

Long-Term Optimization Strategies: Medicare Advantage

In this second in our two-part series on the future of Medicare Advantage, we will cover longer term strategies for sustained success in light of both the internal and external challenges highlighted in our first article on this topic.

In order to maximize opportunities in Medicare Advantage (MA) for the long term, payers/insurers can take steps now to mount a more strategic, agile response. This includes moving beyond a propensity to compete on supplemental benefits, focusing more on holistic, sustainable strategies. The market is shifting toward a “new normal” with tighter margins and greater regulatory scrutiny, requiring insurers to differentiate themselves through operational and clinical excellence, strategic partnerships, and a superior member experience.

To prepare for upcoming challenges, insurers can start by creating a blueprint that includes building better relationships with providers, enhancing member engagement to address care gaps, and identifying members with social risk factors, while maintaining a focus on providing a high-quality member experience. What follows here is an overview of specific actions and strategies that plans intent on continuing to offer and excel at Medicare Advantage can invest in now to fortify for longer term success.

Fortify Utilization and Provider Networks:

Insurers can focus on more tightly controlled provider networks and utilization management to manage costs.

- **Tightening prior authorization: This includes enforcing stricter** authorization for a wider array of services, including expensive procedures and skilled nursing facility stays. However, CMS has also implemented new rules to prevent some of these tactics, so the opportunity here must be carefully considered.
- **Leveraging analytics to identify high-performing providers:** Payers can use data analytics to identify and guide contracting with high-performing providers who deliver high-quality, cost-effective care. This helps optimize the network and reduces the total cost of care.
- **Vertical integration:** Major insurers like CVS Health have continued to vertically integrate, incorporating



Network Performance

Insurers can emphasize network performance over simple network adequacy, favoring providers who can close care gaps, improve outcomes, and support risk adjustment efforts. This involves focusing on more complex populations and leveraging technology and data to optimize financial performance and care management.

primary care clinics (like Oak Street Health) into their offerings. This allows them to directly control more of the care delivery process and improve coordination, ultimately leading to higher quality and lower costs.



Leverage Population Health Management Opportunities:

- **Predictive analytics:** By using predictive models, insurers can better identify members who are at high risk for future medical issues, allowing them to intervene proactively. This helps to reduce care utilization over time and improve health outcomes.
- **Prioritizing long-term quality improvement:** With new regulatory changes making it harder to earn quality bonuses, insurers are focusing on foundational improvements to their Star Rating. This involves investing in specific measures that affect clinical outcomes, member experience, and health equity, which will increasingly factor into Star Ratings. Improved collaboration with providers and enhanced member engagement through personalized outreach are essential for driving better Star performance. We will cover this in more detail in the last section here.



Enhanced Member and Provider Engagement:

- **Refocus on age-in populations:** As the market for switching plans becomes more competitive and commoditized, newly eligible seniors (“age-in”) will be a primary growth driver. Insurers should shift resources toward age-in targeting and personalize outreach via leveraging existing relationships.
- **Deliver whole-person care:** Addressing member health-related social needs is essential for improving outcomes and controlling long-term costs. Insurers can leverage data to identify social determinants of health (SDOH) and partner with community groups to provide wraparound services, such as transportation or nutritional assistance.
- **Invest in member experience:** A seamless member experience is a key differentiator for attracting and retaining members. It includes optimizing digital tools like member portals and mobile apps, personalizing engagement, and onboarding processes.

To establish an enhanced understanding of member needs and preferences, plans can adopt digital tools that compile various data sources (i.e., claims, clinical and prescription data). These data aggregation platforms should include intelligent workflows that update periodically to inform when to contact members. An example is using data to track medication adherence and flag members at elevated risk for noncompliance, prioritizing them for outreach. Plans should also research the best way to reach people. Plans are more likely to reach younger patients via the health system portal but may need providers to engage older members directly.



Harnessing AI to Personalize Member Experience and Streamline Operations:

- **Artificial intelligence (AI) creates significant opportunities for health plans to deliver a more personalized member experience while optimizing operational efficiency:** By analyzing member data, AI can help develop tailored treatment plans and send proactive, customized reminders about medications, appointments, and other relevant health information through members’ preferred communication channels. This approach ensures timely engagement and supports better health outcomes.
- **Virtual health assistants (VHAs), powered by AI, further enhance the member experience by providing 24/7 support:** These assistants can answer urgent questions, schedule appointments outside of regular office hours, and offer remote monitoring services. This continuous support improves accessibility and convenience for members, fostering a stronger connection with their health plan.
- **In addition to member-facing enhancements, AI also streamlines administrative processes:** Automation tools can facilitate appointment, referral, and testing scheduling, generate after-visit summaries by capturing and summarizing patient-physician discussions, and confirm follow-up visits. These efficiencies optimize staff time and allow clinical teams to focus more on direct patient care, ultimately improving both the member experience and operational performance.



