Arbital HEALTH

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EBOOK

Navigating Medicare Advantage Risk Deals in 2025 and Beyond

Significant Changes, Increased Risks, and How to Manage Them

Meet the Experts Guiding You Through Medicare Advantage Complexity

This guide draws on the expertise of four leading authorities in Medicare Advantage and Value-Based Care. With decades of combined experience, they provide actionable strategies to tackle today's most pressing challenges.

Rich Gamret
Chief Delivery Officer
Arbital Health

A leading Medicare Advantage actuary, Rich specializes in financial modeling and risk adjustment. He guides Arbital Health's consulting practice, fostering strategic relationships with clients to help them achieve sustainable financial results and better clinical outcomes.

Andrew Mackenzie
Chief Science Officer
Arbital Health

As co-founder of Santa Barbara Actuaries, Andrew played a key role in shaping the company's trajectory as a leader in actuarial healthcare consulting. At Arbital Health, he oversees value-based care innovation and drives actionable solutions for complex contracts.

Lewis Mattison
Managing Director, Mattison Advisory

Lewis brings extensive expertise in payer-provider partnerships and strategic consulting, supporting stakeholders in Medicare Advantage value-based arrangements that drive mutual success. His focus is on fostering long-term sustainability and collaboration.

Prefer to Listen Instead?

If you'd rather explore these topics with our panelists, you can watch the full expert discussion.

Scan the QR code or visit the link below to access the recording.

hubs.ly/Q02ZJDGN0

Why This Guide Matters

The Medicare Advantage (MA) landscape is evolving rapidly. In 2025 and beyond, value-based care (VBC) stakeholders must adapt to risingy healthcare costs, regulatory changes under the Inflation Reduction Act, the transition to HCC Version 28, and updates to the Centers for Medicare & Medicaid Services (CMS) Star Ratings. These shifts bring heightened financial risks—but also opportunities for those equipped to navigate them.

What's Inside:

This guide distills the insights shared during Arbital Health's expert-led panel discussion, highlighting key challenges and providing actionable strategies. Drawing on their decades of experience, our panelists outline the path forward for payers, providers, risk enablers, and other organizations managing Medicare Advantage VBC contracts.

Structure of the Guide:

1. Rising Healthcare Claims Costs: Understanding cost trends and mitigating MLR pressure.
2. Impacts of the Inflation Reduction Act: Managing liability shifts in Medicare Part D.
3. HCC Model Changes: Adapting to revenue challenges under the new coding framework.
4. CMS Star Ratings Updates: Preparing for quality measure changes and financial impacts.
5. Question and Answer (Q&A)
6. Conclusion

