Key Insights Summary

From Chart Chase to Competitive Advantage: The 2027 Medicare Advantage Playbook
Thursday, September 24, 2026 | 12:00–1:00 PM ET

Executive Summary

Medicare Advantage plans face growing pressure to improve quality performance with limited resources. A late-year push leaves teams less time to address barriers, coordinate care and respond when an intervention falls short. The discussion explored how plans are changing the work earlier in the year to reduce their dependence on that fourth-quarter scramble.

Leaders from Zing Health, CDPHP, UPMC Health Plan and MedOrion shared approaches that connect existing information across departments, expand clinical record review, clarify responsibility for timely follow-up and make better use of member interactions.

Their examples showed that earlier action requires changes beyond the timing of outreach. Plans need information that is current enough to guide decisions, workflows that put it in the right hands, and an understanding of why a member has not received care.

The practical opportunity for 2027 is to identify where those connections are missing and build them into everyday operations. Technology can increase capacity, but provider cooperation, clear ownership and member relationships determine how effectively that capacity is used.

Guests:

- Michael Farina, Vice President, Healthcare Quality, CDPHP
- Mariah Osborn, Director, Medicare Stars, UPMC Health Plan
- Daniel Weaver, Senior Vice President, Stars and Quality, Zing Health
- David Burianek, Chief Strategy Officer, MedOrion, (formerly VP, Corporate Quality at both Anthem and Humana)
- Eric Glazer, CEO, Bright Spots Ventures; Executive Producer & Host, Bright Spots in Healthcare (Moderator)

Bright Spots & Strategies

1. Use What the Organization Already Knows to Start Earlier

Plans do not have to wait for the first HEDIS results to begin acting on the needs of returning members.

Daniel Weaver of Zing Health explained that existing knowledge about members can support work beginning in January, before a HEDIS partner produces initial results in March or April. He

also described finding valuable information within departments that did not recognize how their work connected to quality performance.

The starting point is understanding what information already exists, who holds it and how it could inform another team's work. That discovery can reveal opportunities to begin earlier without waiting for a new reporting cycle.

Takeaway: Review what teams already know about returning members and identify which actions can begin before the first formal performance reports arrive.

2. Use Automation to Expand the Scope of Clinical Review

CDPHP's clinical data work illustrates how technology can increase both the speed and breadth of record review.

Mike Farina described adding natural language processing to an established supplemental clinical data process, supported by investment with IT and a vendor partner. He reported reducing review time from approximately 10–12 minutes per record to under two minutes while expanding the number of HEDIS measures reviewed from four to seventeen.

The work also supports a more current picture of patients for providers. Farina described access to more than 70 electronic medical record systems and emphasized the importance of shared expectations and ongoing collaboration with practices.

Takeaway: Evaluate automation by the additional work it enables, including broader measure coverage and more useful information for providers, alongside the time it saves.

3. Organize Time-Sensitive Follow-Up Around the Member Event

For measures with short follow-up windows, retrospective gap reports can identify an opportunity after the time to act has passed.

Mariah Osborn described UPMC Health Plan's work on seven-day emergency department follow-up. The plan brings together multiple data sources to identify likely eligible members earlier, then coordinates which team should engage them.

That requires decisions about whether a health plan care manager, transition-of-care coordinator or provider partner is best positioned to act. UPMC has worked to clarify those roles and reduce duplicate outreach. Osborn also emphasized capturing the care that occurs so the completed work can be reflected in gap closure.

Takeaway: For time-sensitive measures, connect event identification with a clear owner, a timely response and a process for documenting completed care.

4. Make Each Member Interaction Worth Returning For

An interaction with a difficult-to-reach member may be the only opportunity a team has to establish a relationship.

Weaver described encouraging teams to treat each contact as a “golden encounter.” In his example, a member who had not connected with a new primary care provider needed help getting care and building rapport before the plan could reasonably address a longer list of open gaps.

That approach requires judgment about what matters most in the moment. Helping with an immediate need can create the conditions for the member to answer the next call and continue engaging.

Takeaway: Give teams a way to prioritize immediate care needs and relationship building when completing the full gap list would undermine the interaction.

