



Health System Pulse Survey

Medicare Advantage Is No Longer a Growth Strategy — It's a Capital Allocation Decision

A&M's Medicare Advantage (MA) Pulse Survey—capturing insights from 30 health system senior executives—confirms a decisive inflection point. Broad participation with MA plans, once a growth lever to protect volume, maintain market relevance, and participate in value-based care—now erodes stability. Declining reimbursement, rising utilization, escalating denials, and increasing administrative friction have fundamentally altered the economics of participation.

The implication is clear: MA is no longer a growth strategy; it is a capital allocation and operating model decision. The question for health system CEOs and CFOs is not how to manage MA better, but whether, where, and how to participate at all. Discipline—not scale—differentiates winners. Highly selective systems, deeply aligned with one or two payers, or that operate within vertically integrated models, are regaining control and stabilizing margins.

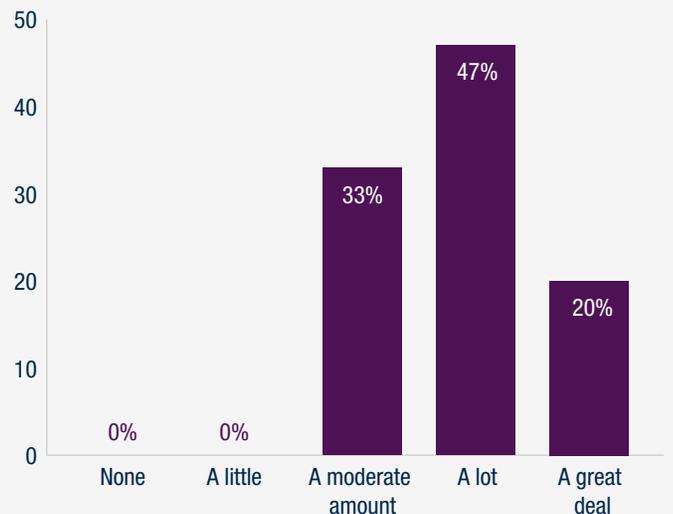
To compete in today's MA environment, health systems must abandon participation models built on volume, optimism, and misaligned payer relationships. Success now depends on disciplined, evidence-based partnerships that tightly integrate clinical performance, contracting discipline, and revenue cycle rigor. Systems that fail to redesign their MA strategy and operating model will see continued margin compression; those that commit to selective, data-driven alignment will restore financial control and create durable growth.

Pulse Survey Insights: Five Structural Pressures Reshaping MA Participation



According to A&M's MA Pulse Survey, health systems are grappling with Medicare Advantage issues that converge in five structural pressure points. Each is backed by survey evidence and together they mark a critical moment of financial and operational transition.

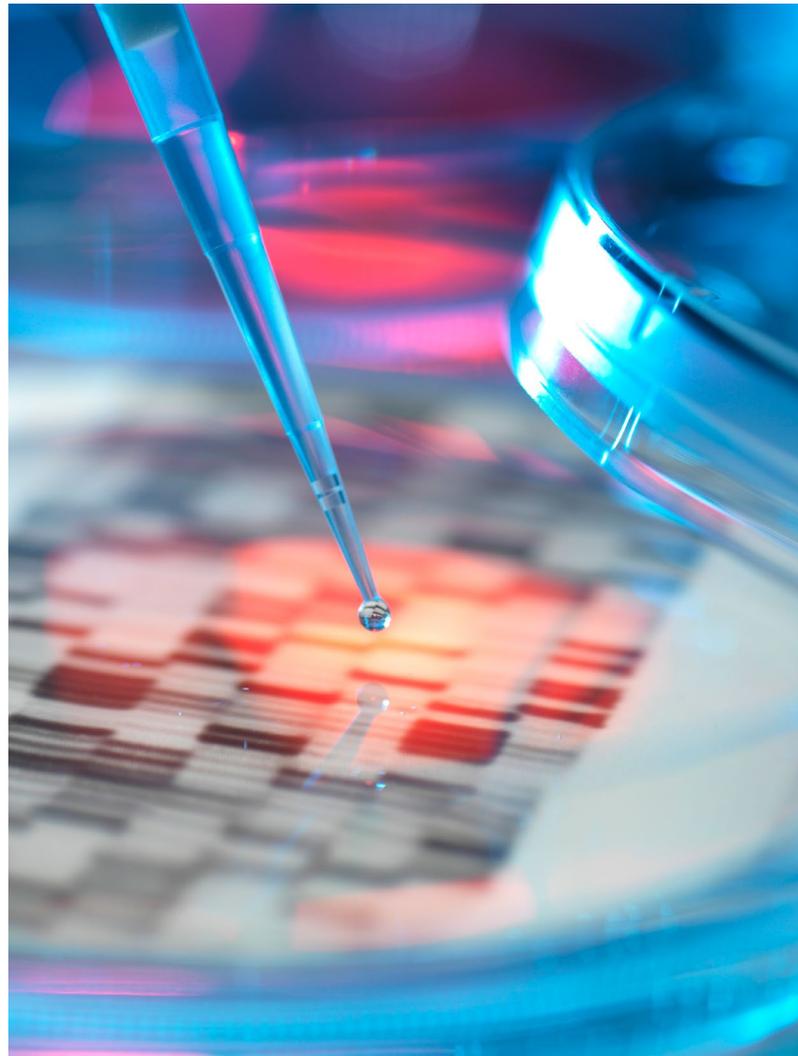
How Much Financial Pressure Do You Anticipate Your Health System Will Face Due To Medicare Advantage Trends In 2026?



