HMA

# Payer Mix Planning: What Hospital Executives Should Know About Medicare and Medicaid

ILLINOIS HEALTH AND HOSPITAL ASSOCIATION LEADERSHIP SUMMIT

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1

## TODAY'S DISCUSSANTS

HMA

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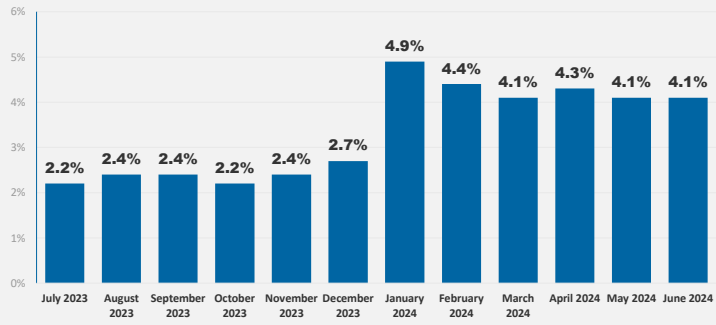
2

## HOSPITAL FINANCES ARE STABILIZING, BUT UNEVENLY

- **Larger systems and for-profit systems are performing better** than smaller, independent and rural hospitals. **Expense growth is easing**—growing at 5% in 2023 as compared to 17% in 2022—and **revenue growth is outpacing expenses**.

**Health System Operating Margins, 2023-2024**




Sources: Kaufman Hall (margins), Strata (margins), S&P Global

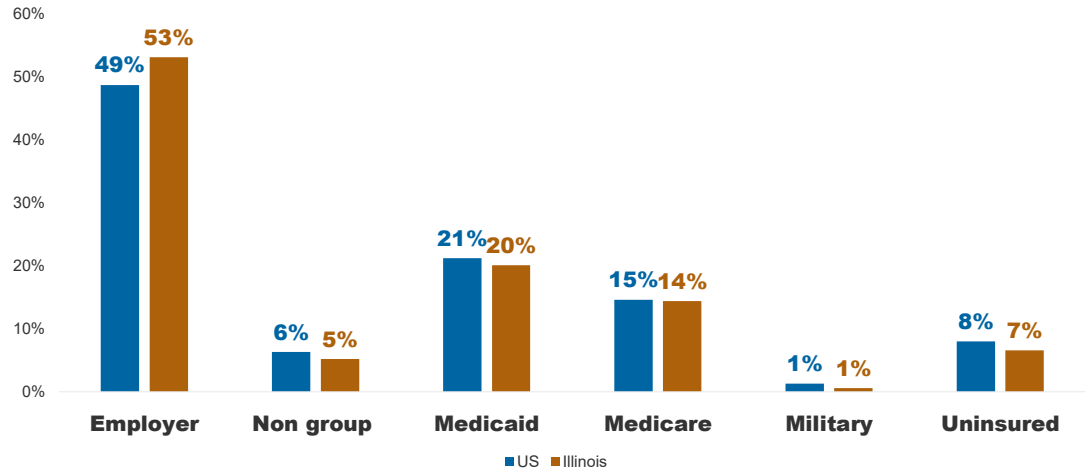


| Bed Size | YOY June | YTD 24 vs 21 |
|---|---|---|
| 0-25 | -11.4% | 7.8% |
| 26-99 | -3.3% | 2.3% |
| 100-199 | 6.5% | -12.8% |
| 200-299 | -4.1% | -5.3% |
| 300-499 | 13.2% | -37.1% |
| 500+ | -18.2% | 4.8% |

3

## ABOUT HALF OF INSURANCE COVERAGE COMES FROM GOVERNMENT PAID OR SUBSIDIZED PROGRAMS, SUBJECT TO FEDERAL RULES.

**Insurance Coverage, as of 2022**






SOURCE: Kaiser Family Foundation, Health Insurance Coverage of the Total Population, 2022 Data

4

## THE FEDERAL GOVERNMENT HAS BEEN ACTIVE IN RULEMAKING AND GUIDANCE TO SHAPE HEALTH PLAN GOALS AND OPERATIONS

- Health plans across the board are being asked to do more to address socioeconomic barriers to health.
- States increasingly use Medicaid to drive broader system and payment reform with providers and health plans in other products in the market (ACA, Medicare, commercial).
- Medicaid has grown through expansion and pandemic rules. These plans are being asked to do more to cover dually eligible Medicare beneficiaries.
- Medicare Advantage continues to grow and innovate but increased scrutiny is putting downward pressure on prices.
- Value-based payment continues to evolve to improve efficiency, equity and outcomes.
- Digital health tools, including AI, and data transparency are disrupting the status quo.



