Pursuing Value: What's Next for Medicare and Medicaid?

Lee J. Handke
CEO, Nebraska Health Network

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Topics for Today…

- Accountable Care Organizations: A brief history
- Value-based agreements: An overview
- A Nebraska Medicare and Medicaid Overview
- Value in Medicare and Medicaid: What's Now, What's Next?
- What is Happening Locally?: A panel discussion

ACOs: A Brief History

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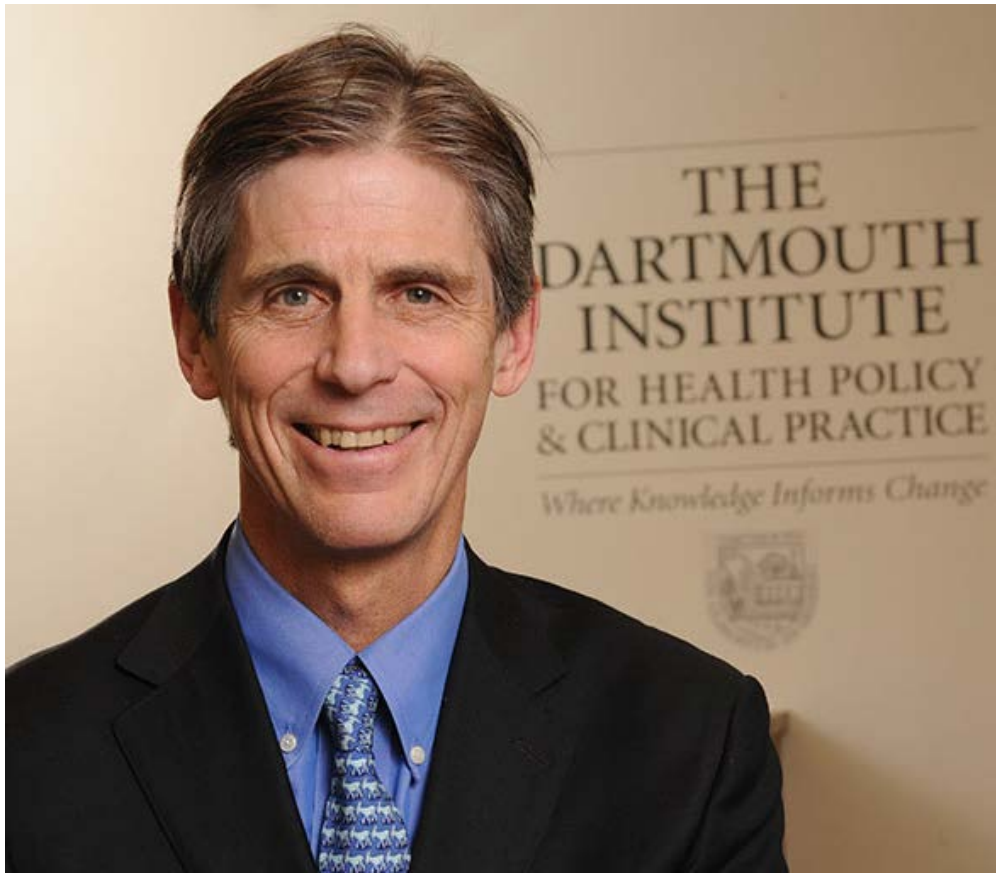
The Birth of the ACO

- Dr. Elliot Fisher coins the term ACO in 2006 in a meeting with Medicare
- Physicians and health systems come together to be accountable for quality performance, cost savings and patient satisfaction



Where Were You 13 Years Ago Today?

Fast Forward to Today

Serving **11 million** Medicare beneficiaries

67% of these ACOs are now at financial risk for performance

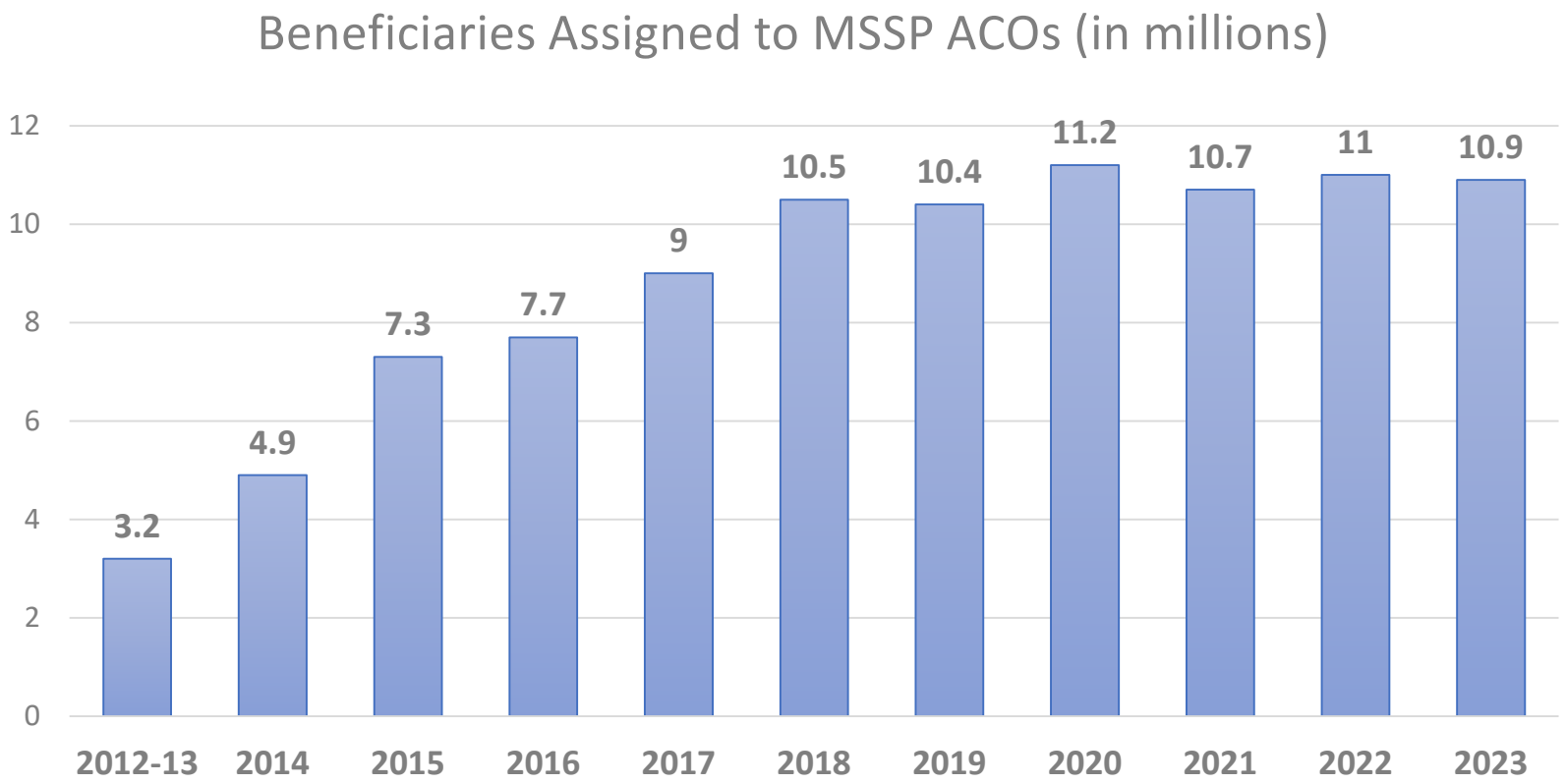
- 99% of ACOs met Quality standards
- 81% generated savings
- 58% received shared savings

ACOs are accountable for:

- Managing the total cost of care
- Achieving Quality Outcomes
- Paying back CMS or plan sponsors if spending exceeds the benchmark in two-sided risk models

There was a high of 561 MSSP ACOs in 2018

ACO Beneficiaries have stalled out



- Why?
  - Risk!
  - Medicare Advantage
  - 2.1 million participants have shifted to Direct Contracting / REACH model

Source: CMS Data, February 20, 2023.

Nebraska ACOs

ACO Business Model

GENERAL INVESTMENT

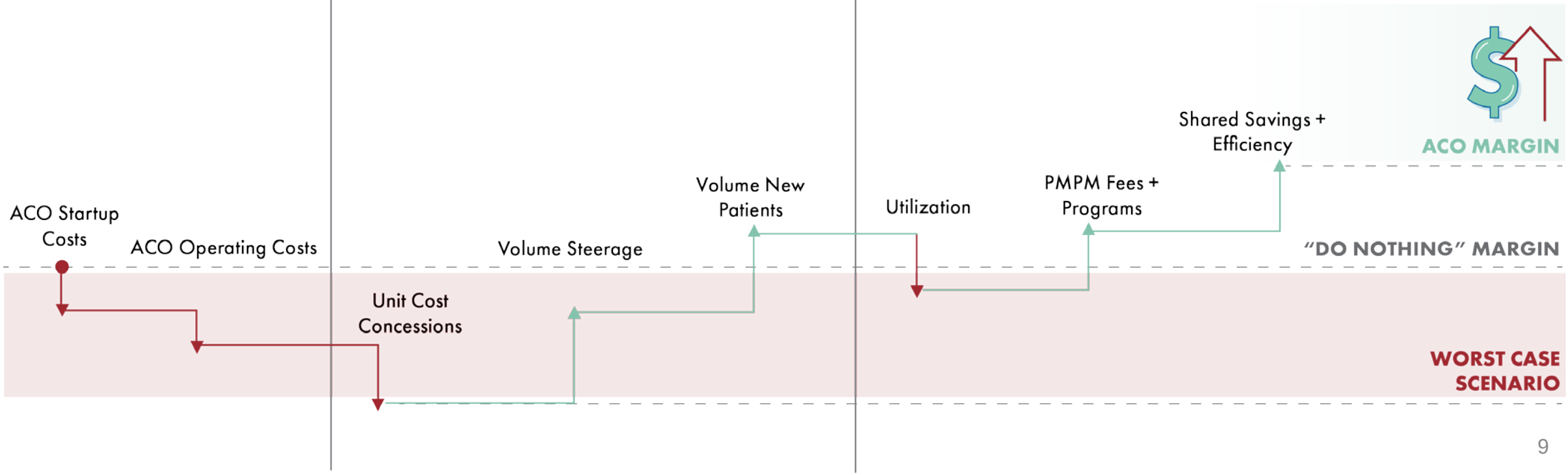
Incur operational costs to establish the ACO.