1. **Declining Reimbursement (60%)** – Six in ten organizations report falling MA yields, underscoring sustained downward pressure on reimbursement and increasing difficulty achieving rates that preserve contribution margin.
2. **Operational Strain from Denials and Payment Delays (74% and 52%)** – Nearly three-quarters of respondents report rising denials, and more than half cite delayed payments, together driving workflow bottlenecks, higher cost-to-collect, and slower cash conversion.
3. **Growing Patient Financial Pressure (35%)** – Over a third of leaders note rising bad debt and affordability challenges among MA patients, creating additional revenue instability and shifting financial risk onto providers.
4. **Escalating Authorization & Appeals Burden** – Expanding prior authorization requirements and increasingly complex appeals processes are consuming staff capacity, reducing productivity, and delaying patient care.
5. **Unfavorable Utilization Trends (52%)** – More than half of systems report higher-than-expected utilization, eroding performance in risk-based arrangements and increasing exposure to medical loss ratio pressures.

Together, these structural pressures point to a single conclusion: the legacy model of broad MA participation is eroding enterprise margin and consuming scarce operating capacity, requiring a more selective, portfolio-driven approach.

Bottom line: Without decisive action, these forces accelerate margin erosion and compel health systems to rethink MA participation on economic — not conventional — grounds.



Strategic Crossroads: Portfolio Discipline Over Volume



Health systems that continue broad, undifferentiated MA participation are increasingly subsidizing payer margin and absorbing disproportionate operational burden. By contrast, organizations that treat MA as a portfolio—pruning low-yield contracts, concentrating bets where alignment exists, and redeploying capacity—are restoring control.

Winning health systems are making explicit choices:

- **Narrow** MA participation to contracts that are economically defensible.
- **Renegotiate** terms to rebalance utilization and administrative risk back to payers.

- **Exit** misaligned arrangements where renegotiation is not possible.
- **Expand risk selectively** where data, scale, and incentives are truly aligned.
- **Own or partner** into MA products where underwriting and design control justify the risk.

These are not incremental optimizations. They are capital allocation and operating model decisions requiring executive sponsorship and cross-functional alignment.



Future Outlook:

From Reactive Optimization to Intentional Portfolio Design

Looking forward, leading health systems are shifting from reactive cost containment to intentional portfolio management—selective partnerships, fair contracts, revenue cycle modernization, and competitive positioning to drive sustainable growth.

■ Narrow Plan Participation & Build Strategic

Partnerships: Reduce plan count, deepen collaboration with a small number of aligned payers, and create differentiated senior offerings.

■ Pursue Fair and Equitable Deal Terms:

Negotiate clauses that curb excessive prior authorization and payment delays; secure rate structures that protect yield.

■ Right-Size Value-Based Care (VBC) Participation:

Scale back unfavorable risk; expand through partnerships with

meaningful scale and enablement where the economics support it.