Chapter 1

Rising Healthcare Claims Costs in 2024

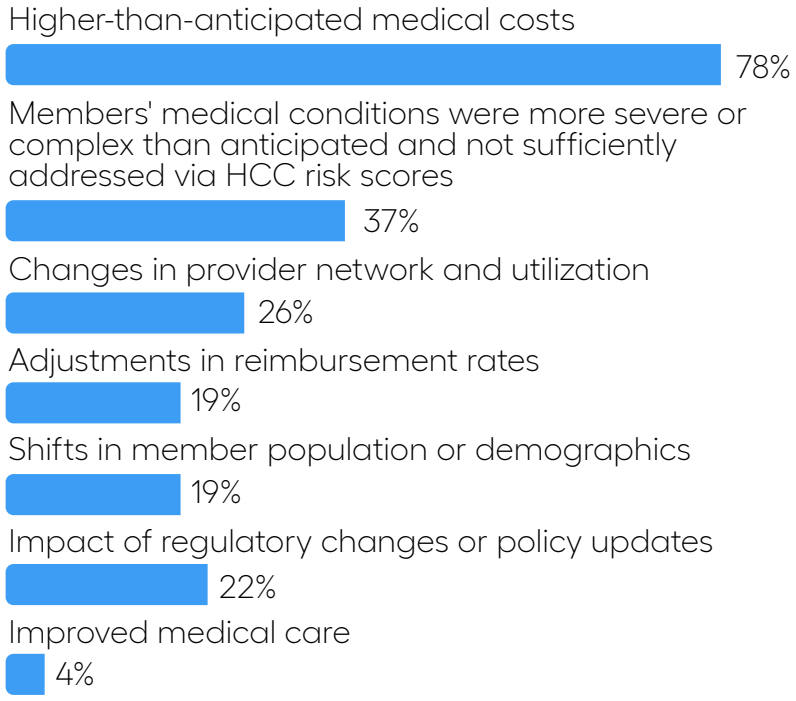
The Challenge

Rising healthcare claims costs, driven by increased utilization, aging populations, and specialty therapy expenses, are amplifying pressures on Medical Loss Ratios (MLRs). For value-based care (VBC) stakeholders, effective cost management is essential for financial sustainability and long-term success.

Audience Poll Insights

Understanding Industry Concerns

What do you believe are the key drivers of the MLR performance changes between 2024 and 2023?



Expert Insights Rising Healthcare Claims Costs in 2024

Lewis Mattison highlighted the growing cost challenge of specialty care:

"We're seeing significant cost spikes in high-expense areas like oncology, musculoskeletal care, and chronic kidney disease. These areas are now dominating MLR performance. What's important to understand is that no single party can solve this—payers, providers, and enablers must come together to address these challenges. Collaborative, specialized VBC contracts are the way forward. They're designed to target high-cost areas and ensure accountability across the board."

Rich Gamret offered additional context on systemic cost drivers:

"Across our client portfolio, we're observing claim costs rising faster than revenue growth. One key factor driving rising costs is the Two-Midnight Rule, which has turned what used to be lower-cost observation stays into full inpatient episodes. This change alone has increased unit costs by $8,000–$12,000 per case in many markets. But this isn't just a one-time challenge—it's part of a broader, systemic trend. The key to managing it is proactive analysis and forecasting; acting early and making adjustments in real time."

Solutions

Create Tailored Specialty-Specific Contracts

Develop contracts focused on high-cost areas like oncology or musculoskeletal care. Include performance metrics tied to cost reductions and patient outcomes to align incentives and share risk effectively.

Implement Ongoing Cost Analysis and Drill-Down Reporting

Establish monthly tracking of high-cost claim categories, such as inpatient stays and specialty drugs, to identify trends early. Use drill-down reporting to uncover which conditions, procedures, or populations are driving costs. This helps organizations address root causes in real-time rather than reacting after settlement.

Strengthening Payer-Provider Collaboration

The rising cost of healthcare cannot be solved in silos. Shared accountability between payers and providers ensures alignment on goals, particularly in managing high-cost specialty areas.

Chapter 2

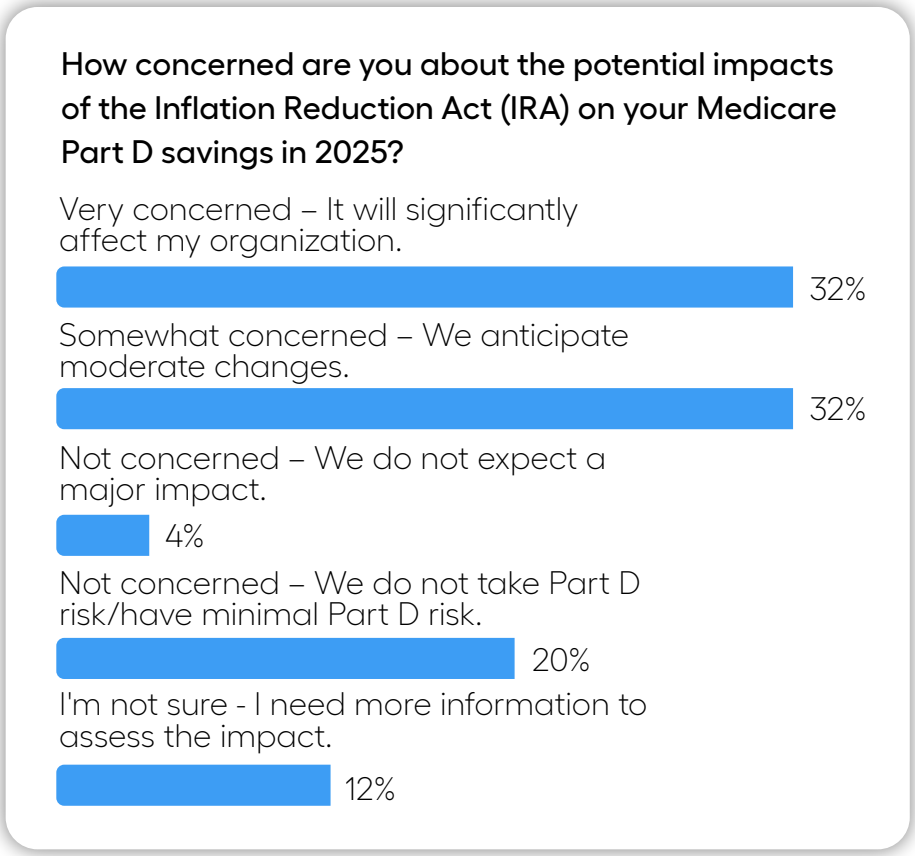
Impacts of the Inflation Reduction Act on Medicare Part D

