The great Medicare Advantage divide

Bridging the gap and finding success

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The great Medicare Advantage divide

How can providers and payers work together in this growing segment?

Around this time last year, we published a blog providing context on the debate over Medicare Advantage (MA) and some anticipated changes around risk adjustment, utilization management (UM) and the Star Ratings system. Over the past year, MA continues to make headlines as the payers tend to raise serious concerns and oppose these changes while providers often supported such changes and encouraged the Centers for Medicare and Medicaid Services (CMS) to strengthen policy proposals, such as those related to UM. Also, over the past year, MA grew by over 1.5 million Americans and national MA penetration increased by 3 percentage points. So how can a program with seemingly so many challenges continue to grow at the pace it has? This report will try to answer that question by outlining some key MA trends, highlighting both the payer and provider viewpoints on these trends and offering some thoughts on a path forward.

Medicare Advantage industry headwinds

Shifting from growth to margin management

It's well known that MA has been a high margin business for plans compared to their other lines of business, but there are several market trends that are either slowing MA margin growth or in some plans creating margin decrement. Many of the MA industry headwinds are the direct or indirect result of the Contract Year 2024 Final MA rule, which included lots of wins for providers and patients, such as additional requirements when providing internal coverage criteria where coverage criteria is not fully established under traditional Medicare, clarification regarding application of the two-midnight presumption and the two-midnight benchmark and prohibiting payment denial for a medically necessary service if it was prior authorized.

The table below identifies some of key environmental headwinds that exist today and outlines their impact to MA plans:

Table 1

	Headwind	Impact to MA plan
	New risk adjustment methodology phase-in	The shift from CMS Hierarchical Condition Categories (HCC) model version 24 to version 28 HCC V28 is currently in its second year and starting next year (CY2025) v24 will be fully phased out with V28 being weighted at 100%. While the number of HCC categories will be increasing, the number of diagnosis codes mapping to HCCs is decreasing, along with some significant changes to HCC coefficients that will negatively impact key chronic conditions like diabetes. While the impact to each MA plan will be different, CMS is projecting the overall impact to MA risk scores due to these changes to be -2.45% in CY2025.
	Changes to quality bonus payment methodology	Plans have long used their Star rating to drive their financial success through bonus payments, a greater share of the rebate (difference between risk-adjusted bid and benchmark), and beneficial enrollment opportunities. However recent changes to the methodology including cut point setting (e.g. “tukey-gate”), changing and re-weighting measures, and the replacement of the reward factor with a Health Equity Index will likely drive more Star rating decreases, however most plans are expected to see little to no impact to their Star ratings.
	New utilization management policies	Ranging from new rules that force MA plans to align their UM policies to that of traditional Medicare, to increased administrative costs for responding to routine audits as well as setting up UM committees and hiring clinicians for more specific peer-to-peer reviews. For MA plans (and their delegated provider groups) this will likely result in an increase in administrative expense, in addition to a rise in utilization and medical expenses.