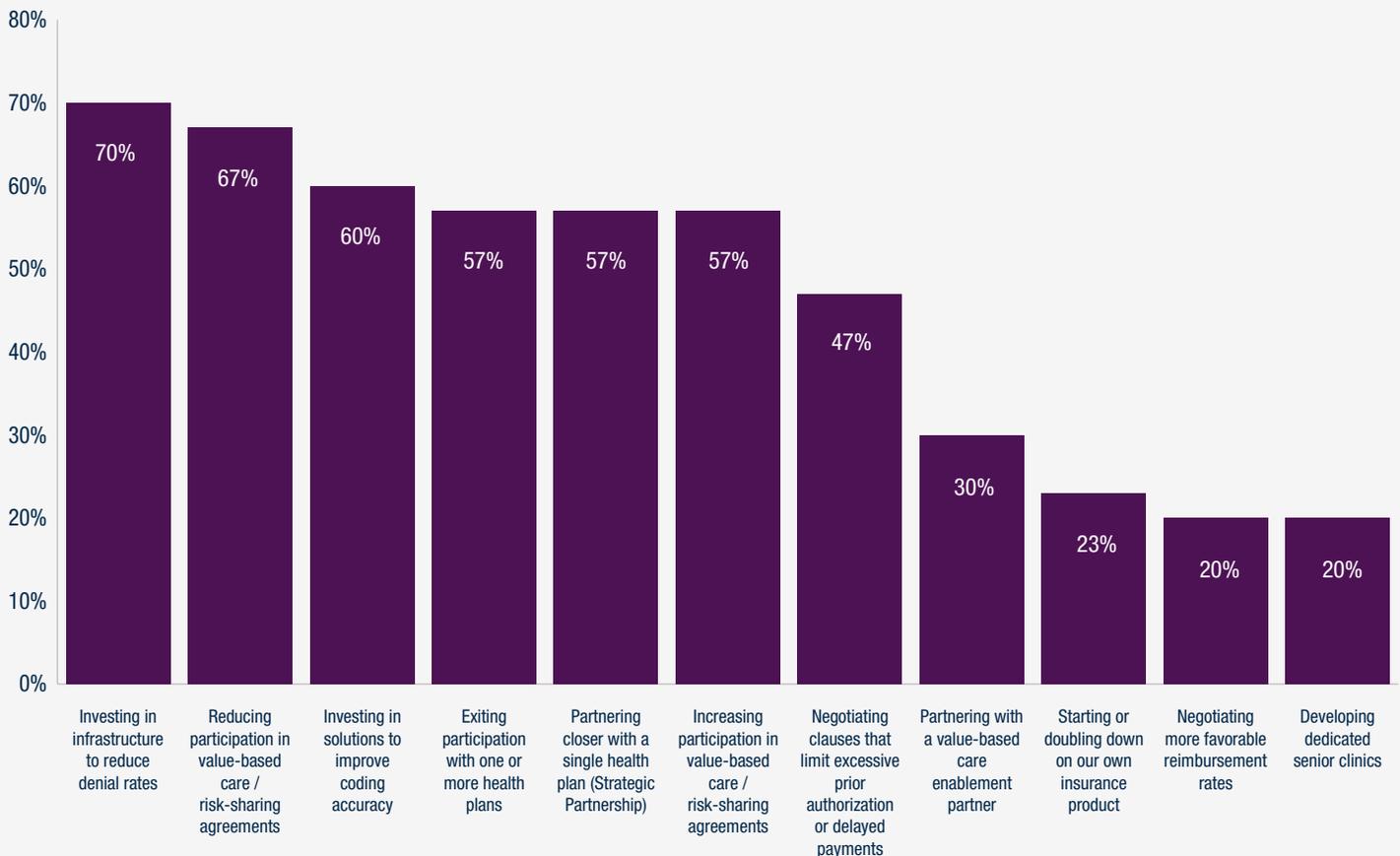
■ Establish Revenue Cycle Resiliency:

Strengthen utilization review, denial prevention, and coding precision to improve first-pass yield and accelerate cash.

■ Position for Long-Term Competitiveness:

Where strategically sound, strengthen provider-sponsored plans or develop senior-focused access models to capture market share and underwriting margin.

What Medicare Advantage Strategies Is Your Health System Prioritizing To Achieve Financial Success In 2026?





Success in today's MA environment requires a disciplined strategy grounded in governance, clear economics, and cross-functional execution. Four pillars guide the journey.

1 Strategic Participation & Contracting: Intentional Portfolio Design

MA contracting is no longer just rate negotiation—it is a capital allocation decision. Narrow participation to economically defensible, strategically aligned plans. Evaluate each contract on total return: reimbursement adequacy, authorization burden, denial risk, payment timeliness, utilization profile, and required operating capacity. Contracts that dilute margin or demand disproportionate resources should be renegotiated or exited. Protective provisions (authorization standards, transparency in risk adjustment, reimbursement escalators, and payment timeliness) are non-negotiable. Simplifying the payer mix stabilizes enterprise yield and strengthens negotiating leverage.

2 Value-Based Care: Focused Risk with Transparent Alignment

Fewer partners enable deeper, more strategic relationships. Winning systems combine robust Stars and RAF strategies with payer transparency, shared data, and effective medical management. Risk participation should be contingent on clear performance levers (quality, pharmacy management, site-of-care, care coordination), balanced risk-sharing structures (e.g., corridors, stop-loss), and complementary operating models. Align provider incentives with contractual objectives to ensure VBC performance remains clinically sound and financially sustainable.