Overarching Importance of Stars Rating

Along with the strategies mentioned above, an overarching area of focus should be on Medicare Advantage Star Ratings program. Plans that emphasize achieving better Star program performance tend to have an advantage. Among other considerations, according to the 2023 McKinsey Medicare Shopping Survey, 50% of respondents noted that a plan's ratings were among the top features they considered. As a result, 76% of MA members are currently enrolled in a 4+ Star plan.

Changes to the Stars rating system planned for 2026 and beyond will make it difficult for health plans to attain four or more stars. These changes in measures used to evaluate plan performance will force new approaches for achieving the coveted four plus ratings.

- **Several of these changes will have material impacts on measure weighting:** Chief among these is the reduction of the weighting of CAHPS/complaints. As a result of this shift, clinical HEDIS and Part D measures have gained greater relative importance, including transitions of care and Part D medication adherence measures.

The Medicare program's previous emphasis on CAHPS survey results drove many plans to focus heavily on member experience. Now, plans need to realign their quality improvement priorities by shifting emphasis to clinical outcomes and factors like medication adherence to sustain and enhance Star ratings.

- **An evolutionary change beginning in 2027 is introduction of the Excellent Health Outcomes for All index (EHO4all) formerly known as the Health Equity Index (HEI):** The EHO4all marks a major shift in the Stars program. Starting with data collection initiated in 2024, it incentivizes plans that enroll a substantial proportion of members facing social risk factors, including those also on Medicaid or receiving a low-income subsidy; along with demonstrating strong performance metrics for these vulnerable populations.

Ongoing success will thus be weighed toward elevating clinical quality measures, integrating more comprehensive health equity strategies through leveraging advanced technologies to engage and support populations with significant social risk characteristics.

- **Focus on gap closure:** Some simple steps plans can take now that do not involve a fundamental overhaul of efforts related to Medicare Advantage optimization include ensuring that all their clinical gap closures are documented so they get credit for all the good work already being done. Additionally, care management notes tend to contain a lot of available information, which plans can mine to create supplemental claims for services performed.
- **Another relatively easy adaptation is for plans to cover more clinical quality measures by grouping them:** Since there are about 40 measures, it is sometimes difficult for plans to address all individually. Thus, to address an expanded number of measures, plans can group them based on each member's clinical footprint, taking a whole-person approach.

For example, for patients with diabetes, plans can build clinical workflows that extend routine visit attention to condition-relevant needs beyond blood sugar control (i.e., focus on kidney function evaluation, eye exams, and medication adherence).

In summary, excelling in Medicare Advantage Star ratings requires a focused and strategic approach. It is important to recognize that achieving the highest score, such as 5 Stars, on every measure may be unrealistic. Instead, plans should concentrate on understanding the specific thresholds that distinguish between ratings. For example, the difference between earning 4 versus 5 Stars on each measure.



CMS Star Ratings

The Centers for Medicare & Medicaid Services (DM) introduced Star Ratings in 2007 to improve the quality of care for members, with the expectation that the ratings would evolve over time. However, MA insurers have gotten caught up in the complexity and number of changes, some debating the value of the program, questioning the effectiveness of the Star measures to improve clinical outcomes. Nonetheless, Insurers who put less emphasis on achieving a 4+ rating may find it hard to maintain a margin-positive offering, standing to lose out on payments and rebates tied to the Quality Bonus Program.

Where attaining a 5-star rating appears out of reach, organizations should consider implementing targeted strategies aimed at securing sufficient improvements to achieve at least a 4-star rating. This practical perspective enables plans to maximize their impact within available resources.

There are numerous strategies and approaches available for improving Star ratings. However, the key is to realistically evaluate the factors that influence current performance. By gaining a deeper understanding of how each measure's ratings are determined, plans can direct their efforts strategically, making the most of their resources and driving the best possible overall outcomes.

Bottom Line:

Strategic Considerations for Continued Medicare Advantage Participation

Health plans and providers participating in Medicare Advantage must critically evaluate the level of effort and resources required to fully optimize the available opportunities. This assessment should be carefully balanced against the potential business benefits that these offerings provide. Deciding whether to continue offering Medicare Advantage plans is not a straightforward choice; it depends on a plan's capacity to maintain financial sustainability while adapting to ongoing regulatory changes and addressing the evolving needs of beneficiaries.

In summary, remaining competitive in the Medicare Advantage market typically depends on consistently achieving higher Star Ratings (4 or more stars). Equally important is the ability to sustain a robust provider network, which is crucial for ensuring long-term organizational stability. By focusing on these priorities, health plans can better position themselves for continued success in an increasingly complex and competitive environment.

DataWELL has expertise and experience in several of the areas (i.e. clinical quality and network performance measures, population data analysis) involved in formulating optimization strategies and is well positioned to help organizations conduct an evaluation and formulate a plan for moving forward.