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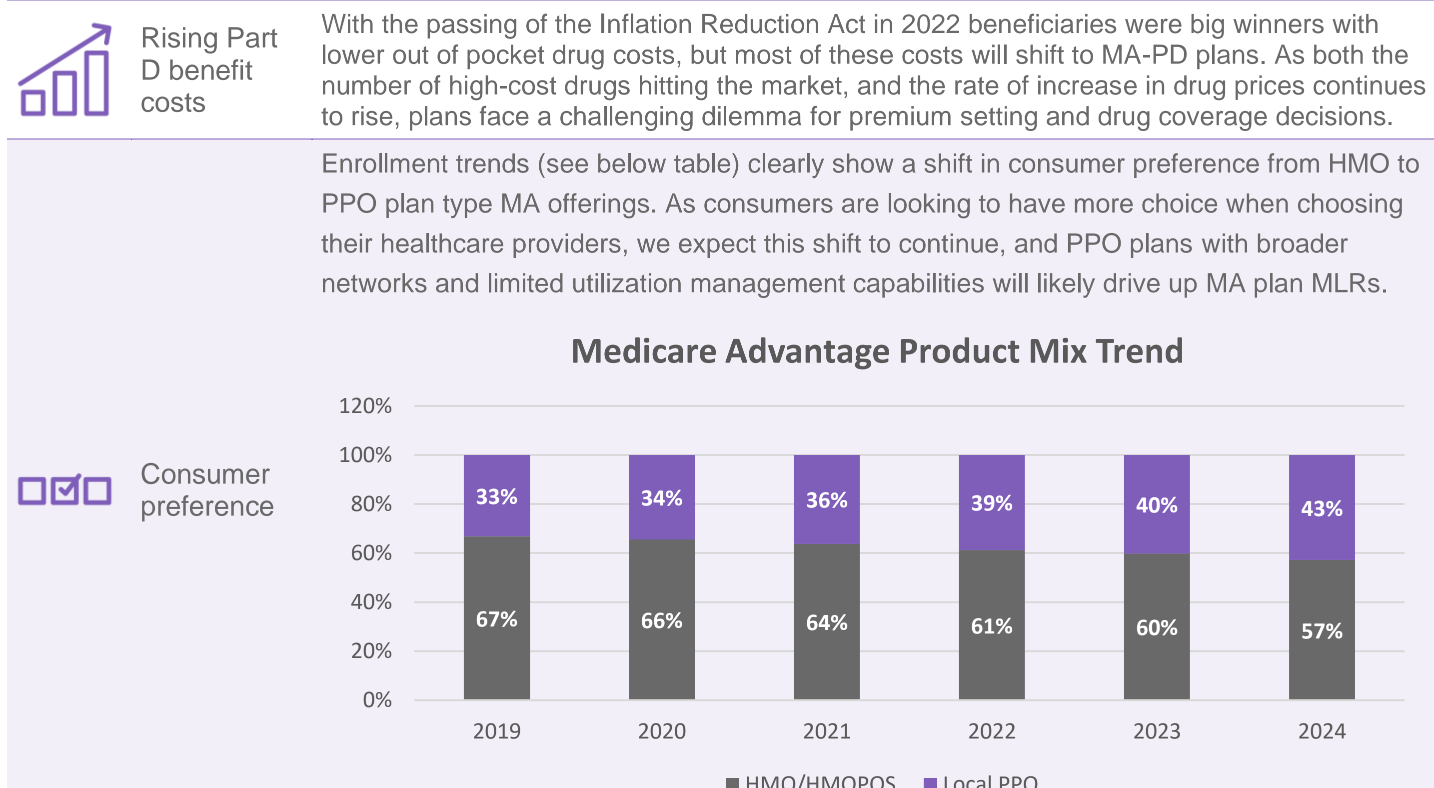

Rising Part D benefit costs	With the passing of the Inflation Reduction Act in 2022 beneficiaries were big winners with lower out of pocket drug costs, but most of these costs will shift to MA-PD plans. As both the number of high-cost drugs hitting the market, and the rate of increase in drug prices continues to rise, plans face a challenging dilemma for premium setting and drug coverage decisions.
Consumer preference	Enrollment trends (see below table) clearly show a shift in consumer preference from HMO to PPO plan type MA offerings. As consumers are looking to have more choice when choosing their healthcare providers, we expect this shift to continue, and PPO plans with broader networks and limited utilization management capabilities will likely drive up MA plan MLRs.

There are also several other long-term issues that eventually the MA industry will need to grapple with if it looks to bridge the gap between plan and provider:

Supplemental benefit oversight

- Providers are tired of bearing the load of supplemental benefits they have no say in against their MLR targets and in some cases question their efficacy in reducing total cost of care spend. CMS recently issued a memo detailing guidelines for submitting encounter data on supplemental benefit utilization, which despite being a challenge for plans and their vendors to comply with, signals that CMS is seeking more information on how rebates are being used to provide supplemental benefits and how these benefits are used by plan members.
- In a 2024 Request for Information, CMS expressed interest in data-related recommendations related to cost and utilization of different supplemental benefits and noted that it issued requirements for collecting more data related to supplemental benefits in the updated Part C reporting requirements.