3 Revenue Cycle Modernization: Automate the Friction Out

MA economics demand an intelligent, automated revenue cycle to neutralize administrative burden. Automate prior authorization and financial clearance, deploy AI-enabled documentation and precision coding, and apply predictive analytics to prevent denials and speed adjudication. Measure and manage to first-pass yield, cost-to-collect, avoidable denial rate, and cash conversion cycle. Prioritize investments where the MA portfolio has the clearest path to ROI.

4 Operational Efficiency: Redeploy Capacity to Value

Rationalize operating cost and redesign roles and workflows to align staffing with patient volume. Shift teams from transactional tasks to value-creating work; standardize processes and deploy digital tools to boost productivity. Embed payer-specific playbooks so front-line operations reflect the narrowed payer mix, reducing variability and leakage while strengthening resilience.



Key Roadblocks and Practical Mitigations

- **Cultural Resistance:** Counter with strong change management, transparent communication, and clear decision rights.
- **Patient Access Complexity:** Standardize intake and referral workflows; use EHR flags to guide routing and reduce leakage.
- **Financial Clearance Gaps:** Automate eligibility/benefits verification and deploy predictive denial tools before service.
- **Human Capital Friction:** Pair role redefinition with training, analytics-driven performance management, and continuous development.



Transformation Blueprint: Three Phases



Phase 1: Rapid Diagnostic & Cultural Alignment

Establish momentum with a focused diagnostic and unified strategy.

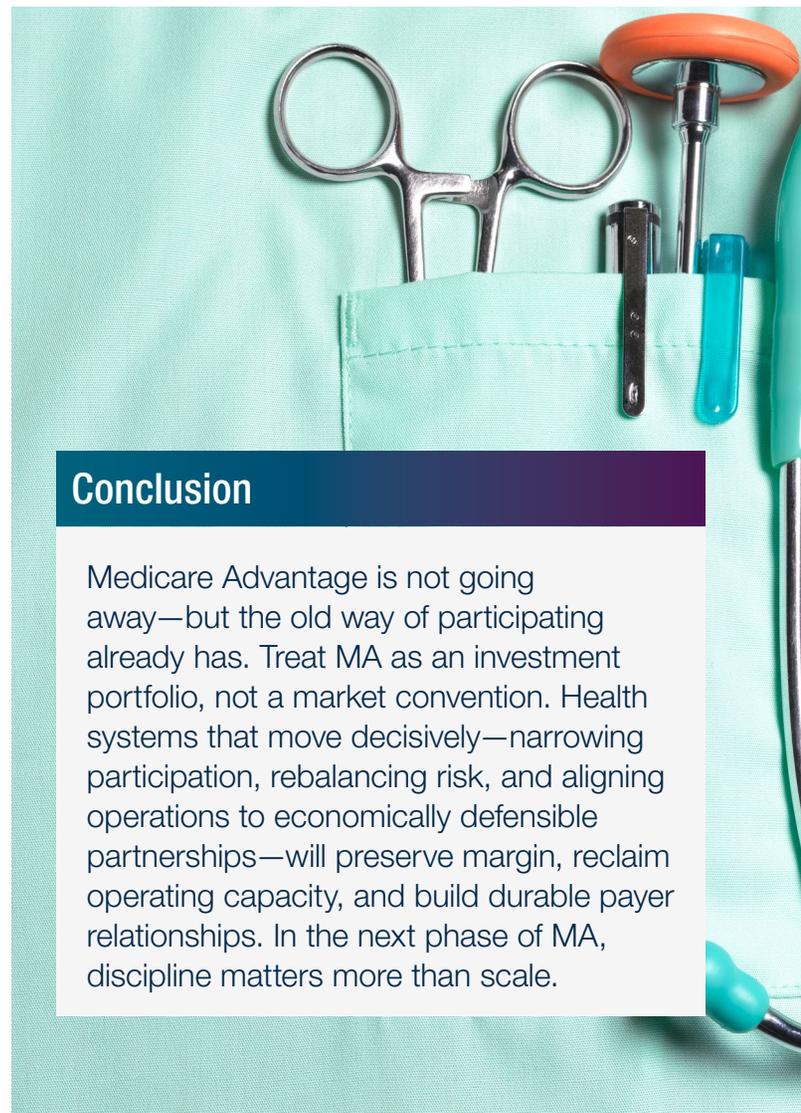
- **Evaluate payer performance** across each pillar; build a contract-level P&L and total cost-to-serve view.
- **Pinpoint reimbursement gaps** and administrative inefficiencies; quantify operational capacity consumed by each plan.
- **Assess cultural readiness** for selective participation; define decision criteria and exit triggers.
- **Run financial models** and risk scenarios to guide capital allocation.
- **Unify leadership** around a clear, data-driven payer strategy and governance cadence.