5

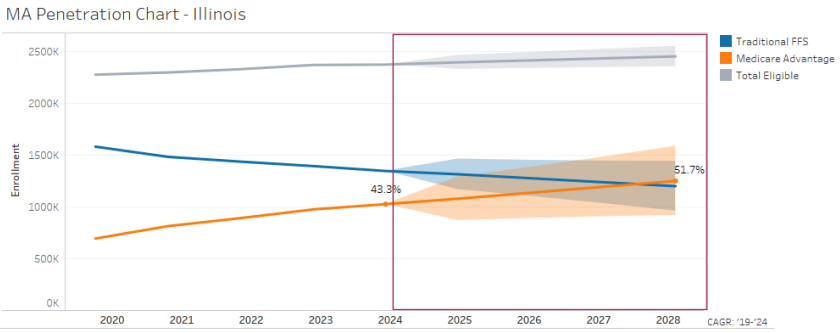
## DATA AND PRICE TRANSPARENCY ARE MOVING QUICKLY

| | |
|---|---|
| **Interoperability and Prior Authorization Rule** | • Improves health information exchange to achieve appropriate and necessary access to complete health records for patients, health care providers and payers. The rule seeks to increase data sharing, reduce overall payer, healthcare provider, and patient burden through proposed improvements to prior authorization practices. |
| **No Surprises Act** | • Prohibits patients from receiving surprise medical bills when seeking emergency services or certain services from out-of-network providers at in-network facilities. |
| **Transparency in Coverage Final Rule** | • Requires most non-grandfathered group health plans and health insurance issuers in the group and individual market to disclose cost-sharing information to participants, beneficiaries and enrollees. |
| **Executive Order on Improving Price and Quality Transparency** | • Requires hospitals to disclose negotiated rate information for common and shoppable services in a format understandable by consumers using machine readable format |



6

## MEDICARE ADVANTAGE WILL GROW, BUT FACES UNCERTAINTY




| | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 | 2026 | 2027 | 2028 | CAGR: '19-'24 |
|---|---|---|---|---|---|---|---|---|---|---|
| Medicare Advantage | 696.1K | 816.1K | 893.8K | 977.4K | 1,028.6K | 1,081.5K | 1,138.8K | 1,196.1K | 1,253.4K | 10.25% |
| Traditional FFS | 1,584.3K | 1,485.7K | 1,439.5K | 1,396.7K | 1,349.2K | 1,317.4K | 1,278.9K | 1,240.5K | 1,202.0K | -3.94% |
| Total Eligible | 2,280.4K | 2,301.8K | 2,333.3K | 2,374.1K | 2,377.8K | 2,399.6K | 2,418.7K | 2,437.9K | 2,457.1K | 1.05% |

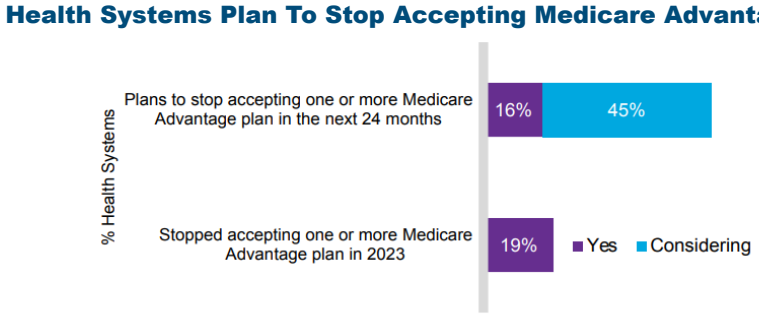
Source: MA State/County Penetration, https://www.cms.gov/data-research/statistics-trends-and-reports/medicare-advantagepart-d-contract-and-enrollment-data/ma-state/county-penetration, through March 2024