The Challenge

The Inflation Reduction Act (IRA) has shifted more financial responsibility for prescription drug costs onto Medicare Part D plans. Increased reinsurance thresholds and changes to cost-sharing dynamics demand precise financial modeling to mitigate risks and adapt effectively.

Audience Poll Insights

Understanding Industry Concerns



Expert Insights

Impacts of the Inflation Reduction Act on Medicare Part D

Rich Gamret expanded on the complexities of Part D cost structures:

"Medicare Part D is already one of the most complex insurance products, with multiple entities—CMS, manufacturers, and members—sharing the risk. Gross pharmacy expenses can appear enormous, but when you factor in rebates, subsidies, and risk corridors, the plan's liability becomes a fraction of the initial costs. The IRA, however, changes these calculations significantly, forcing plans to revisit their pricing and contracting strategies to remain sustainable."

Andrew Mackenzie discussed the magnitude of the liability shift:

"In 2024, net plan liability accounted for about 42% of gross drug costs. By 2025, we expect this to rise to around 70%, representing a seismic shift in financial responsibility. The IRA offsets some of this liability change with a direct subsidy increase, but high-utilizer populations—those requiring specialty drugs, for example—remain particularly vulnerable. Plans must reassess their financial projections around Part D headed into 2025 and make sure they have appropriate contractual protections in place."

Solutions

Model and Adjust for Direct Subsidy Impacts

Use financial modeling tools to calculate how rising liabilities and subsidy changes under the IRA will affect your plan's margins. Adjust VBC contract pricing in 2025+ accordingly.

Population-Specific Risk Assessment

High-utilizer populations, such as those requiring expensive specialty drugs, demand careful evaluation. Plans should analyze whether risk scores and reimbursement structures adequately reflect the increased financial burden and negotiate adjustments as needed.

Audit Contracts for Liability Sharing

Contracts should include provisions that allow for recalibration as IRA-related changes take full effect. This flexibility is essential for mitigating uncontrollable financial impacts.

Chapter 3

HCC Model Changes and Risk Adjustments

The Challenge

CMS's transition to Hierarchical Condition Category (HCC) Version 28 reduces risk-adjustable codes and recalibrates factors influencing risk scores. These changes impact high-acuity populations, lowering revenue potential despite accurate coding. Adapting requires advanced analytics and strategic planning to achieve financial alignment.

Audience Poll Insights

Understanding Industry Concerns

Expert Insights HCC Model Changes and Risk Adjustments

Rich Gamret explained the rationale and impact of the HCC updates:

"CMS regularly updates the risk adjustment model to improve accuracy and fairness. HCC v28 reduced risk-adjustable diagnosis codes by 2,000, significantly impacting categories like vascular, psychiatric, and metabolic diseases. Plans that historically focused on high-acuity populations are seeing the largest headwinds, with lower risk scores and revenue declines despite accurate coding."

