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The Medicare Advantage landscape:

Challenges, risks and the move to value-based care

Medicare Advantage plans are facing considerable disruptive challenges due to shifting market forces. These challenges are resulting in significant payment and business model changes that are having huge ramifications for the marketplace. Some of these challenges include:

- **Silos and segmentation:** Inefficiencies persist within the traditional delivery structures, creating barriers to seamless care delivery.
- **Inefficiencies in the fee-for-service model:** Medicare Advantage plans have been shown to overspend compared to traditional Medicare.
- **Disparities in care delivery:** Competition among plans will require more benefits in the plan to gain members, but that will also require more costs to the plan. This comes at a time when an increasing number of eligible participants are encountering a shrinking network. This creates a perfect storm of greater demand and restricted access.
- **Narrowing provider networks:** Smaller regional plans are struggling as providers in some areas are refusing to accept Medicare Advantage patients due to lower reimbursement rates. This shift will favor national insurers in the future.
- **Rising healthcare costs:** Escalating medical costs are putting additional strain on health plans and providers.
- **Provider burnout:** Many provider networks are declining new Medicare Advantage patients due to resource limitations, while overall participation in the program continues to grow. This particularly impacts smaller providers who don't typically have the resources of larger organizations.

Addressing these issues is crucial to ensuring the sustainability of Medicare Advantage plans, as well as the broader healthcare ecosystem.

Star bonuses and risk adjustments: The financial backbone of Medicare payments

The Centers for Medicare and Medicaid Services (CMS) has structured payments to Medicare Advantage plans based on two core components: Star Ratings and risk adjustment.

Star Ratings:

If a health plan maintains a Star Rating of four or higher, it qualifies for the remaining 6% of CMS payments. The operating margin for most health plans is typically around 5%. Plans that fall below four stars face a 6% to 7% reduction in their Medicare payments, which can lead to financial instability for some providers, especially if they don't have the resources of the larger plans.

Risk adjustment:

Approximately 94% of CMS payments to health plans are determined by a member's risk score. CMS has set up an effective model that requires a health plan to be creative and innovative in order to boost their Star Rating. The key is having proper documentation and diagnosis coding to ensure accurate reimbursement.

But in this environment of risk adjustment and Star Ratings, many smaller health plans find it increasingly difficult to sustain operations in the Medicare Advantage market. If the risk score goes down, plans can receive minimal reimbursement from CMS. The financial strain has led to market exits, mergers and a reluctance to continue serving the Medicare population.

Accurate data is vital in the Medicare environment

In today's Medicare environment, accurate data is everything. Not surprisingly, the backbone of the risk adjustment and Star Ratings is accurate data. Ensuring that clinical, claims and social data are accurately collected and properly analyzed is key to designing supportive benefits and understanding the full measure of member needs. Accurate data collection allows health plans to:

- Identify chronic conditions and the severity of illnesses among members
- Tailor benefits and programs based on demographic and geographic factors
- Ensure timely and appropriate reimbursement by capturing accurate diagnostic codes
- Promote interoperability, which enables seamless data sharing among compliance-based organizations

Without accurate data, health plans risk losing more premium revenue from CMS than they have in the past. The Office of Inspector General (OIG) is also auditing Medicare Advantage plans to make sure submitted data is accurate, reflecting real, verified medical conditions. Because of these changes, and the $11 billion that CMS is trying to recoup from plans, many plan providers are stepping away from offering Medicare Advantage.

The move to a value-based care model for Medicare

CMS is actively working to shift Medicare Advantage from a traditional payment structure to a value-based care model. This transition is driven by several key initiatives:

- **Reducing Medicare Advantage spending:** CMS aims to recoup $11 billion from Medicare Advantage plans, prompting health plans to reassess their financial viability
- **Mandating supplemental benefits:** Health plans are required to bundle benefits such as wellness programs, meal delivery and transportation into their offerings to improve care quality

- **Increasing regulatory oversight:** The OIG is intensifying audits to ensure that reported data accurately reflects members' medical conditions
- **Market contraction:** As mentioned before, many health plans are withdrawing from Medicare Advantage in favor of more financially viable government programs like the Affordable Care Act (ACA) and Medicaid
- **Tracking value-based benefits utilization:** Despite offering enhanced benefits, health plans struggle to ensure members take advantage of them, prompting greater efforts in member outreach and engagement
- **Strengthening payer-provider collaboration:** Effective value-based programs require close coordination between payers and providers to optimize care delivery and benefit utilization

By 2030, Medicare Advantage is expected to operate under a fully value-based payment model. Achieving this goal will require enhanced collaboration and technology-driven solutions to streamline payer-provider interactions and optimize member care.

To compete in this environment, providers offering these plans will need to pay particular attention to how they deliver their plan benefits so that it makes financial sense, while enhancing quality of care and the patient experience, improving administrative efficiency and lessening provider burnout in a value-based care environment. That's a tall order. Many providers of these plans are discovering they need additional support from a partner who can help them chart a path through these turbulent waters.

TriZetto government and quality solutions: A unified approach to Medicare Advantage

Cognizant's TriZetto government and quality solutions are designed to do just that and help health plans navigate the complexities of Medicare Advantage.

Our solutions align with our technology roadmap to support the following:

- **Regulatory security compliance:** Ensuring adherence to evolving CMS guidelines
- **Product care and ongoing value enhancement:** Continually refining offerings to meet market demands
- **Digital, data, AI and technology:** Leveraging advanced tools to drive efficiency and accuracy
- **Growth through innovation:** Developing new strategies to maintain competitiveness in the Medicare space

Cognizant's TriZetto suite of solutions provides the necessary tools to optimize Medicare Advantage operations:

- **TriZetto® StarSERV®:** Enables performance trend analysis, goal-setting and progress monitoring to enhance Star Ratings
- **TriZetto ClaimSphere®:** A hosted regulatory reporting service that facilitates retrospective data collection by focusing on enrollment and reconciliation, data submissions, risk adjustment and quality management
- **TriZetto Value-Based Benefits Solution:** Encourages healthy member behavior, reduces high-cost treatments and enables advanced reward programs
- **TriZetto NetworX Pricer®:** Automates claims pricing for improved speed, accuracy, and efficiency in provider contract administration

In the face of Medicare Advantage's evolving challenges, Cognizant's TriZetto solutions provide the capability, flexibility and innovation necessary to thrive in a rapidly changing environment. By leveraging advanced data capabilities, fostering payer-provider collaboration and embracing value-based care, health plans can position themselves for long-term success, while helping to improve member health outcomes.

Through our comprehensive suite of tools and strategic insights, we empower health plans to make informed decisions, streamline operations and ultimately enhance the Medicare Advantage experience for all stakeholders. The future of Medicare Advantage is complex, but with the right solutions in place, health plans can confidently navigate these changes and emerge stronger than ever.

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