EMPLOYER/INSURER PRODUCTS

As you establish relationships with payers, you negotiate prices to help drive steerage and overall patient volume.

VALUE-BASED INCENTIVES

Value-based agreements drive appropriate utilization. PMPM fees for care coordination help offset costs and shared savings incentivize ACOs for meeting cost and quality measures.



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METHODIST + Nebraska Medicine 2010

Partnered to create an

ACCOUNTABLE CARE ORGANIZATION

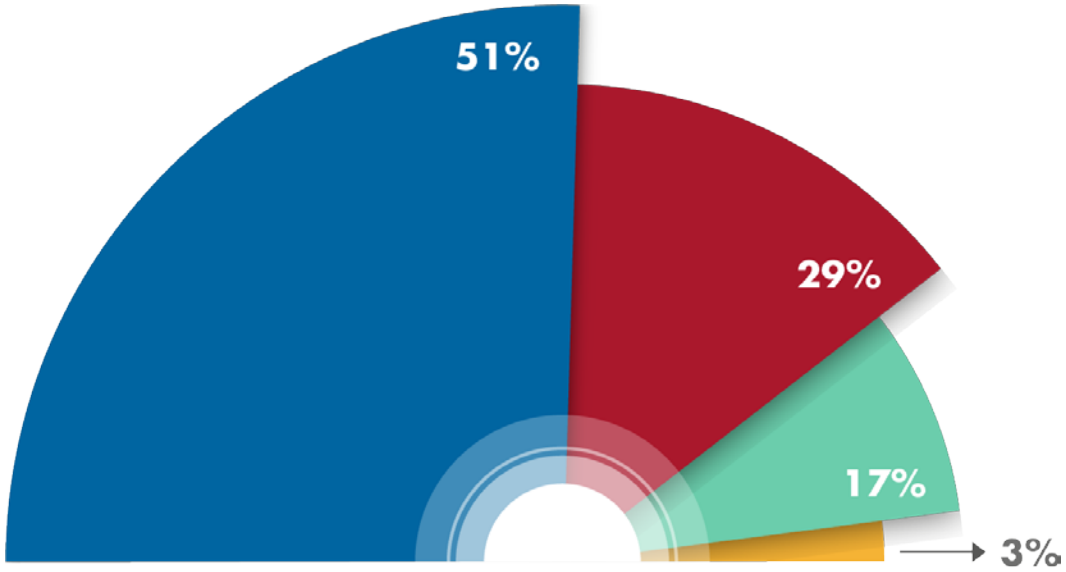
The Nebraska Health Network includes:

8 Hospitals

More than 3,200 physicians and advanced practice providers

2023 Value-Based Contracts

210,936 Covered Lives



- Commercial: 107,946 (51%)
- Medicare: 60,242 (29%)
- Medicaid: 34,939 (17%)
- Commercial IFP: 7,809 (3%)

Commercial Group	Aetna Commercial	11,400
	Blue Cross ACO	66,229
	Ne Furniture Mart DTE	1,285
	UHC Commercial ACO	33,032
Medicare	Aetna MA	5,317
	Blue Cross MA	1,463
	Humana MA	4,650
	MSSP Basic Level E	37,484
	NTC MA (Wellcare)	550
	UHC MA	10,778
Medicaid	Healthy Blue Medicaid	13,153
	Ne Total Care Medicaid	13,140
	UHC Medicaid	8,646
Commercial Individual	Medica IFP (Elevate)	7,612
	NTC IFP (AmBetter)	197

Updated 2/21/2023

Our Core Responsibilities

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Enter into **value-based** agreements with payers

Use data to assess **opportunities** to improve quality & cost

Communicate those opportunities to the network

Collaborate with the network to drive performance

Distribute rewards from success

Value-Based Agreements: An Overview

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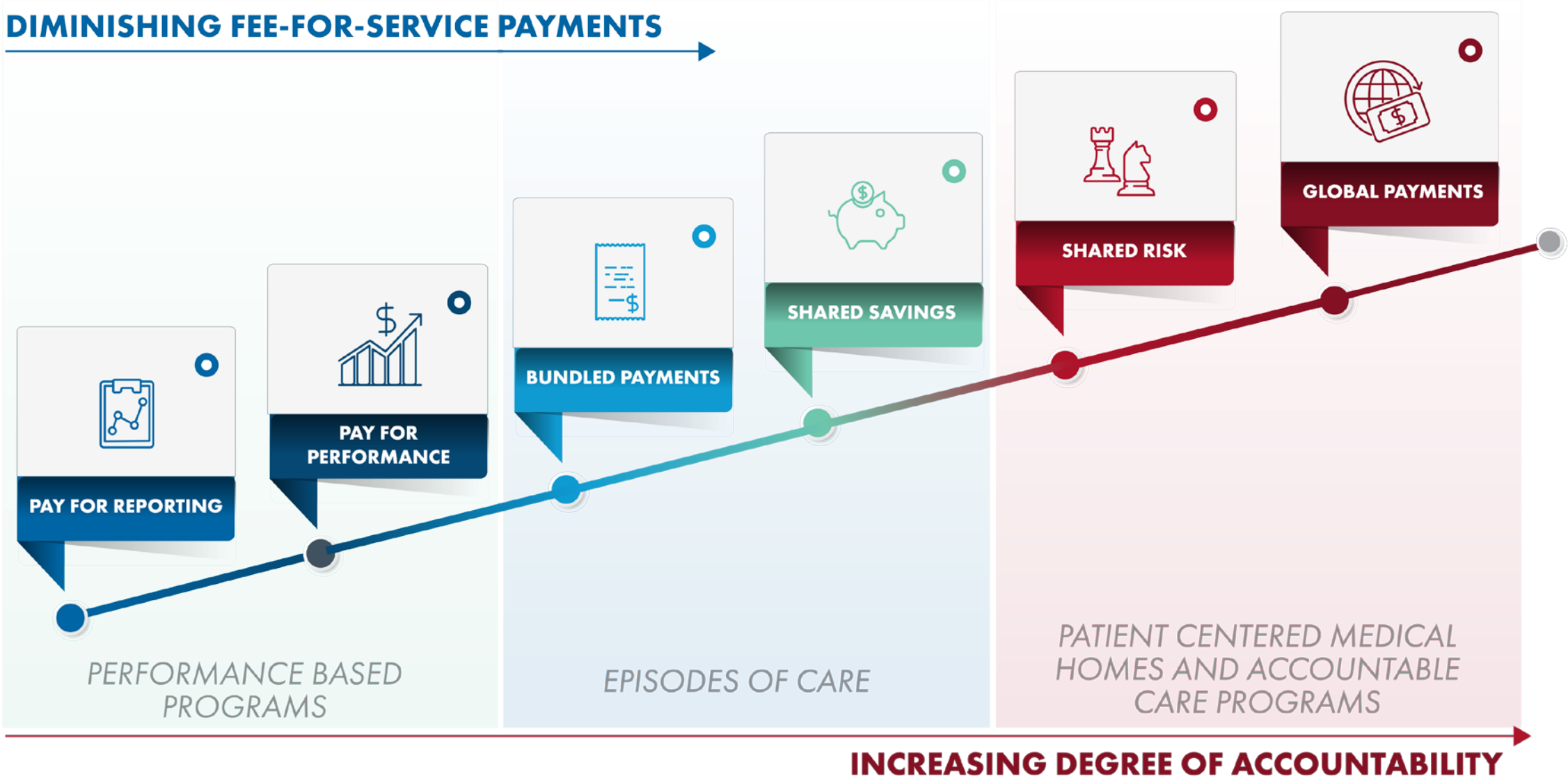
The Journey from Volume to Value



Retrospective Rewards

Most Contracts have two components:

Quality

Targets are set for specific measures – meeting these targets qualify providers for shared savings