Andrew Mackenzie emphasized the importance of adapting to healthcare changes:

"It's important to set your VBC price targets consistently with the external environment in future years. As this relates to HCC coding, MLR targets in 2025-26 should reflect the correct weighting on v28, not v24. We help our clients set appropriate price targets for future years, accounting for known changes like HCC versions, Star ratings, or Part D reinsurance due to the introduction of the IRA. A broad statement about external changes often falls short of fully addressing their impacts. Such protection should be seen as a last resort, not a primary strategy."

Solutions

Invest in Technology for Coding Accuracy

AI-powered tools and advanced analytics can streamline documentation processes and improve risk score accuracy. These technologies help teams prioritize the most impactful categories under the updated HCC model, ensuring resources are allocated effectively.

Enhance Provider Training and Support

Educating providers on updated coding guidelines and best practices ensures they can document accurately under HCC v28. Strong payer-provider collaboration is essential to reduce gaps in coding and avoid missed revenue opportunities.

Run Simulations on Risk Score Adjustments

Use historical data to calculate how v28 changes will impact your population's risk scores. For example, simulate how a reduction in risk-adjustable codes for vascular diseases will affect revenue and adjust pricing strategies accordingly.

Chapter 4
CMS Star Ratings Updates

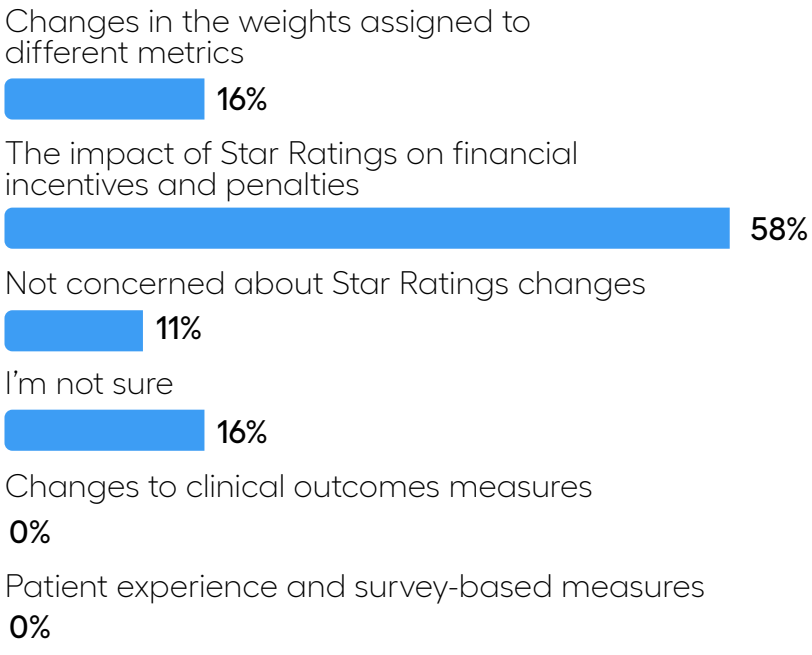
The Challenge

CMS Star Ratings are critical to Medicare Advantage plans, directly influencing revenue and competitiveness. Star Ratings have reached their lowest levels in four years, with many plans dropping from 4 to 3.5 stars. These declines jeopardize financial incentives and rebates, increasing the urgency for payer-provider alignment on goals while focusing on controllable metrics to maintain high ratings.

Audience Poll Insights

Understanding Industry Concerns

Which aspect of the CMS Star Ratings changes are you most concerned about in relation to your VBC contracts?



Expert Insights CMS Star Ratings Updates

Rich Gamret outlined the financial risks of declining ratings:

"Star ratings are CMS's method of rewarding high-performing plans with additional rebates and revenue. However, many plans are now dropping from 4 stars to 3.5, losing a ~5% rebate and potentially seeing a lower savings percentage. This drop is becoming more common and can lead to an ~8% revenue swing, significantly impacting a plan's ability to offer competitive benefits or maintain member premiums."