Phase 2: Execution & Financial Stabilization

Translate strategy into results through contract optimization, denial reduction, payment timeliness enforcement, and cash acceleration. Right-size VBC exposure, renegotiate or exit misaligned plans, and redeploy capacity to high-value partners.

Phase 3: Performance Monitoring & Continuous Optimization

Institutionalize best practices with real-time dashboards and operating reviews. Track contract-level return on invested capital, Stars and RAF integrity, cost-to-collect, avoidable denials, prior-auth turnaround, and access standards. Iterate portfolio choices as market conditions evolve.

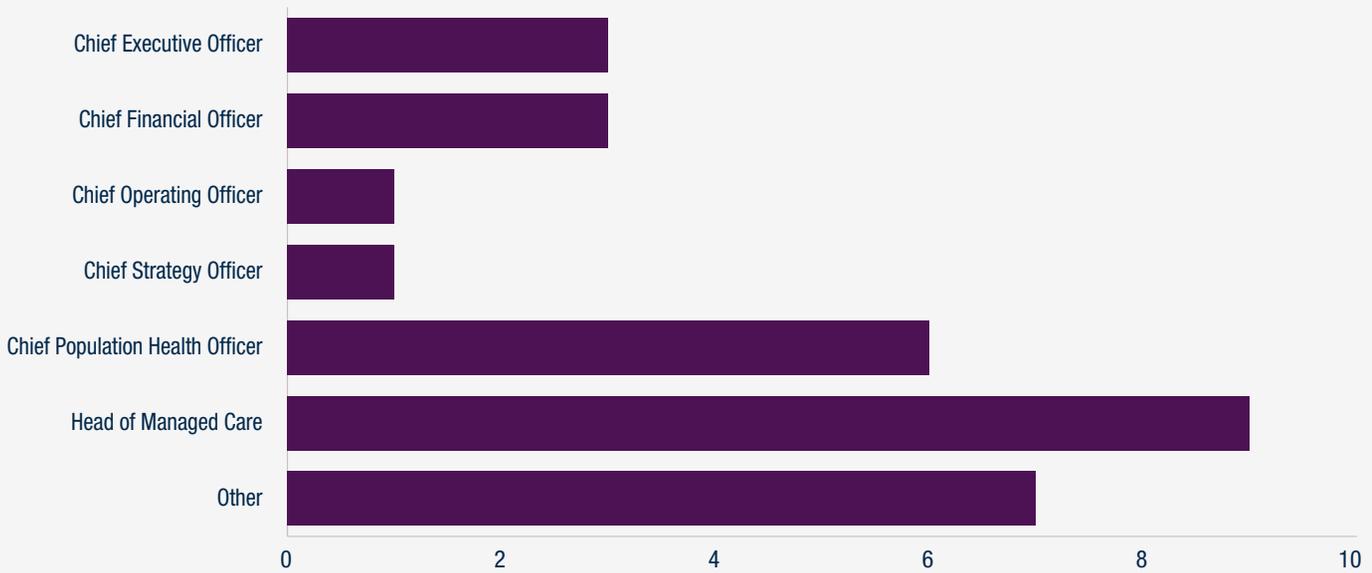


Conclusion

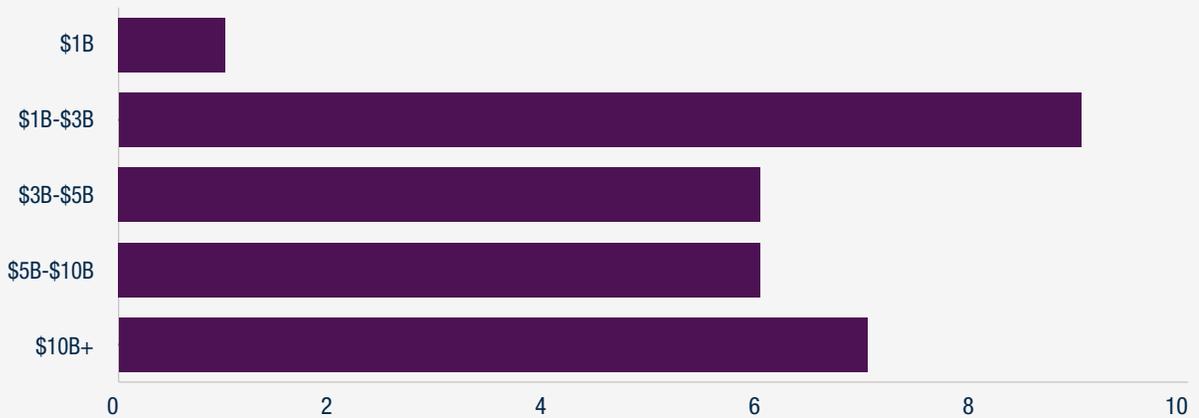
Medicare Advantage is not going away—but the old way of participating already has. Treat MA as an investment portfolio, not a market convention. Health systems that move decisively—narrowing participation, rebalancing risk, and aligning operations to economically defensible partnerships—will preserve margin, reclaim operating capacity, and build durable payer relationships. In the next phase of MA, discipline matters more than scale.