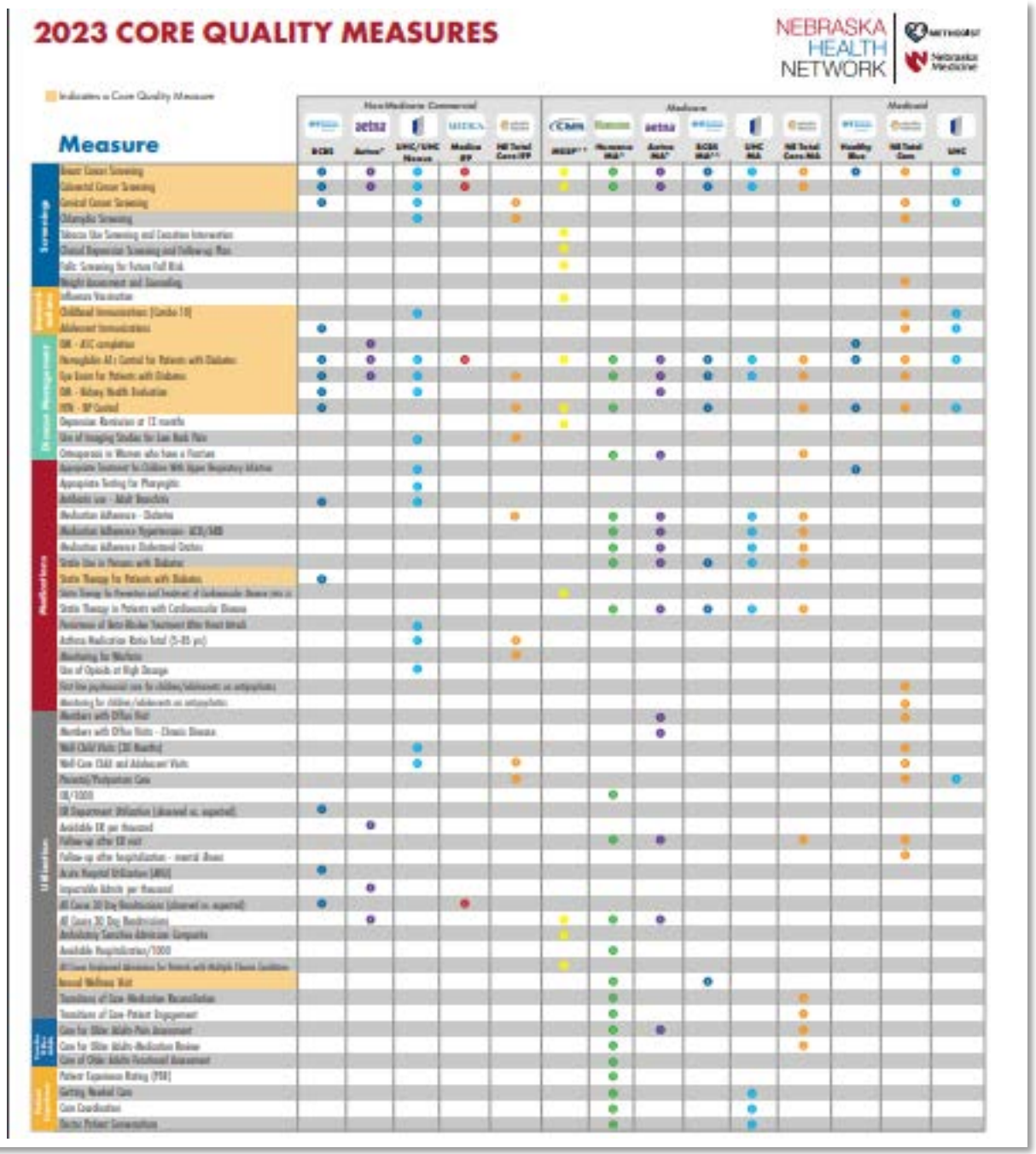
Cost

Based on historical claims, a cost target is set and adjusted for patient health status (risk).

- Any savings below the targets are shared between insurer and provider
- Contracts can be “upside only” while others have transitioned into risk

Focus on Quality?

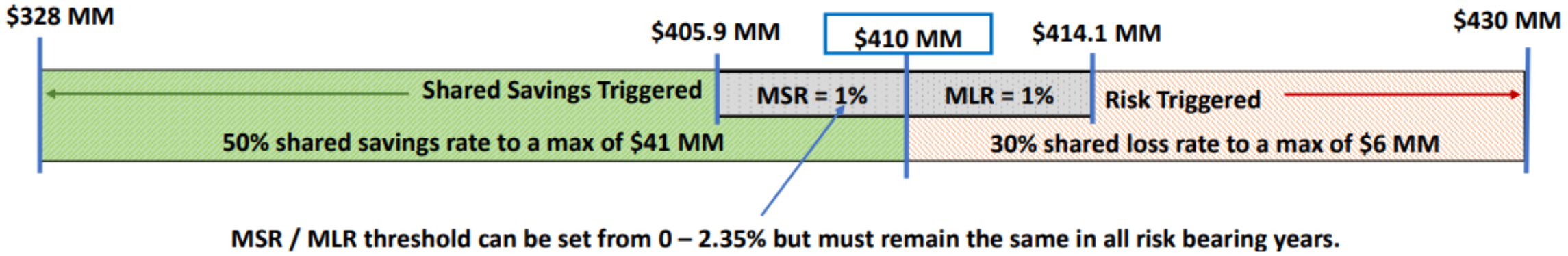
- Quality Measures
  - 64 measures across 14 agreements
  - Difficult to measure, manage and communicate
- Developed 12 Core Quality Measures
  - 3 Screening Measures
  - 2 Immunization Measures
  - 5 Disease Management
  - 1 Medication Adherence
  - 1 Utilization Measure



Cost

- A target is set typically as a Medical Loss Ratio (MLR)
  - Medical expenses as a percent of total premium
- Total cost of care based on historical spend, trend and risk

MSSP Illustration



Nebraska Medicare and Medicaid Market Overview

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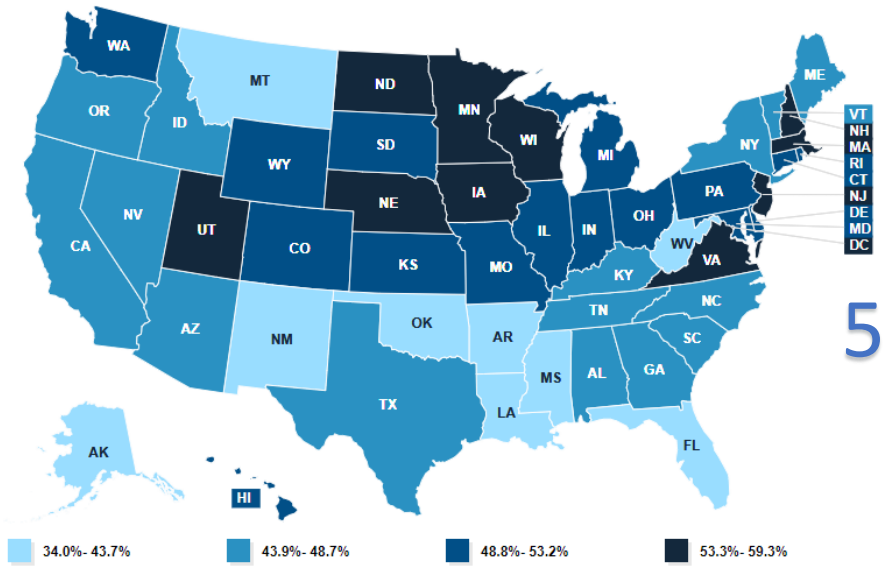
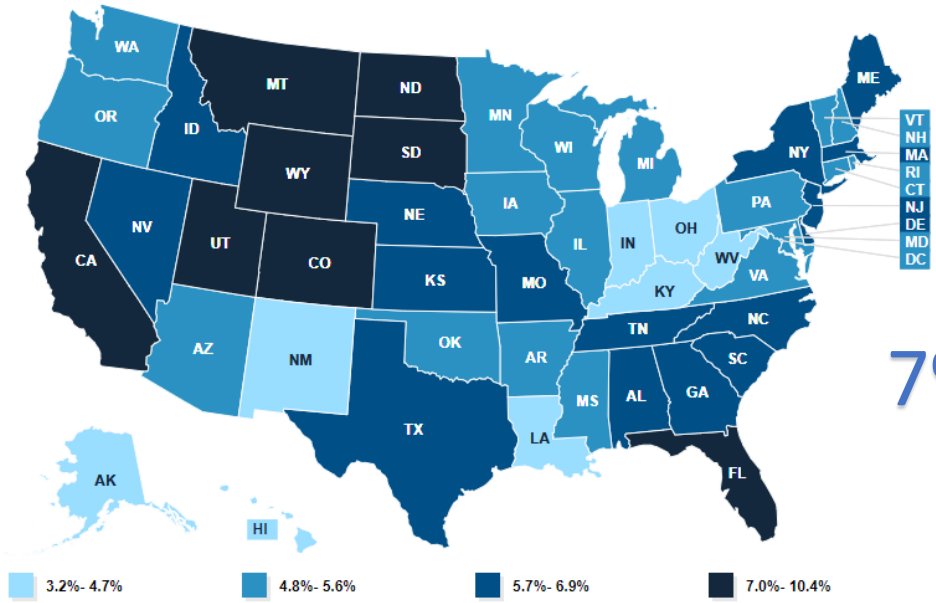
Nebraska Insurance Coverage Overview