5. Bring Community Knowledge Into Quality Decisions

Clinical data can show where care is missing without explaining the circumstances preventing it.

Mariah Osborn described how UPMC combines quality analytics with provider feedback, complaints, grievances, member surveys and community engagement insights. Those perspectives help distinguish among barriers such as transportation, appointment access, caregiving responsibilities and lack of trust.

Bringing community engagement under quality improvement has helped connect that understanding with action. UPMC’s eight-week Medicare Faith and Wellness Challenge creates recurring opportunities to engage members in trusted community settings. Osborn emphasized the importance of returning consistently and using what members share to shape future interventions.

Takeaway: Include community and member feedback in quality planning so interventions address the reasons care is not happening.

6. Use Benefit Communications to Prevent Avoidable Member Problems

Required communications can create an opportunity to help members prepare for changes that will affect their care.

Dave Burianek of MedOrion described a client plan’s approach to the Annual Notice of Change. The plan monitored engagement and used two-way texting to offer additional help to members who had not engaged.

The goal was to address questions before members encountered changes while using their benefits in January, including at the pharmacy. Burianek reported that earlier communication reduced call volume in January and February.

The example illustrates how an existing communication process can support earlier problem resolution when it includes a clear route to assistance.

Takeaway: Build follow-up into benefit communications so members can understand relevant changes and get help before those changes disrupt their care.

What Health Plan Leaders Can Take Back

The discussion raised five practical questions for plans preparing for 2027:

1. **Earlier action:** What do we already know about returning members that could support action before the first HEDIS results?
2. **Capacity:** Where could faster clinical review allow us to cover more measures or give providers more complete information?
3. **Ownership:** When a time-sensitive event occurs, is it clear who will act and how completed care will be captured?
4. **Member barriers:** How do provider, community and member feedback change the interventions we choose?
5. **Prevention:** Which existing member communications could help us resolve problems before they affect access, experience or service demand?

Bottom Line

The opportunity is to make earlier action a routine part of how the plan operates. That requires knowing **what can be addressed now, who is best positioned to act, and what the member needs to move forward.**

For Medicare Advantage plans, reducing reliance on the year-end chart chase means connecting information across teams, building timely follow-up into everyday workflows and using each member interaction to support the next step in care.

Key Points Made by Each Guest

Daniel Weaver, Zing Health

- **Start with what the plan already knows.** Information about returning members can support action in January, before initial HEDIS results arrive.
- **Connect knowledge across departments.** Teams may hold information valuable to quality performance without recognizing how another function could use it.
- **Treat each interaction as a "golden encounter."** Addressing an immediate care need and establishing trust may take priority over the rest of a member's gap list.

Mike Farina, CDPHP

- **Move the work earlier in the year.** CDPHP's clinical data process supports a shift from a fourth-quarter push toward action in the first and second quarters.
- **Use technology to increase review capacity and coverage.** Farina reported reducing record review from approximately 10–12 minutes to under two minutes while expanding from four HEDIS measures to seventeen.
- **Build the process with providers.** Shared expectations, access to clinical information and ongoing collaboration help the plan give practices a more current view of their patients.

Mariah Osborn, UPMC Health Plan

- **Match timely information with clear responsibility.** For seven-day emergency department follow-up, identifying eligible members earlier must be accompanied by decisions about who will engage them and how completed care will be captured.
- **Understand what clinical data cannot explain.** Provider feedback, complaints, surveys and community insights help reveal barriers that another reminder may not resolve.
- **Make community engagement part of quality improvement.** The Medicare Faith and Wellness Challenge illustrates how a consistent presence in trusted settings can build relationships and inform future interventions.

Dave Burianek, MedOrion

- **Understand what is behind low engagement.** A lack of response does not necessarily mean the member does not care; the intervention needs to address what is preventing action.
- **Coordinate outreach across the member's needs.** Burianek described the value of ongoing engagement across measures and the need to move beyond separately executed projects.
- **Use the ANOC as an opportunity for earlier assistance.** His client example showed how monitoring engagement and offering follow-up could help members understand benefit changes before January and reduce subsequent call volume.