflated certa condition coefficients while deflating others.

The skin substitute story is worth understanding because it illustrates how FFS payment policy changes ripple through MA in unexpected ways. Spending on physician-administered drugs, which includes skin substitutes, went from 9.66 per member per month in 2023 to 22.26 in 2024 to 40.04 in 2025, and then CMS projects it crashes to 1.53 in 2026 because of the CY 2026 Physician Fee Schedul that reclassified skin substitutes from biologicals to incident-to supplies. That reclassification cut payment by roughly 90 percent. CMS tested what would hap they reduced skin substitute prices in the proposed model and found that raw M risk scores would have been only 0.1 percent lower, meaning the skin substitute distortion was real but small in aggregate. But the condition-level impacts were over the place. Skin condition relative factors went up 42.9 percent in the propo

model versus the 2024 model, while lung conditions went down 14.3 percent, kid went down 14.3 percent, and metabolic went down 8 percent.

By freezing the model at the 2024 version, CMS avoided this mess for now. But t have signaled clearly that they will recalibrate in a future year. For startups in th adjustment space, this creates a window of relative stability in the HCC coefficie structure. But it also means that when the recalibration does come, it will be a b jump than if it had been done incrementally. Companies that help plans model t financial impact of risk adjustment model changes, stress-test their revenue und different coefficient scenarios, and optimize their coding and documentation strategies around the specific HCCs that are most likely to move are going to be high demand when CMS proposes the next recalibration.

The normalization factors for 2027 are also worth noting. The 2024 CMS-HCC n normalization factor is 1.079, up from where it has been. Normalization is CMS' mechanism for keeping the average MA risk score anchored to 1.0 in FFS, and th factor trends upward as coding intensity in FFS increases. The 5.90 percent codi pattern difference adjustment, which is the statutory minimum, continues to be blunt instrument that some commenters argue should be higher and others argu should be lower. For risk adjustment vendors, the normalization and coding patt dynamics are the bread and butter of their value proposition, and nothing in this Announcement changes that.

GLP-1s, BALANCE, and the Part D Pharmacy Benefit Chaos

The Part D sections of the Rate Announcement are a masterclass in reading betv the lines. CMS finalized updated RxHCC models using 2023 diagnoses and 2024 expenditure data, reflecting IRA benefit changes for 2027 including the increase manufacturer discount for specified small manufacturers. The deductible for th defined standard benefit goes from 615 dollars to 700 dollars, and the out-of-poc threshold goes from 2,100 to 2,400. The annual percentage increase driving thes parameter updates is 13.65 percent, which reflects a 9.37 percent annual drug

spending trend plus 3.92 percent in prior year revisions. That 9.37 percent trend you everything about what is happening in Part D drug spending.

Multiple commenters raised concerns about the BALANCE Model, which is the Innovation Center model focused on GLP-1 receptor agonists scheduled to start CY 2027. CMS basically said that the design of Innovation Center models is outs the scope of the Rate Announcement. But the anxiety is real. GLP-1 utilization i accelerating, and the Part D benefit redesign has increased plan liability in the catastrophic phase. Plans are simultaneously dealing with higher drug costs, hig plan liability, and uncertainty about whether CMS will negotiate prices on addit drugs.

The startup opportunities in this space are obvious and large. Part D actuarial a bidding support tools that can model the interaction between GLP-1 utilization projections, IRA benefit changes, risk corridor parameters, and premium stabili scenarios. Specialty pharmacy management platforms that help plans manage hi cost drug categories while maintaining Star Ratings performance on medication adherence measures. Prior authorization and utilization management tools speci calibrated for the post-IRA Part D benefit structure. And formulary optimizatio engines that can account for maximum fair prices on negotiated drugs, manufac discounts under the redesigned benefit, and the new separate PDP/MA-PD normalization dynamics.