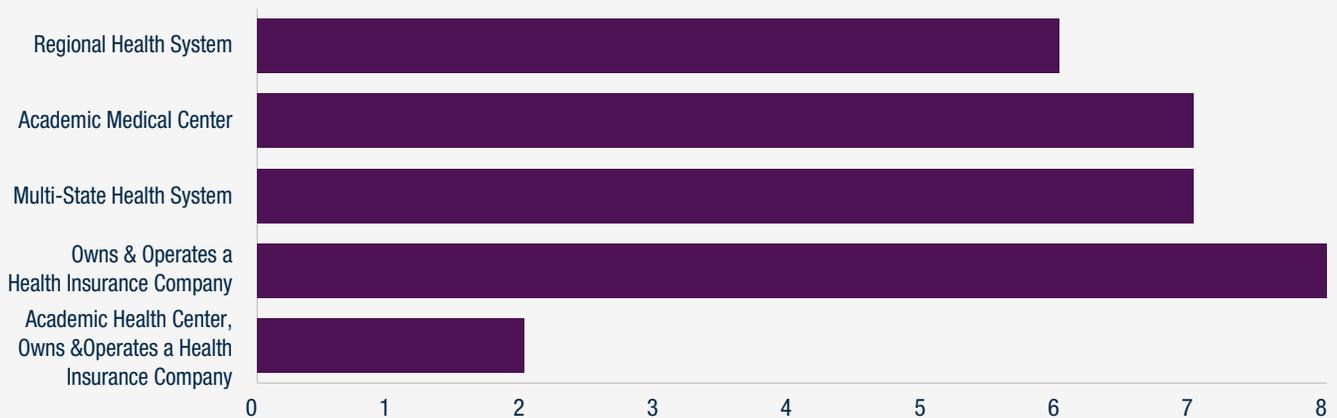
What Is Your Current Role?



What Is Your System's Total Net Revenue?

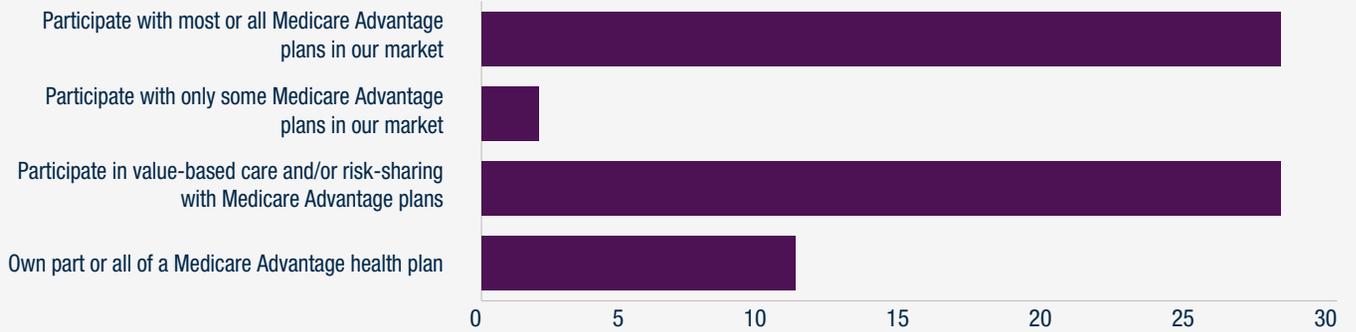


What Best Describes Your Health System?