Free-market approach to Medicare coverage options

- Technically MA members can switch back to traditional Medicare, and some are doing so after feeling like they didn't realize the tradeoffs they were agreeing to when signing up for Medicare Advantage over traditional Medicare ("TM"). However, many MA members that leave their existing plan tend to switch MA plans rather than switch back to TM, due to challenges associated with obtaining Medigap coverage.
- Medigap or Medicare supplemental insurance is an important type of coverage that helps Medicare beneficiaries cover their out-of-pocket costs. Federal law provides consumer protection such as "guaranteed issue" where plans can't deny coverage or conduct medical underwriting, but these protections are limited to only after a one-

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time 6-month open enrollment period that begins when a beneficiary first enrolls in Medicare part B. States do have flexibility to establish their own consumer protections, but only four states currently require guaranteed issue protections for Medigap.

- Given these dynamics, MA plans have a built-in membership retention mechanism, and they don't operate on a level playing field with traditional Medicare when it comes to obtaining and retaining members. Until these issues are addressed at either the federal or state level, it will continue to be challenging for beneficiaries to switch back to TM from MA.

Make quality performance more sustainable and relevant to members

- Star ratings are currently rolled up to the contract level, which can create some misleading expectations beneficiaries may have of a specific plan they enroll in. If Star ratings were at the plan/segment level and possibly even at the county level, beneficiaries could make better informed decisions about plan quality that is more specific to where they live and receive care.
- MedPAC which has recognized many of the challenges with the existing QBP has recommended a replacement option they call MA value incentive program (MA-VIP). The MA-VIP would seek to focus on a smaller set of population-based measures, evaluate quality at the local market level, stratify results by defined peer groups using social risk factors, make performance more transparent and predictable, and introduce penalties to make the program budget-neutral.

Plan responses and provider implications

Payer responses to headwinds and downstream implications to providers

CMS finalized their 2025 MA rates, and despite significant pushback from payers, the final rate announcement held to its advance notice with an impact of -0.16% and overall anticipated year-to year percentage change in payment increases of 3.70% (after accounting for MA risk score trend).

Table 2

Impact	2025 Advance Notice	2025 Rate Announcement
Effective Growth Rate	2.44%	2.33%
Rebasing/Re-pricing	TBD	0.07%
Change in Star Ratings	-0.15%	-0.11%
MA Coding Pattern Adjustment	0%	0%
Risk Model Revision and FFS Normalization	-2.45%	-2.45%
Sub-Total	***-0.16%***	***-0.16%***
MA risk score trend	3.86%	3.86%
Expected Average Change in Revenue	**+3.70%**	**+3.70%**

Source: https://www.cms.gov/newsroom/fact-sheets/2025-medicare-advantage-and-part-d-rate-announcement

A key point of contention amongst MA plans is that the final rate announcement did not account for a spike in utilization that some MA plans experienced in the second half of 2023. Some influential MA players like Humana, believe CMS did not factor in these utilization spikes and it could potentially be driven by MFFS claims lag, which would mean it will eventually show up in 2026 rate setting. However, other health plans like Clover Health claim that CMS rates were in line with what they expected, and they didn't see the utilization spikes above what they expected that other MA plans saw.