Lewis Mattison emphasized the importance of payer-provider collaboration:

"As Star Ratings become harder to achieve, payer-provider collaboration is more critical than ever. Including HEDIS measures in contracts ensures both parties have clear, aligned goals. Providers are best positioned to impact HEDIS metrics through patient care, and payers can help providers identify HEDIS gaps. This alignment supports quality ratings and simultaneously improves outcomes through better preventive care and coordination, creating mutual accountability and success."

Solutions

Include Star Rating Contingencies in Contracts

Incorporate provisions that allow for adjustments to financial targets or performance metrics in response to Star rating changes. This flexibility minimizes risks associated with unexpected declines.

Focus on Metrics You Can Control

Prioritize HEDIS measures, such as readmissions and care coordination, that providers can directly influence. Aligning contracts around these metrics supports both quality improvement and revenue stability.

Simulate Revenue Impact of Star Rating Changes

Perform actuarial analysis to model how shifts in Star ratings will affect plan revenue and member premiums. Share these insights with stakeholders to align on strategies to mitigate financial risks.

Question & Answer (Q&A)

During our live panel discussion, participants submitted questions, and we've included the most relevant ones to clarify key points from the guide. These questions highlight the challenges and concerns of stakeholders navigating the evolving Medicare Advantage landscape. Below are detailed answers to help you better adapt to the changes discussed.

Q **Can you share insights into how the IRA in 2025 has impacted mandatory supplemental benefits? We were expecting them to decrease and were surprised to see only minimal decreases. We suspect this is due to the IRA, but would appreciate your thoughts.**

A The full impact of the IRA will be felt in 2025, though we started seeing early signs in 2024. As we move into the 2026 bid cycle, we'll likely see more pronounced effects. The reason the decreases in supplemental benefits haven't been as large as expected is primarily due to the significant increase in the direct subsidy. While plan liabilities are rising, the direct subsidy increase helps offset much of that burden. However, to cover the additional liabilities, the funding has to come from somewhere—either through reductions to Part C mandatory supplemental benefits or higher member premiums. So, the adjustments are more of a mix, with some benefits being reduced and premiums rising in certain cases. Overall, the direct subsidy increase has helped, but the financial balance is shifting between benefits and premiums.

Q **Are you hearing anything about how MA plans adjusted their bid/pricing strategy for 2025 to address the increased spend/utilization that affected many plans in Q4 2023? Did they catch this in their 2025 bid cycle? Any insights on 2026?**

A For 2025 bids, plans would have calculated their pricing in the Spring of 2024, using data from the full year of 2023. While the increased spend in Q4 2023 did have an impact, the effect on 2025 bids will be somewhat limited, as it reflects only a portion of that year. The real impact will be felt in the 2026 bids, which will be based on a full year of 2024 data. Given that 2024 has already been an elevated year in terms of spending, the 2026 bids are likely to reflect these higher costs more significantly.

Q **How are you seeing VBC vendors address the attribution complexity with multiple organizations involved in plan members?**

A Attribution is a significant challenge, especially with multiple VBC arrangements interacting with the same patient populations. Some strategies rely on sophisticated algorithms to predict events, while others are based on provider utilization. Payers may have ~12 different VBC arrangements for the same patients, making overlap a critical concern.

The challenge lies in ensuring that the attribution hierarchy is properly defined in the contract and applied consistently through eligibility files and attribution rules. Our recommendation is for VBC vendors to gather the necessary data early, run attribution, and verify that it aligns with the contract terms. Addressing issues early—before settlement—is crucial to avoid discrepancies later, which can lead to significant financial implications.

Waiting until settlement to resolve attribution issues is problematic because it can alter financial forecasts, affecting year-end profit and loss projections. Identifying problems early in the attribution process, or addressing contract discrepancies as they arise, ensures more accurate reporting and helps maintain trust in the partnership.

For payers, managing attribution in a unified system is key. Without centralized technology, members may be incorrectly attributed to multiple programs. Systematized technology to manage attribution holistically represents a major opportunity for payers to streamline the process and reduce complexity.