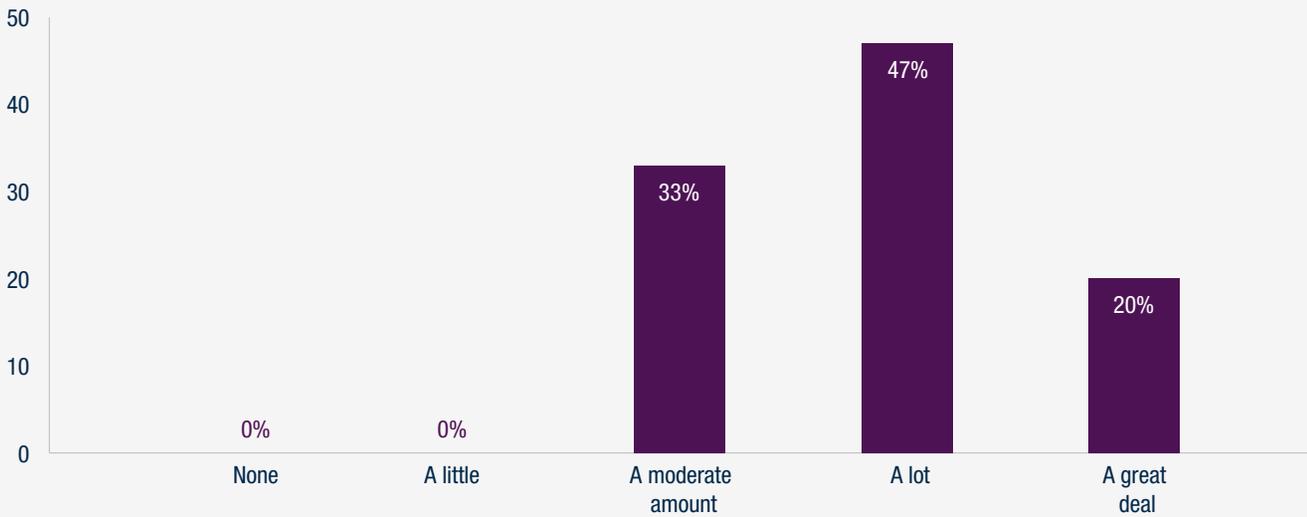




What Best Describes Your Health System Medicare Advantage Strategy?