- Medicare Advantage (MA) penetration in the state of Illinois is at 43.3%, which is well below the national average of 50.7%.
- MA penetration is growing faster than the national average: 9.1% to 5.6%.
- MA enrollment is growing at a faster rate than FFS.
  - MA enrollment has an average trend of 10.3% trend Year over Year.
  - FFS enrollment has an average trend of (3.9%) trend Year over Year.
- MA will likely continue to be attractive to enrollees and is projected to grow to over 50% of the Medicare population growth over the next 4-5 years.

7

## HOSPITALS FACE INCREASED CHALLENGES WITH MA YIELD RELATIVE TO TRADITIONAL FFS LEADING SOME TO QUESTION PARTICIPATION




- **Between onerous authorization requirements and high denial rates, health systems are frustrated with Medicare Advantage.**
- **19% of health systems have stopped accepting a Medicare Advantage Plan 61% are planning to or are considering.**



Source: https://www.hfma.org/wp-content/uploads/2024/03/Overview-2024-CFO-Pain-Points-Study.pdf

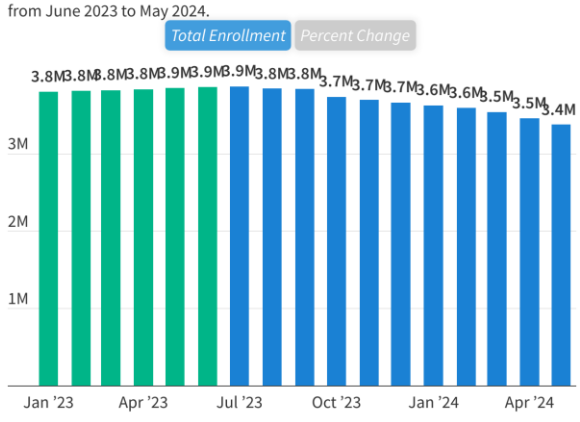
8

## POST COVID MEDICAID REDETERMINATIONS REMOVED NEARLY 650K BENEFICIARIES IN ILLINOIS, 2/3 FOR PROCEDURAL REASONS, 1/3 DETERMINED TO BE INELIGIBLE

Figure 1

**Illinois Medicaid/CHIP Monthly Enrollment**

Disenrollments in Illinois began in July 2023. Enrollment declined by 486,441 from June 2023 to May 2024.




Source: KFF analysis of CMS, Medicaid & CHIP: Monthly Application and Eligibility Reports

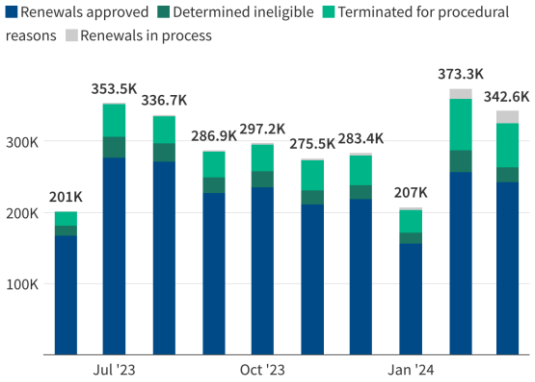
KFF

https://www.kff.org/report-section/medicaid-enrollment-and-unwinding-tracker-state-enrollment-and-unwinding-data/

Figure 2

**Illinois Monthly Renewals**

As of March 2024, 2,259,988 enrollees renewed their coverage and 647,904 enrollees were disenrolled, including 220,701 who were determined ineligible and 427,203 who were terminated for procedural reasons




Source: KFF Analysis of Monthly State Unwinding Dashboard

KFF

https://www.kff.org/medicaid/issue-brief/medicaid-enrollment-and-unwinding-tracker/