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MA plan bids were due to CMS on June 3rd, 2024 (although CMS is allowed resubmitted bids for certain plans through June 28th due to the recalculation of all 2024 MA Star ratings stemming from “Tukeygate” related lawsuits) and there is considerable speculation as to how MA plans will respond to the CY2025 rate announcement along with the industry headwinds. MA Plan Benefit Package information will become publicly available in October at which point we will understand how MA plans responded to these headwinds. Until then, the table below identifies some potential MA plan responses to these challenges and what their implications to providers could be:

Table 3

Potential CY2025 MA plan strategies	Provider implications
Raise premiums/Offer fewer $0 premium plans	• Has potential to shift MA plan market share (churn), potentially impacting those providers who are strategically aligned with certain plans • Rising premiums potentially means more premium allocated to at-risk providers given percentage of premium structure used in MA APMs
Exit unprofitable markets	• While some providers might rejoice at the idea of certain MA plans exiting their market, the reality is that will increase market concentration for other MA plans which is a net-negative impact for providers. Additionally, it may prove to be burdensome to primary care providers who may receive questions from concerned beneficiaries
Cut supplemental benefits	• Negative impact for providers who have invested in providing these benefits • Potential impact to core provider services (e.g. no transportation benefit means more missed appointments)
Reduce provider reimbursement	• Providers already struggle with MA margins as rates sometimes barely met 100% of MFFS and revenue yields commonly sit at 80%-90% of MFFS, so this would further reduce those margins
Narrow provider networks	• Impact will vary based on which plan’s network the provider is left out of but in general providers will be better served choosing to exit on their own rather than being driven out by the MA plan
Tighten utilization management	• Net negative impact to providers through reduced utilization, increased length of stay, and administrative burden • Historically MAOs have used coverage and prior authorization criteria separate from that of traditional Medicare creating increased denials and administrative burden for participating providers. Even with the wins for providers in the CY24 MA final rule that aim to better align coverage with traditional Medicare, MAOs will likely find ways to tighten utilization management
Specialty carve-outs (e.g. GLP-1 and gene therapies)	• Novel drug classes like GLP-1s and gene therapies have the potential to dramatically impact future medical spending for large segments of the population. However, currently the price for these therapies has many payers considering a range of coverage and reimbursement options for them • In the near-term we may see carve-outs or caps placed on these therapies which has the potential to negatively impact provider revenue. Longer term, expect to see reimbursement for these expensive therapies factored into comprehensive PMPM payments for certain populations or chronic conditions. Providers will need to incorporate these therapies into a more comprehensive approach (e.g.

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	comprehensive weight management program) but ultimately their impacts to clinical outcomes and total cost of care for attributed MA members should be favorable

Key takeaways for providers

Setting your strategy and creating win-win situations

As MA plans shift from a grow membership at all cost strategy to a margin management approach, providers face a pivotal decision in how they can position themselves for success. Since many of the challenges plans face are expected to “trickle down” to the provider community, being prepared with a well-considered Medicare Advantage strategy is more important than ever. As we’ve previously written about, we believe provider MA strategies should be thought of as a spectrum which is depicted in the below diagram and it’s important to know that each option is not mutually exclusive.

Table 4

Options	Elements
Pioneer Develops competencies to run own health plan	• Maximum upside, maximum downside • Significant capital requirements • Growing an MA plan alone is challenging • Many providers have struggled/failed
Partner Partners with select payer(s) who meet your requirements	• Limits financial exposure and leverages payer expertise in administrative services • Potential animosity with non-partnered payers • Ability to maximize value-based competencies to net better financial results than FFS alone
Price Taker Contracts with all plans in the market	• Negotiates FFS rates, if able • Risk of being left out of networks • Margin loss with decreasing reimbursement, administrative burden and limited upside
Non-participant Contracts with no MA plans in the market	• Out-of-network for all plans • Reimbursed at 100% of Medicare • Risk substantial volume loss due to increased beneficiary costs

In addition to setting a thoughtful MA strategy, providers should be thinking about “win-win” tactics that help address MAOs current challenges but also support and enhance the care delivery mission of their own organization. We’ve outlined below some areas and ways providers can add value to their payer partnerships:

- **Quality**: We’ve talked at length about how important Star rating and the underlying quality measures are to an MA plan. Providers should work collaboratively through joint operating committees to identify the most important and impactable measures for a plan contract year. Preventative care such as screenings can make a big impact to Star ratings, but many providers struggle with access to these services with next available visits commonly being over six months out. Providers should continue to look for ways to make these services more accessible to patients (e.g. mobile screenings, direct patient scheduling, removing social determinants of health barriers etc.).and work with MAOs on ways they can support these initiatives. Going forward, providers should understand how their specific quality performance contributes to the MAO overall Star rating, and what that contribution is financially worth in terms of bonus premium and increased rebate share to understand the value they drive for their MA plan partners.
- **Network adequacy**: Not only can building out your System of CARE (Clinical Alignment and Resource Effectiveness) help with access for services that can drive Star ratings, and drive domestic utilization, but it can help your MA plan partner meet network adequacy requirements. By helping your MA partner meet network

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adequacy requirements it gives them the ability to rely less on other providers to meet their network needs and reduces administrative complexities associated with provider directories and network management.

- **Medical management**: All providers should be looking to align contractual language with the coverage and prior authorization provisions set forth in the CY24, but when working with a MA plan partner should take that a step further through creative agreements around caps on denial rates or gold-carding for select services. An increasingly popular "win-win" in this area has been through collaboration on electronic exchange of patient information. Providers and payers that successfully execute on this can experience significant decreases in denials, automated prior authorizations, streamlined appeals and clinical review process, and improved population health management execution through claims data exchanged.
- **Supplemental benefits**: As we mentioned, many providers have been skeptical of certain supplemental benefits being offered by MAOs, such as a fitness related supplemental benefit being used for golf clubs and bowling balls, and providers feel it's more geared towards growing enrollment than controlling medical expense and thus is just reducing the available incentive a provider can earn. While it's important for providers to build into their contracts language around how supplemental benefits impact their MLR targets, providers may want to consider building the more robust capabilities on offering and managing supplemental benefits themselves. Benefits like dental, vision, and telehealth are natural places for providers to start but long-term providers should consider their capabilities around less common supplemental benefits like food, transportation, and acupuncture.
- **Delegated activities**: Providers who can build capabilities to handle the administrative (e.g. credentialing, provider directory management) and medical management activities of their MA plan partner can help plans free up resources and reduce their expenses, while the provider can get more of the premium allocated to them.
- **Risk adjustment**: Providers can play a big role in helping their MA plan partners navigate the risk adjustment changes negatively impacting them by building out supporting risk adjustment processes and investing in related resources. Going forward MAOs will likely not be able to offer the level of coding related support they historically have and thus providers can invest in provider education, clinical suspecting tools, and annual wellness visits in order to fill this gap, all while helping them accurately segment the populations they are at risk for so they can effectively allocate their own care management resources.

Formulating your overall Medicare Advantage strategy is difficult work, and even harder can be figuring out how to collaboratively work with potential MA plan partners. Additionally, annual timing of when making certain strategic decisions with MA plans is a critical part of executing your strategy and now is a good time to address your strategy as we approach AEP and OEP. Our expertise and experience in value-based care and payer strategy, can help your organization achieve success in this challenging MA environment. See how Vizient can help position your organization for success in Medicare Advantage and connect with us today!

About the author

William Ringwood, associate principal on the Vizient consulting team, specializes in financial planning and forecasting for value-based care, physician alignment, managed care contracting and payer strategy initiatives. With over 15 years of healthcare provider, payer and consultancy experience, he brings a unique strategic perspective to his clients that is rooted in financial rigor. He also has extensive experience in network development, medical group operations, physician compensation, service line strategy and transaction advisory. Ringwood earned his master's degree in business administration with concentrations in healthcare management and finance from the Simon Business School at the University of Rochester and his bachelor's degree in business administration from the State University of New York at Geneseo. He is an active member of the Healthcare Financial Management Association and holds Healthcare Financial Professional and Specialist Managed Care certifications.

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