Employer



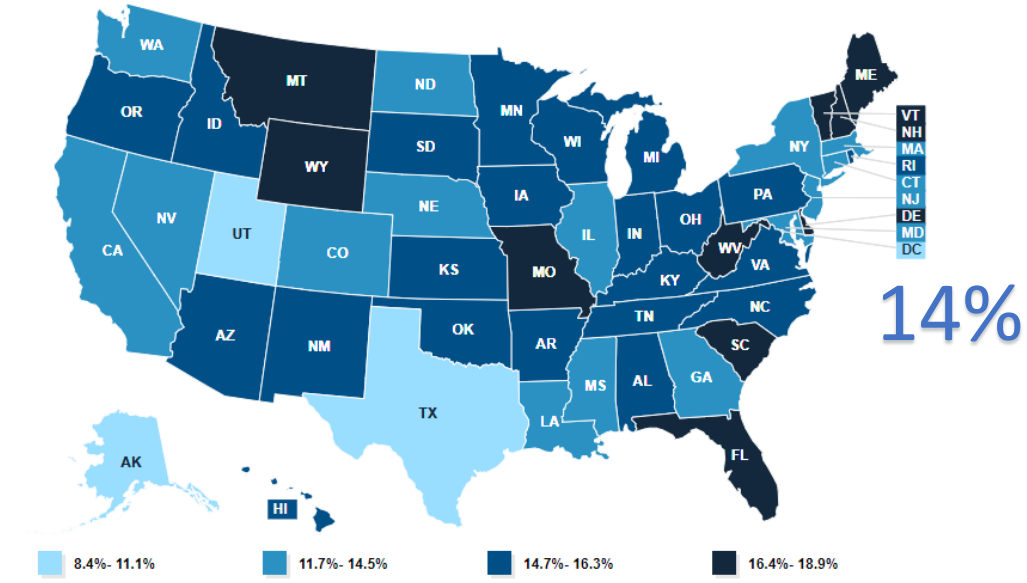
55%

Individual



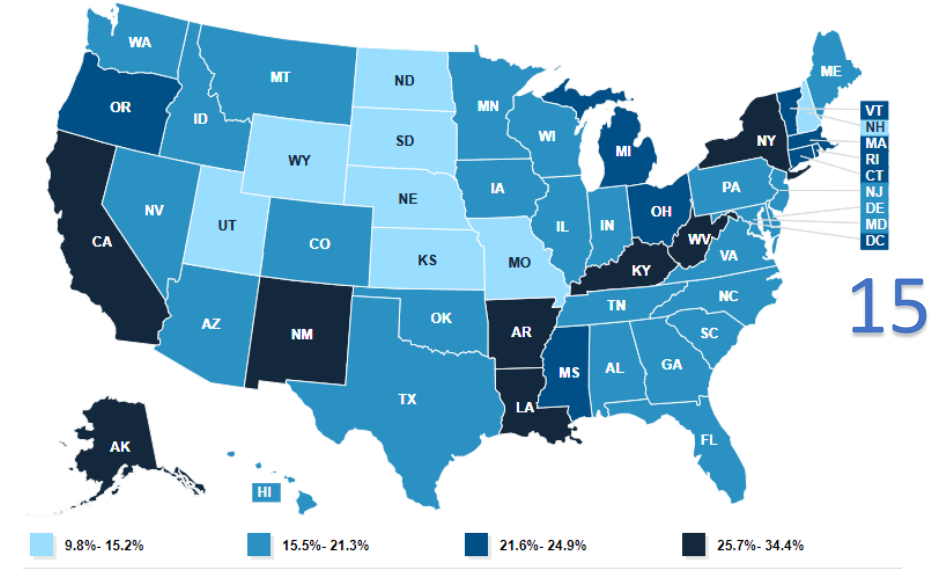
7%

Medicare



14%

Medicaid



15%

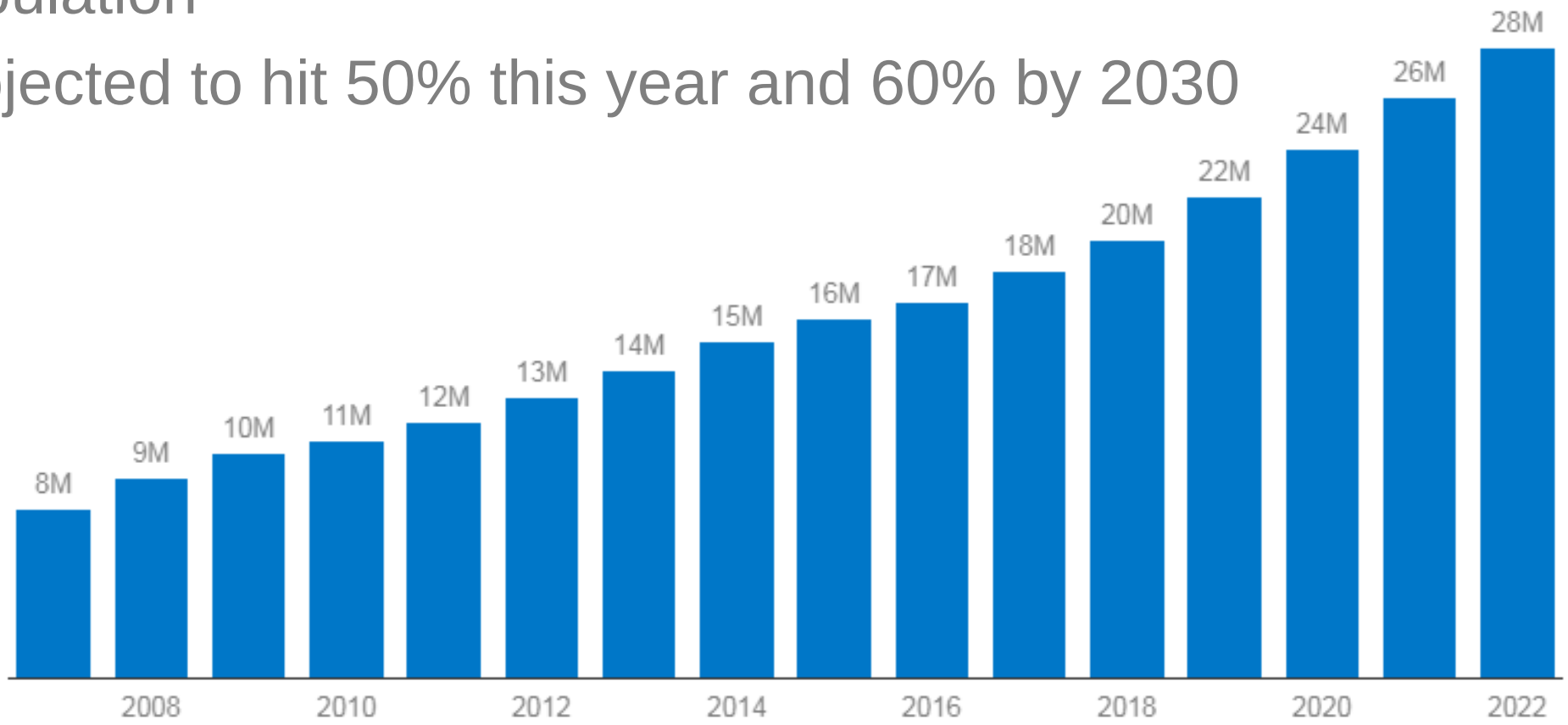
Source: Kaiser Family Foundation State Health Facts, 2021

Medicare and Medicare Advantage

- 367,000 Nebraskans are enrolled in a Medicare plan
  - 182,000 have a Medigap plan to supplement traditional Medicare
  - ~90,000 are enrolled in a Medicare Advantage plan
- 48 companies provide Medigap plans in Nebraska
- Medicare Advantage varies significantly by county
  - 27 MA plan options in Douglas and Sarpy counties
  - 0 MA plan options in 9 Nebraska counties