Q **Have you run into any issues calculating trend without the use of IBNR, such as claim payment speeds changing from year to year?**

A Calculating trends without the use of IBNR can be particularly challenging, especially when external factors, like the Change Healthcare ransomware attack in early 2024, disrupt claim payment speeds. During this time, payment speeds varied significantly, making it difficult to track claims volume accurately. For a period, it felt like "flying blind," as payment cycles were unpredictable, and understanding the actual flow of claims was more complex than usual.

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Q&A (continued)

A *(...contiuned...)* In general, running IBNR is crucial for managing contracts in real time, as it helps account for the current risk population and ongoing claims activity. However, when comparing trends across different periods, IBNR can become a moving target, leading to potential distortions in trend analysis. For instance, without factoring in abnormal events like the Change Healthcare attack, payment speeds and claims volumes may not accurately reflect the true underlying trend. Therefore, while IBNR is essential for real-time contract management, it's important to be mindful of its potential to skew year-over-year comparisons.

Q **How has technology evolved to solve these contract issues?**

A In the past, many clients relied on spreadsheets and one-off consulting to manage their contracts, which often led to inefficiencies. The need for technology to support value-based care (VBC) at scale was one of the driving factors behind starting Arbital Health. We recognized a significant opportunity to build systems that could more effectively price, manage, and monitor contracts—taking into account attribution, claims, revenue, and quality metrics.

The core of VBC is to support the Triple Aim framework: improving quality, reducing costs, and enhancing overall health. However, achieving these goals is impossible if contracts can't be priced and measured accurately. Without the ability to track and manage contracts efficiently, both parties struggle to meet objectives. That's why we're focused on building technology that provides greater transparency, utility, and faster review of actual results.

Looking ahead, there's tremendous potential for systematized scaling of VBC contracting through machine learning. This would enable better monitoring, timely interventions, and data-driven insights to help organizations make informed decisions and drive better outcomes.

Conclusion

As Medicare Advantage plans face evolving challenges in 2025 and beyond, the need for strategic adaptation is greater than ever. From rising healthcare claims costs to sweeping changes like the Inflation Reduction Act, HCC model updates, and shifts in CMS star ratings, the landscape is changing rapidly. For those managing value-based care contracts, staying ahead requires proactive, data-driven strategies.

Throughout this guide, we've shared insights from industry experts on how to navigate these complexities. Their advice emphasizes the importance of collaboration, technology, and flexibility in real-time response. Whether it's leveraging analytics to manage rising costs, adjusting financial models for the IRA's impacts, or ensuring contracts align with the latest HCC model changes, the solutions here are designed to help you stay ahead.

Want to Learn More?

If you found this guide helpful and want to dive deeper into the topics discussed, we encourage you to watch the full live panel discussion. Scan the QR code or visit *https://hubs.ly/Q02ZJDGN0* to access the recording.

About Arbital Health

At Arbital Health, we'll handle the complexities of your Medicare Advantage risk contracts, so you don't have to. Our platform centralizes, measures, and adjudicates contracts at scale, providing the transparency and precision needed for success. With data-driven tools and actuarial advisory services, we help our partners achieve financial stability while delivering high-quality care.

Don't wait for change to overwhelm you, let us help you adapt and succeed in the evolving healthcare landscape.

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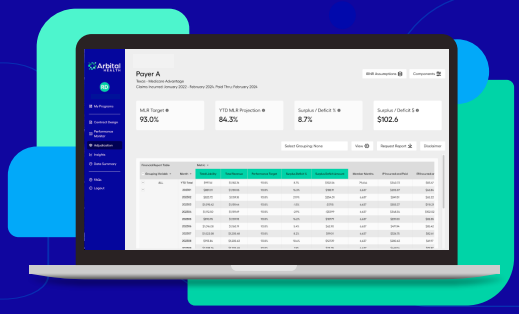
Arbital HEALTH

Let Us Do The Heavy Lifting in Your Value-Based Care Contracts

Arbital Health Platform

Your Unified Solution for VBC Contract Management

- **Centralize** all contracts in a single platform
- **Predict** financial outcomes with confidence
- **Measure** performance across contracts in real-time
- **Adjudicate** monthly and final contract results
- **Partner** with expert value-based care actuaries
- **Improve** patient outcomes and quality of care



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