ESRD and the Kidney Care Opportunity

The ESRD payment sections got a lot of comment activity. Several commenters a that state-level ESRD rate setting masks within-state variation in kidney care co and that the MOOP limit creates an implicit cross-subsidy from non-ESRD to E enrollees. CMS acknowledged the concerns but did not change the methodology agency pointed to prior analyses showing that moving to sub-state (CBSA-level) rates would actually reduce payments in areas with higher deprivation indices, w is why they have not pulled the trigger.

For kidney care startups, the signal is that CMS is aware of the ESRD payment adequacy problem but is constrained by the statute (Section 1853(a)(1)(H)) from making dramatic changes. Plans are going to have to manage ESRD costs within existing rate structure, which means they need better tools for kidney care management, transplant coordination, dialysis utilization management, and functioning graft monitoring. The ESRD risk adjustment models (2023 ESRD CM HCC models) are separate from the regular HCC model and have their own normalization factors and coefficient structures. Companies that build ESRD-sp analytics and care management tools have a niche but defensible market because payment mechanics are genuinely different from the rest of MA.

Puerto Rico as a Micro-Market

CMS continues its longstanding adjustments for Puerto Rico, basing MA county on beneficiaries with both Part A and Part B (unlike the mainland, where Part A and Part B-only beneficiaries are included) and adjusting for the higher proport zero-claims beneficiaries. The adjusted FFS costs in Puerto Rico get a 4.4 percer uplift from the zero-claims adjustment. Multiple commenters, including plans operating on the island, argued that rates are still inadequate given the extremel MA penetration (far higher than any state), the high proportion of dual-eligible beneficiaries, provider infrastructure challenges, and the ongoing movement of l providers and beneficiaries to the mainland.

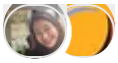
This is a small market but a real one. Companies that can serve the specific operational needs of MA plans in Puerto Rico, including bilingual member engagement, provider network management in a strained delivery system, and D operations for the heavily dual-eligible population, have limited competition and genuine demand. The political dynamics also make it likely that CMS will eventu do something more substantial for Puerto Rico rates, whether through demonstr authority or legislative action, which would expand the market further.

What to Build

Reading this Rate Announcement as a venture thesis, the highest-conviction opportunities cluster around a few themes. Encounter data infrastructure and cl review linking tools are the most urgent, because the unlinked chart review excl takes effect for CY 2027 and plans need to adapt now. Point-of-care risk adjustn capture tools that reduce dependence on retrospective chart review are the medi term play. Part D bidding, analytics, and formulary optimization platforms that account for the separate PDP/MA-PD normalization and the IRA benefit redesig underfunded relative to the complexity of the problem. Depression screening an behavioral health quality measurement tools are a new category created by the S Ratings changes. Medication management platforms targeting the new polyphar and opioid safety measures have a clear regulatory catalyst. And ESRD-specific c management platforms address a payment adequacy problem that CMS has acknowledged but not solved.

The common thread is that CMS is simultaneously tightening the rules on how p get paid (chart review exclusions, audio-only exclusions, coding pattern adjustm while increasing the operational complexity of what plans need to do (new qualit measures, IRA benefit changes, separate Part D normalization). That gap betwee tighter payment rules and higher operational demands is where startups live. Pla not have the internal capability to build all of this themselves, and the timeline i short for them to try. They need to buy.

For angel investors and seed-stage builders in health tech, the Rate Announceme basically a procurement forecast disguised as a regulatory document. Every man CMS finalizes is a purchase order that has not been written yet. The plans know need to comply. The question is just who builds the tools they will buy to do it.

 3 Likes

← Previous

Discussion about this post

Comments Restacks

Write a comment...

Human Systems Human's Substack 3h

Hey — I came across your writing and really liked how you think.

I'm exploring something similar from a different angle — writing about human bel through a system design lens (like debugging internal patterns).

Just started publishing on Substack. If you ever get a moment to read, I'd genuine your perspective.

Also happy to support your work — feels like there's an interesting overlap here.

LIKE REPLY