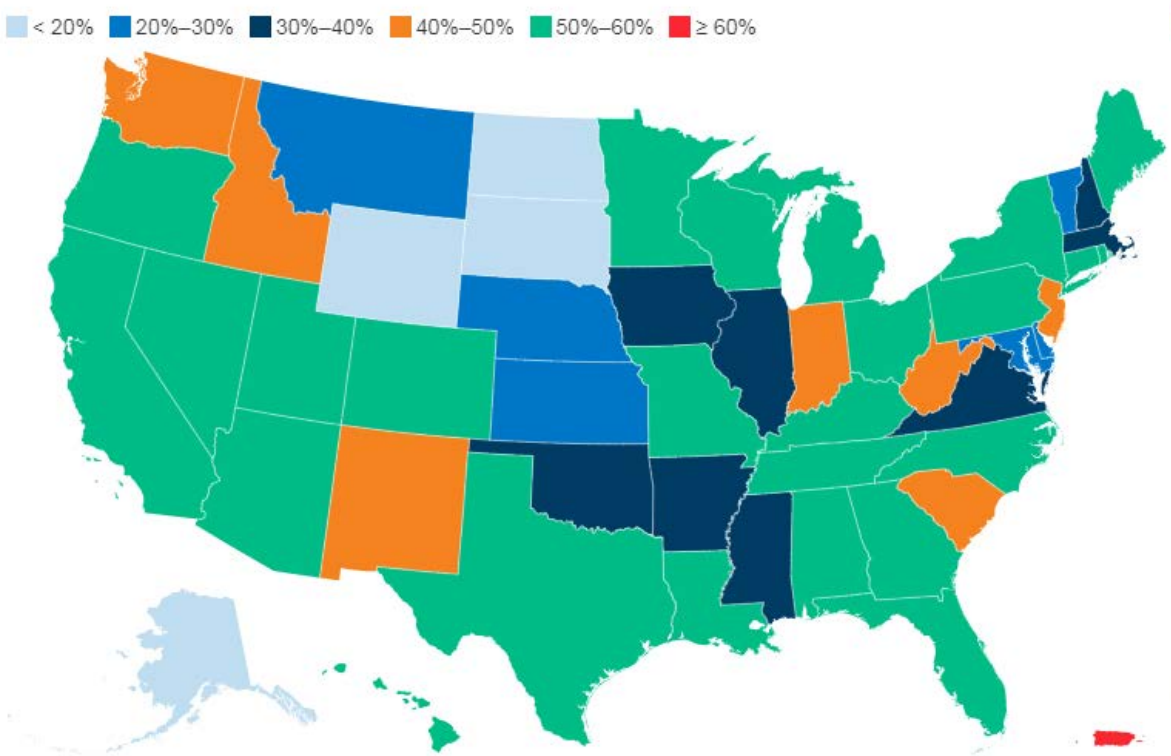
U.S. Medicare Advantage Enrollment

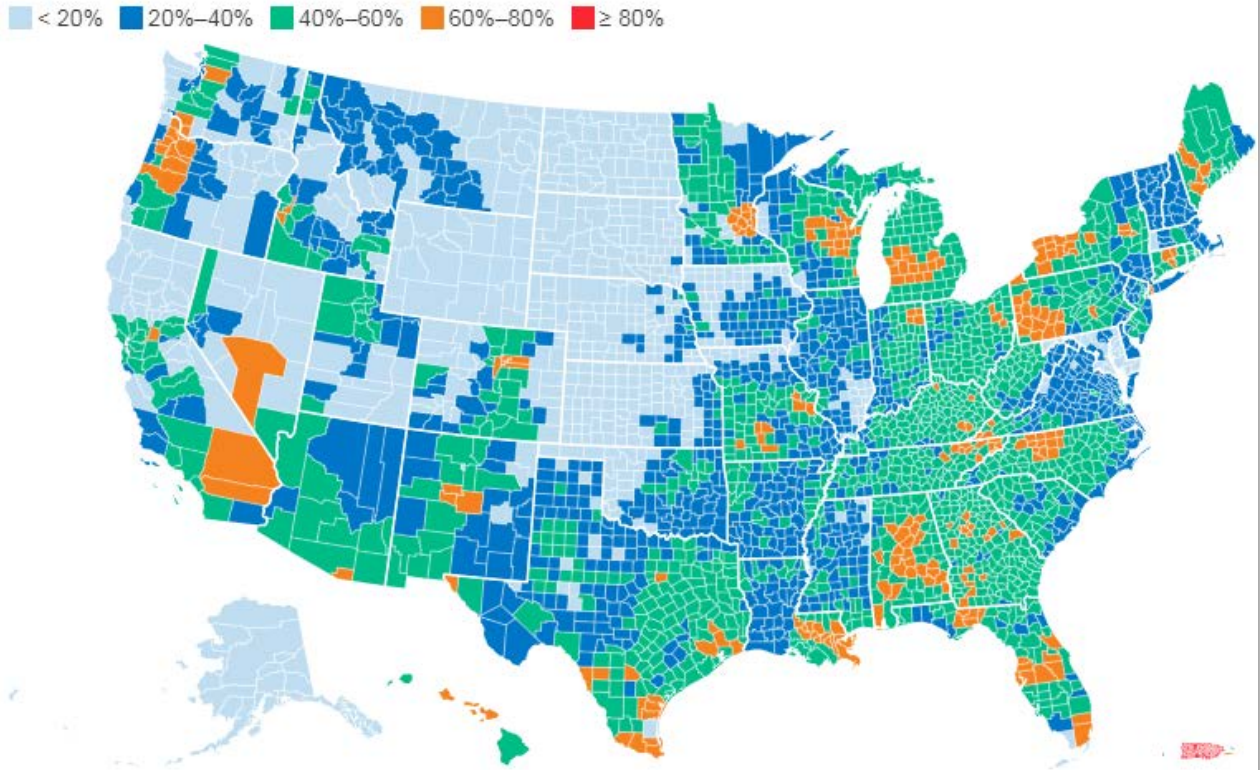
- 2022: Total enrollment of 28 million – 48% of the Medicare population
- Projected to hit 50% this year and 60% by 2030



Patterns of National and Local Variability

- Nebraska 27% and Iowa 30%



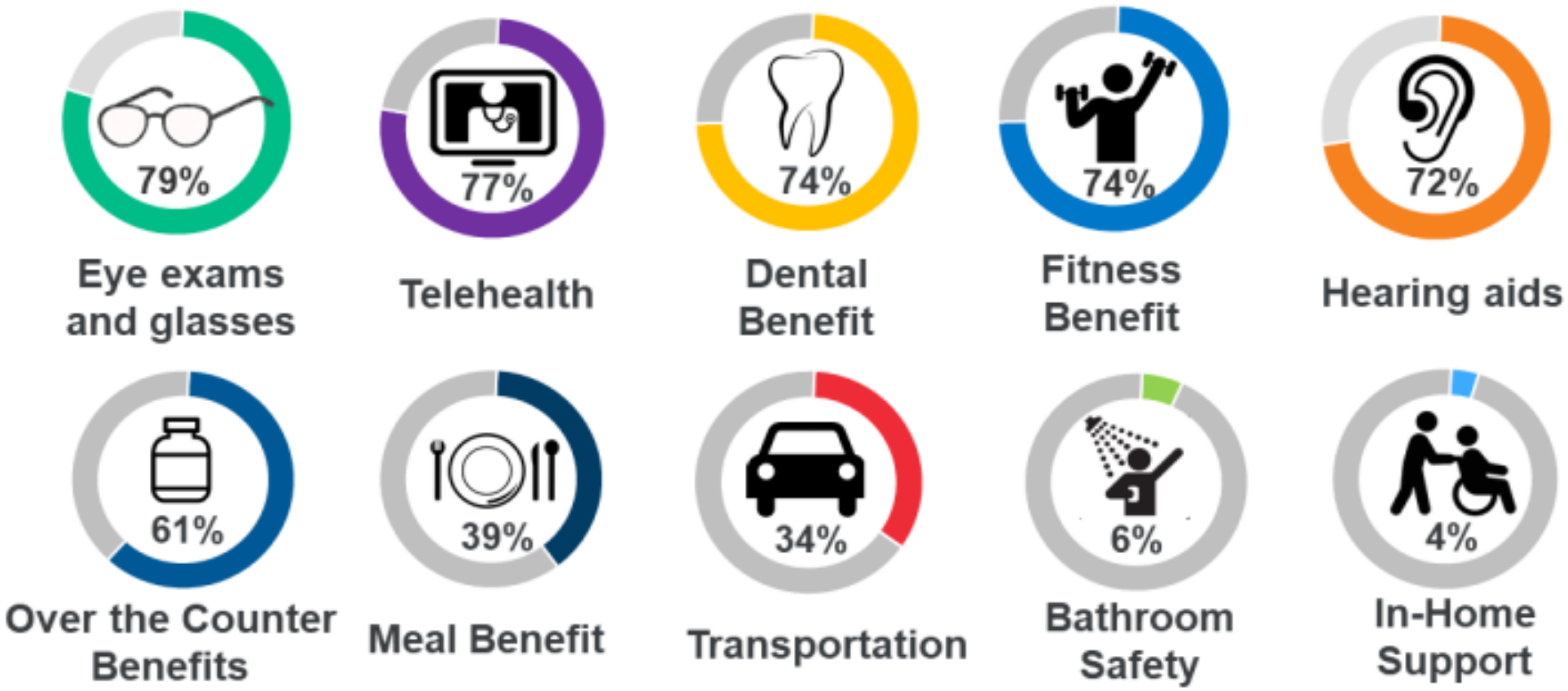


Source: Kaiser Family Foundation, Medicare Advantage in 2022

Why the Growth in MA?

- 60% of MA plans nationally have no premiums
- One-stop shopping – most plans bundle Part D prescription drug coverage
- Aggressive marketing campaigns
- CMS has been investing in these plans
  - MA plans are allowed to provide seniors with additional benefits not covered by traditional Medicare and Medigap plans

Extra Benefits Offered by MA Plans



Medicare Plan Comparison

	Medicare Advantage	Medicare + Supplement
Monthly Premiums	Low to no monthly Cost	High Monthly Cost
Copays / Deductibles	Larger copays and deductibles	No additional cost shares
Extra Benefits	Extra benefits included	No additional benefits are allowed
Provider Choice	Networks are often limited	Open choice of providers
Enrollment	Annual enrollment – Oct 15 to Dec 7	Only guaranteed coverage at age 65

OWH – Point / Counter-point

MIDLANDS VOICES

Medicare Advantage — whose advantage is it?

DONALD R. FREY, M.D.

You turn on your TV and hear a litany of monotonous, mind-numbing exaggerations. You go to your mailbox and find it stuffed full of slick marketing materials.

Of course, I'm talking about Medicare Advantage. Just call our toll-free number.

In 1997, after intense lobbying by the private insurance industry, Congress approved a plan allowing older Americans to enroll in private programs, rather than traditional Medicare. Instead of paying for an enrollee's medical expenses directly, Medicare would instead turn over a fixed sum of money to a private insurer to "manage" the patient's care.

Since then, Advantage plans have been marketed non-stop. They've become a gold mine for private insurers, but a multi-billion dollar drain on

Upcoding works like this. The money the Medicare Trust Fund

According to an investigation by the Kaiser Family Founda-

MIDLANDS VOICES

Even with challenges, Medicare Advantage is still the better option

FRANK ADKISSON

I don't dispute Donald R. Frey's statistical analysis of Medicare vs. Medicare Advantage plans (World-Herald, Dec. 13), but there are a lot of financial issues completely omitted from his op-ed.

He is approaching things from the doctor (and billing) perspective and I respect that.

Our office must approach things from the Medicare beneficiary (client) point-of-view.

Dr. Frey compares original Medicare vs. Medicare Advantage but omits the fact that original Medicare has very high inherent risks unless it is paired with a Medicare supplement plan. If one fails to purchase a supplement to work in tandem with original

tient could pay for care is infinity. Twenty percent of a lot can still be a lot.

At least with Medicare Advantage plans (in Omaha), typically the maximum medical out-of-pocket is $3,600 to $4,500 for competitive established plans.

In the early 1980s, there was a competition for supremacy in the VCR battle. Beta vs. VHS. Slowly, VHS won the war and Beta machines started gathering dust in people's basements.

Dr. Frey is pretty much already conceding Medicare Advantage has won the market share battle with original Medicare.

Paired with original Medicare:

- Medicare supplements increase their premiums like clockwork every year.

now become 12-plus% annual increases.