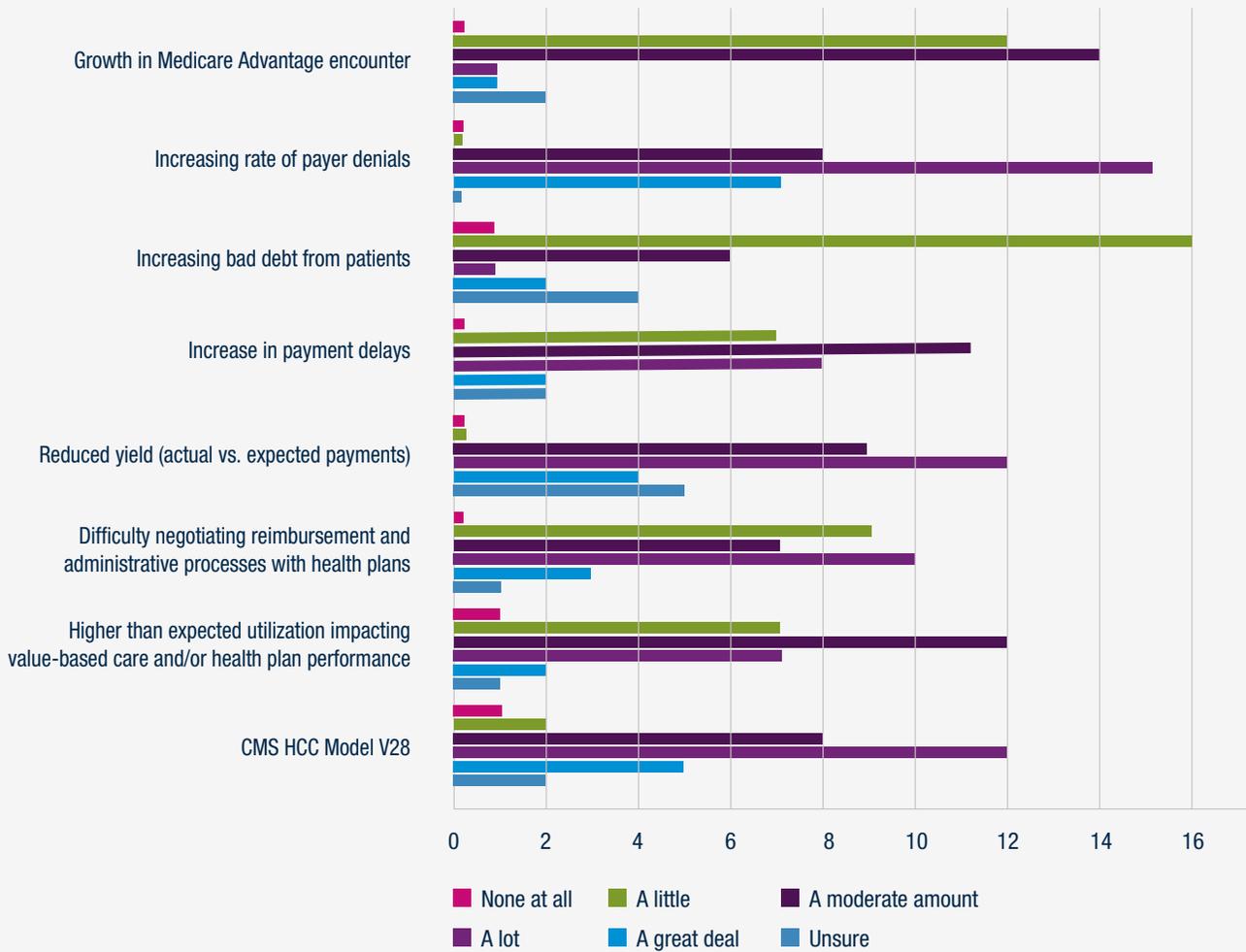


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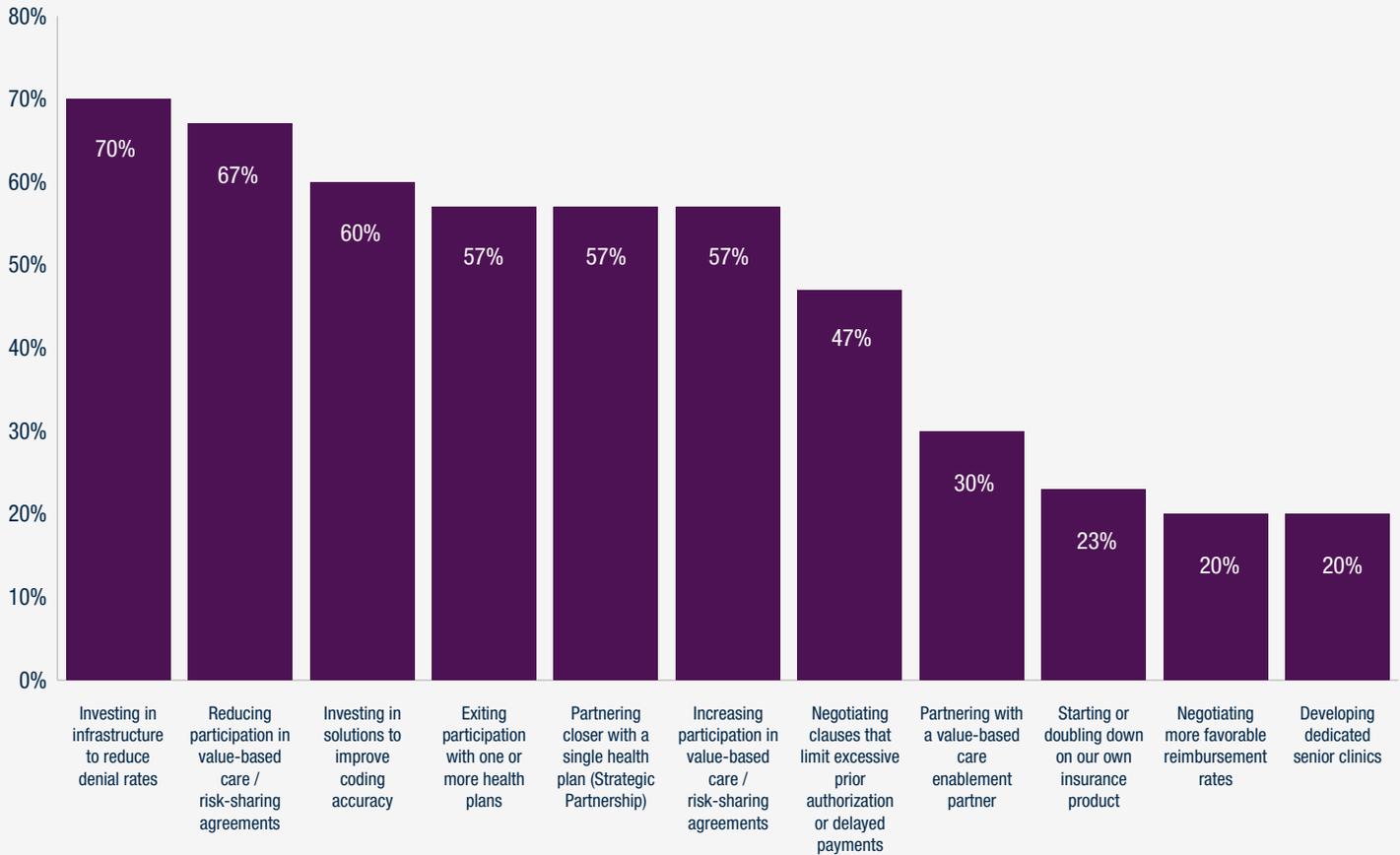


To What Extent Do You Expect The Following Medicare Advantage Trends To Negatively Impact Your Health System?





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