- Underwriting for those wishing to change plans or companies has gotten far more stringent.
- They only want the healthiest of the healthy on their plan and still increase their premiums regularly.
- Popular plans — like comprehensive F plans — have been mothballed, increasing premiums further.

If you are age 75 to 90 and have been afflicted with health challenges, no other supplement company will likely accept you while your premiums annually skyrocket. Your only other alternative is a $0 premium Medicare Advantage plan, who gladly accepts all comers without health questions.

a month for a Medicare supplement, and your budget is already stretched, what other alternative is there?

The advent of the Medicare Advantage plan is coinciding with a decline in the Medicare supplement industry. Berkshire Hathaway-owned Central States is exiting the Medicare supplement market on Dec. 31. Why? That would not be happening if oodles of money were still flowing in. We all read how Warren Buffett loves insurance premium "float"; but not anymore in this instance.

A responsible course of action is to show both scenarios to those who are enrolling into Medicare for the first time to ensure they have a solid understanding of both options pros and cons. Even

tation, each year fewer opt for the premium-laden supplement plan and choose the $0 premium Medicare Advantage plans with additional dental, vision, fitness benefits not found in original Medicare.

Does Medicare Advantage have challenges? No doubt. The unscrupulous operators behind TV advertising and non-stop unsolicited illegal outbound phone calls certainly gives it a negative image. But the bottom line is the marketplace has spoken and original Medicare plus a Medicare supplement is like your basement artifact, the Beta video system, like it or not.

Frank Adkisson is a principal agent with National Senior Insurance of

Arguments For and Against MA - OWH

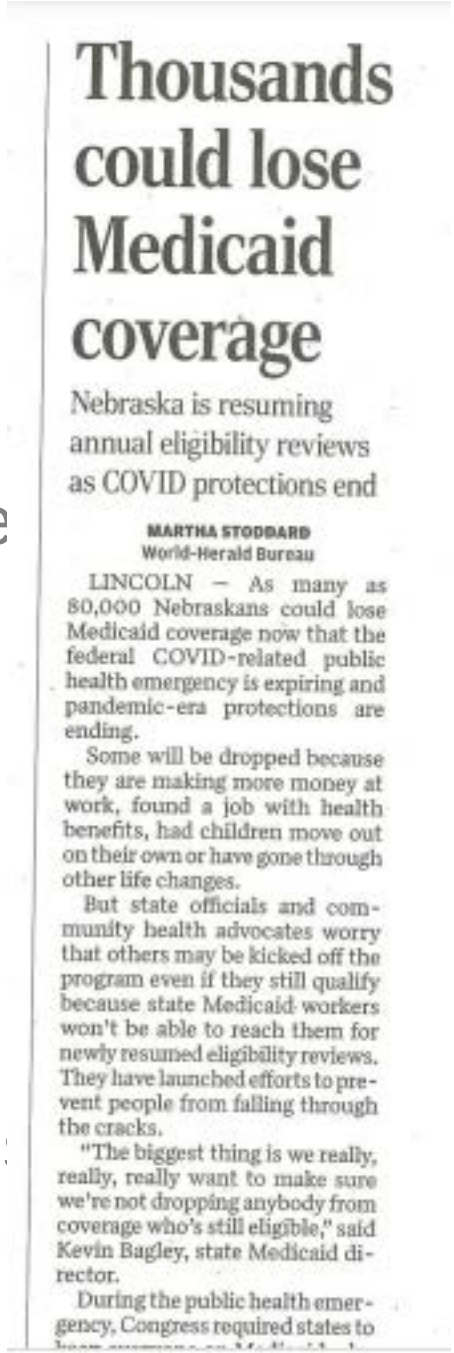
Against: Donald Frey, MD	For: Frank Adkisson, Broker
• Traditional Medicare has a 2% overhead, vs. 12% for MA Plans • Through “diagnosis upcoding” and “care management”, payers increase revenue/profits • 4 of 5 of the largest MA plans have been found guilty of overbilling by the Office of Inspector General • Increased denials – a recent audit found 14% of denials were for things Medicare should cover	• No max out of pocket costs with traditional Medicare plans if not paired with a gap plan • Supplement plans increase premiums averaging 12% a year • Medi-gap plans are not accepting sicker patients • $0 premiums and additional benefits work well for seniors on fixed incomes

Medicaid

- 390,642 enrollees
- Three managed Medicaid plans operate in Nebraska
- Medicaid expansion extended coverage to 138% of the federal poverty level
  - Added over 70,000 enrollees
- January 1, 2024: Molina will replace Healthy Blue as the third managed Medicaid plan

Medicaid Redetermination Project

- Up to 80,000 Nebraskans at risk of losing coverage
  - 14 million nationally
- PHE required to keep everyone on Medicaid that enrolled afte 3/18/2020
- PHE ends 5/11/2023 creating an “unwind” process
  - Efforts underway to review and verify eligibility
- Full court press to contact enrollees
  - Letters from the state to the last known address
  - Outreach from Medicaid plans and healthcare providers
  - Efforts from advocacy organizations
- Danger of some being inappropriately dropped if they don’t re



Thousands could lose Medicaid coverage

Nebraska is resuming annual eligibility reviews as COVID protections end

MARTHA STODDARD
World-Herald Bureau

LINCOLN – As many as 80,000 Nebraskans could lose Medicaid coverage now that the federal COVID-related public health emergency is expiring and pandemic-era protections are ending.

Some will be dropped because they are making more money at work, found a job with health benefits, had children move out on their own or have gone through other life changes.

But state officials and community health advocates worry that others may be kicked off the program even if they still qualify because state Medicaid workers won't be able to reach them for newly resumed eligibility reviews. They have launched efforts to prevent people from falling through the cracks.

"The biggest thing is we really, really, really want to make sure we're not dropping anybody from coverage who's still eligible," said Kevin Bagley, state Medicaid director.

During the public health emergency, Congress required states to

Value in Medicare and Medicaid: What's Now and What's Next?

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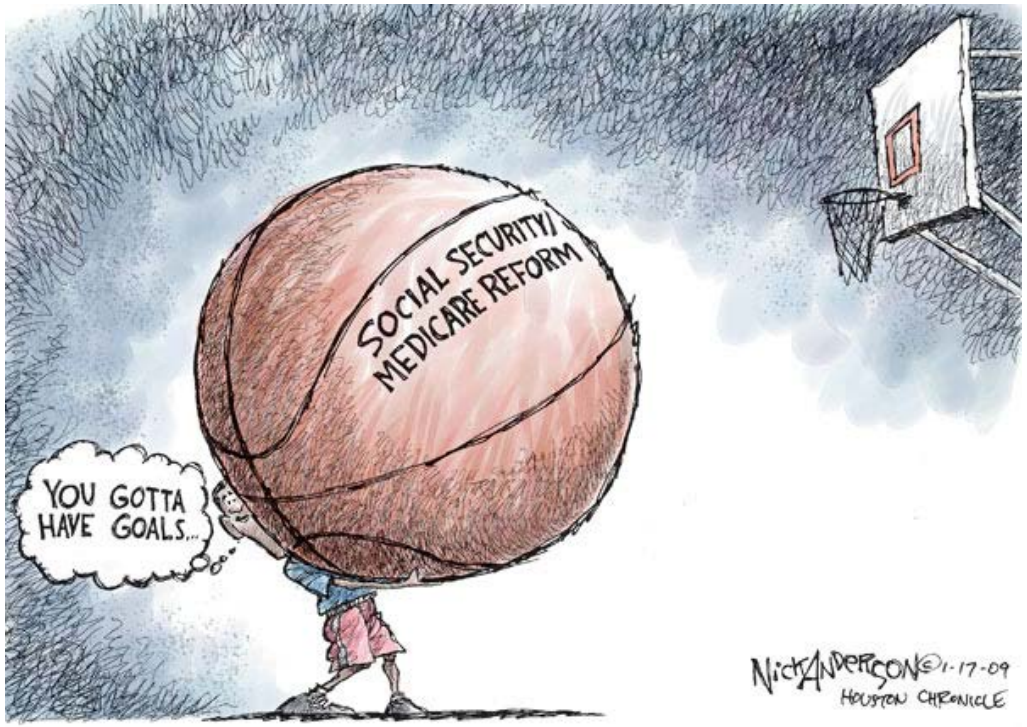
The Government as Innovators

- What is their incentive?
  - They pay for the majority of healthcare services in the U.S.
- What are they doing?
  - Setting aggressive targets
  - New and consistent focus on “value”
  - Directly linking payment to outcomes
    - And assessing penalties when outcomes are not achieved
- Goal:
  - **All** Medicare fee-for-service beneficiaries will be in a care relationship with accountability for quality and total cost of care **by 2030**



Current CMS Innovation Center Programs

- The Center for Medicare and Medicaid Innovation (CMMI), also known as the “Innovation Center,” was authorized under the Affordable Care Act (ACA)
- Tasked with designing, implementing, and testing new health care payment models to address growing concerns about rising costs, quality of care, and inefficient spending
- CMMI has launched over 40 new payment models

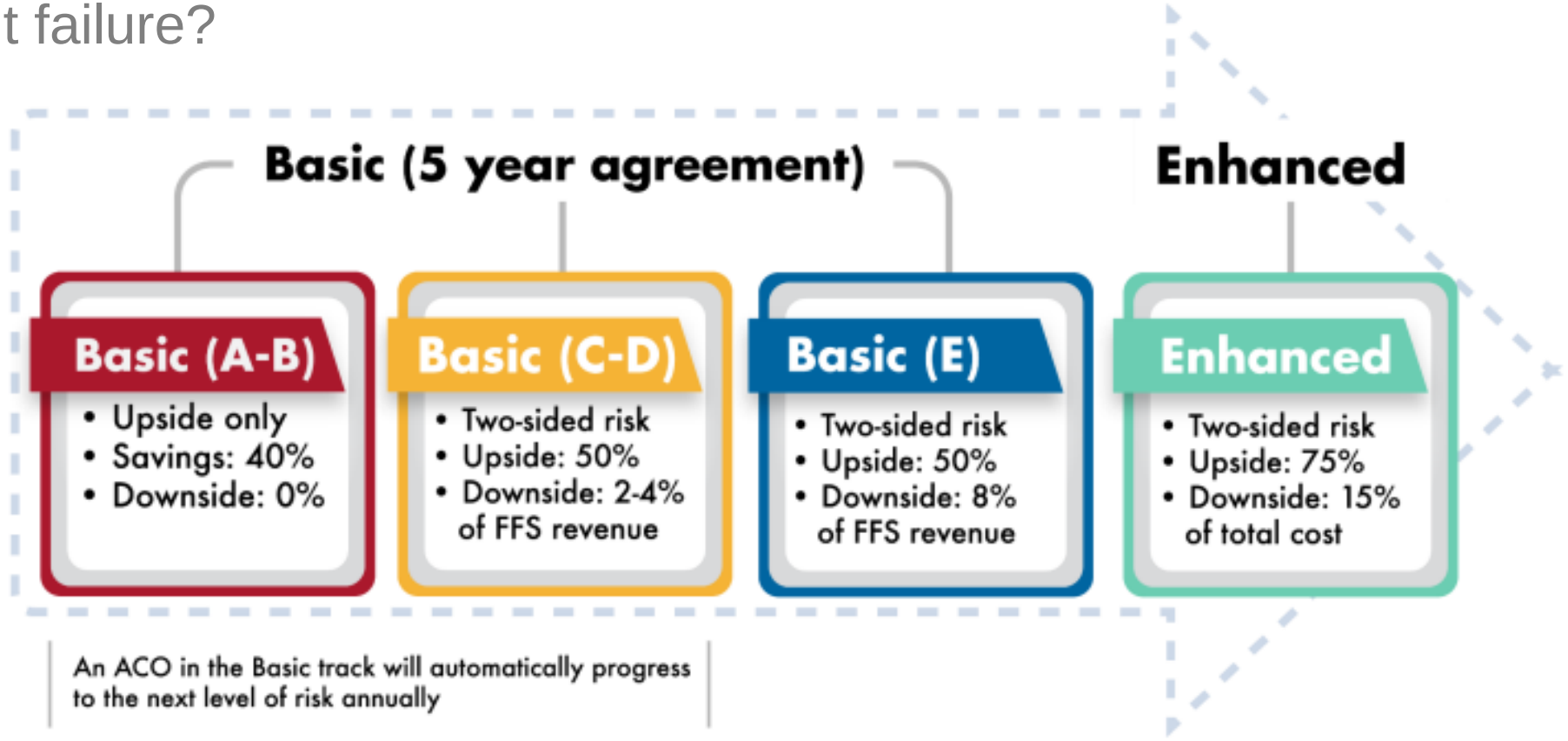
Innovation Center Vision

- CMMI has launched over 40 total value-based models
- Three popular models:
  - Medicare Shared Savings Program (MSSP)
  - Primary Care First
  - Realizing Equity Access and Community Health (REACH)

Source: CMS Innovation Center Strategy Refresh, 2022.

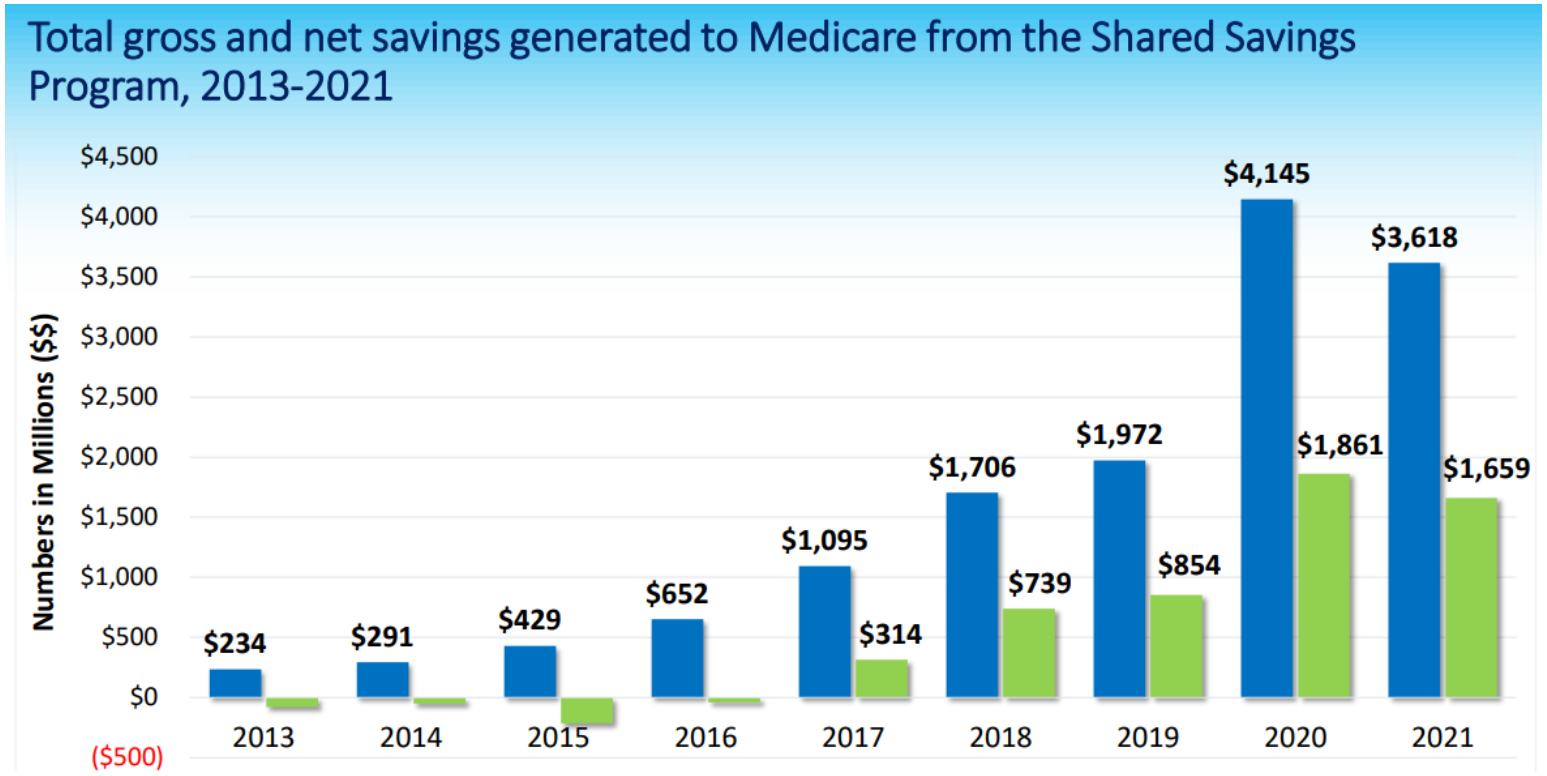
MSSP Track Overview

- Pathway to Success…
  - Or is it failure?



MSSP ACOs are Showing Success

- 81% of ACOs saved CMS money, and 58% received shared savings
- 2021 gross savings per patient was $370
- 99 percent of ACOs met the quality threshold necessary to receive shared savings



REACH ACO Model – Introduced 2/24/2022

- Realizing Equity Access and Community Health (REACH)
  - Replaced CMS's Direct Contracting model in 2023
  - Does not allow for joint participation in the MSSP Program
- Will require ACOs to:
  - Manage to a global budget
  - Receive global payments and pay providers/facilities
  - Develop and implement a Health Equity Plan to identify underserved patients and implement initiatives to measurably reduce health disparities

REACH Payment Model

Professional	Global
• **50% risk** on total cost of care (Parts A & B spending relative to benchmark) • **Capitation** for **primary care** required (7% of benchmark) • **Must pay claims** to ACO Participant Providers for capitated services (and may do so for Preferred Providers)	• **100% risk** on total cost of care (Parts A & B spending relative to benchmark) • **Capitation** for either **primary care** or **total cost of care** • **Must pay claims** to ACO Participant Providers for capitated services (and may do so for Preferred Providers)

Quality

2% of benchmark payments will be withheld for quality performance:

- All-cause readmissions
- Unplanned admissions for individuals with chronic illness
- CAHPS (Patient Satisfaction) survey

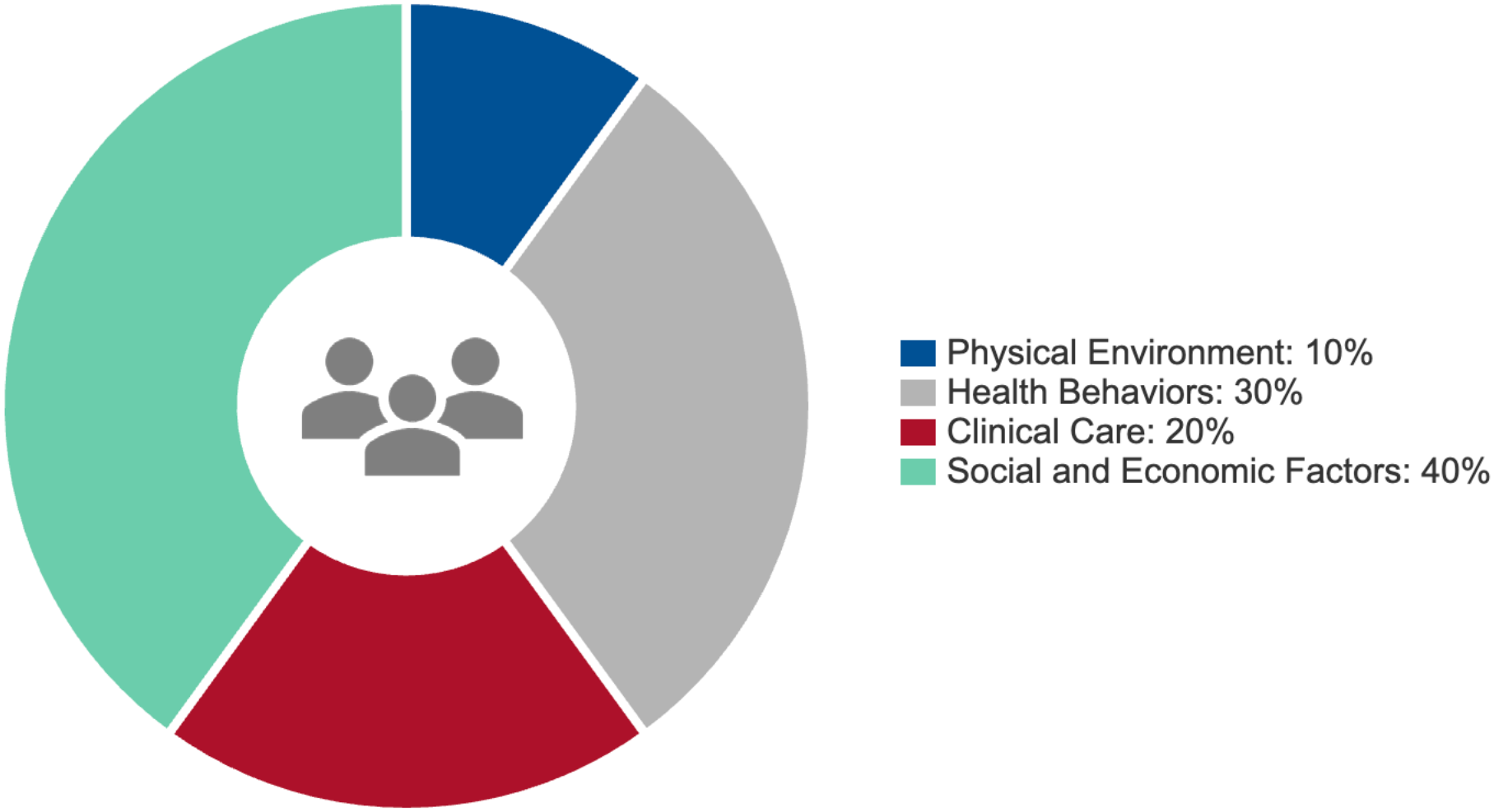
Primary Care Capitation (7% of Benchmark[1]) = **Base Primary Care Capitation** (e.g. 4% based on historical spend) + **Enhanced Primary Care Capitation** (e.g. 3% loan, must repay in full)

How do you Distribute a Global Payment?

What about Value in Medicaid?

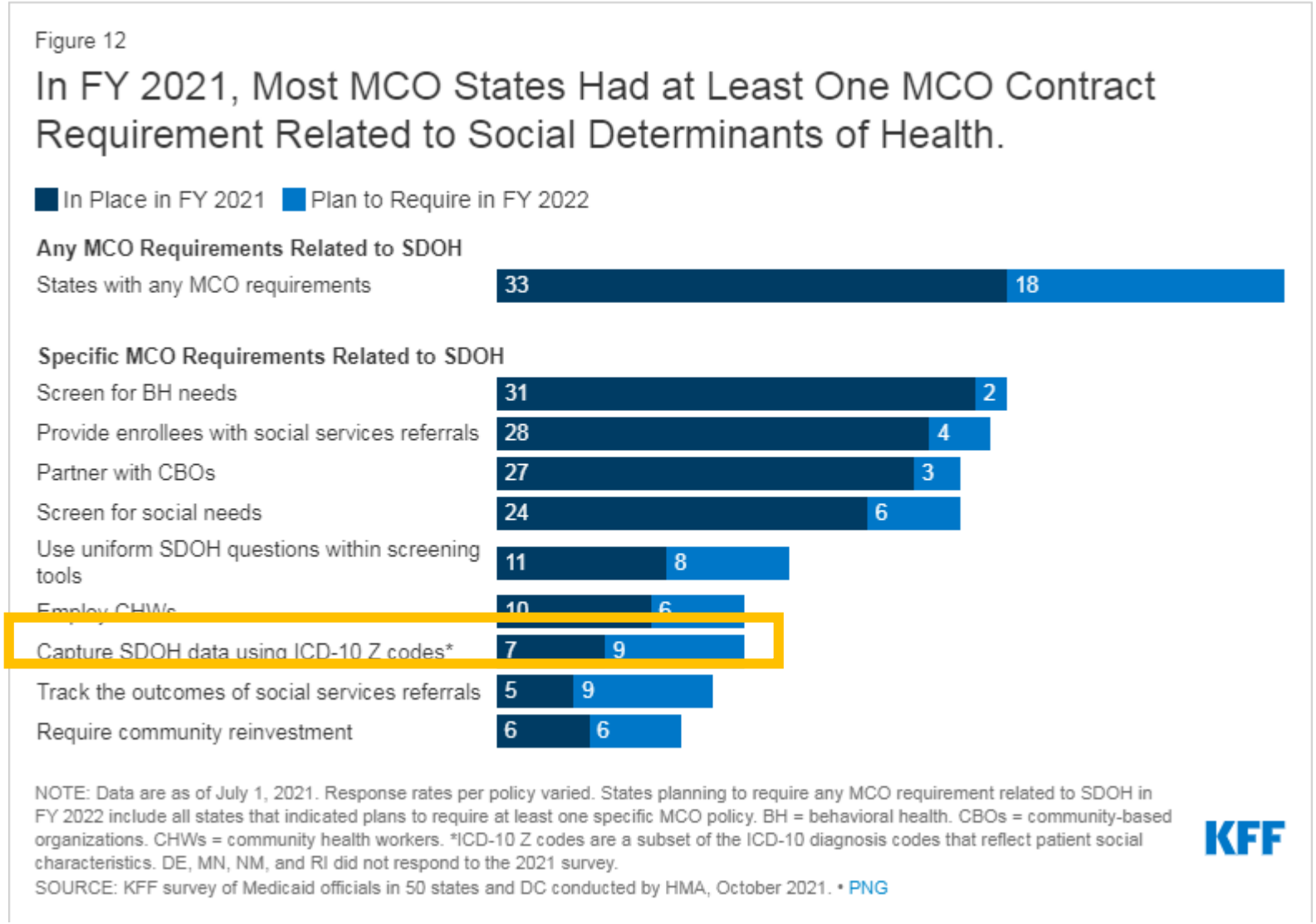
- Each of Nebraska's managed Medicaid plans offers strong value-based incentive programs
- Some states are looking at additional programs
  - Maine: Community Health Worker incentive
    - Higher reimbursement linked to providing access to community health workers
  - Colorado: Advanced Primary Care
    - Proposing to increase Medicaid reimbursement by16% (matching Medicare) for providers who adhere to their advanced primary care model
  - Arizona, Massachusetts, Minnesota: Social Risk Adjustment
    - Risk adjust for drivers of inequitable health outcomes – payment is adjusted for behavioral health status, housing status and other social factors

Clinical Outcome Dependencies



Source: Robert Wood Johnson Foundation

Including SDoH as Contract Requirements



Including SDoH Z-Codes in Risk Calculation

Table 4: Model Comparison of Predictive Ratio Statistics

Calibration Risk Cohort	SDOH-Related Risk Marker	CDPS+Rx Nationwide Weights [1]	CDPS+Rx AZ Specific Weights [2]	CDPS+Rx AZ Specific Weights+SDOH [3]
Age 1-20	Z59, Housing problems	0.898	0.780	0.995
	Z62, Parent problems	0.669	0.602	0.994
	Z63, Family problems	0.745	0.667	0.996
	Z65, Criminal problems	0.629	0.550	0.993
	SVI Zip Code	0.982	0.934	1.000
TANF	Z59, Housing problems	0.714	0.847	0.997
	Z62, Parent problems	0.743	0.868	1.004
	Z63, Family problems	0.848	0.939	0.998
	Z65, Criminal problems	0.747	0.879	1.005
	SVI Zip Code	0.940	0.974	1.003
SSI Without Medicare	Z59, Housing problems	0.871	0.948	0.956
	Z62, Parent problems	0.628	0.722	0.938
	Z63, Family problems	0.898	0.969	0.923
	Z65, Criminal problems	0.831	0.907	0.964
	SVI Zip Code	0.994	1.057	1.006

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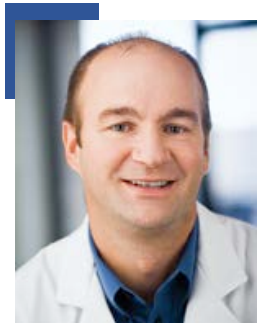
Panel Discussion

Panelists

Brad Sher
Vice President, Network Development and Contracting
Nebraska Total Care

Katherine Miller, PharmD, BCPS, CRC
Director, Value Based Care and Population Health
Nebraska Medicine

Barry Hoover, MD, MBA
Chief Medical Officer
SERPA-ACO



Hank Sakowski, MD
Senior Medical Director
CHI Health Partners