9

## ILLINOIS MANAGED MEDICAID TRENDS

**Illinois has 3.4 million Medicaid beneficiaries as of May 2024 and spends $26B, of which $19B goes to managed care plans.**

**Reimbursement challenges endure, though spending has increased substantially.**

**The state's 1115 waiver creates significant opportunity for greater collaboration, particularly in value-based care and health related social needs. (*ADT)**

**Many hospitals do not realize all the reimbursement that is available to them under Medicaid (claim vs other capture, 3rd party liability transfers, etc)**

**Illinois will issue a new Medicaid managed care RFP next year, though current contracts extend thru 2026…providers should be developing strategies for their plan negotiations now.**



10

## 2025 MEDICARE FINAL RULE IS CHANGING IN THE WORLD OF DUAL ELIGIBLE SPECIAL NEEDS PLANS

| CMS's Overall Goal | Expected Outcomes | Accomplished by... |
|---|---|---|
| ▪ Increase the percentage of dually eligible managed care enrollees Who receive Medicare and Medicaid services from the same organization | ▪ Increase in the % of full-benefit dual eligibles enrolled in fully integrated D-SNPs<br>▪ Increase in the percentage of beneficiaries enrolled in D-SNPs that directly or through affiliated Medicaid MCOs are also contracted to cover Medicaid benefits | ▪ Implementing changes that will accelerate the alignment or integration of Medicare and Medicaid coverage for full benefit dual eligibles<br>▪ Special enrollment periods<br>▪ D-SNP enrollment limitations<br>▪ Limitations on the number of D-SNPs<br>▪ New crosswalk exception<br>▪ D-SNP look-a-likes |

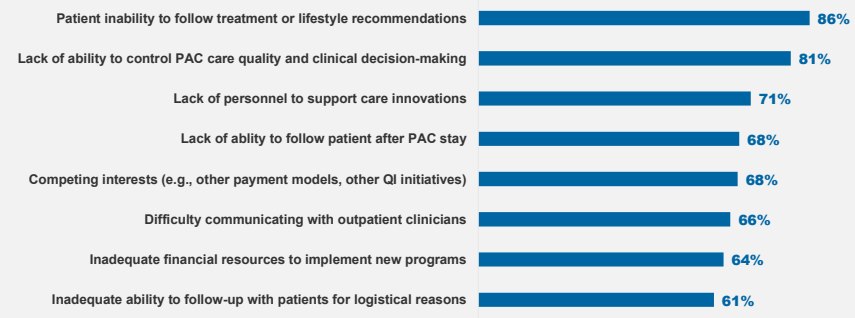
11

## VALUE-BASED PAYMENTS, MODELS ARE GROWING & EVOLVING

**As of 2022, nearly 60% of all health care payments across lines of business had some link to quality or value; nearly 25% of all payments involved financial accountability for downside risk.**

**CMS aims to move 100% of Medicare beneficiaries and the majority of Medicaid into accountable relationships by 2030.**

### Top Barriers to VBP Success




Sources: VMG Health, The American Journal of Managed Care, FTI Consulting



### Relevant New CMMI Models

**TEAM**
- 5-year, mandatory episode-based model for acute care hospitals in ~25% of CBSAs beginning in 2026
- Covers five 30-day episodes

**IOTA Model**
- 6-year proposed mandatory model set to begin in 2025 for all eligible kidney transplant hospitals in half of kidney donation service areas (DSAs)

**AHEAD Model**
- Voluntary participation in hospital global budgets in up to 8 states (MD, VT, CT, HI known)
- First two cohorts began pre-implementation in July 2024

12

## PAYER STRATEGY QUESTIONS CRITICAL FOR HOSPITAL SUCCESS

**Do you have a strategy for success in Medicaid? Are you leaving money on the table?**

**Have you identified alternative payment strategies to meet federal goals and help improve patient outcomes?**

**Do you have the right MA contracting strategies given changing requirements?**

**Do you have a strategy for sharing patient and pricing data?**

**Are you engaging with payers and community partners to leverage the opportunity with 1115 waivers?**



13

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# WHAT CAN WE DO FOR YOU?

Our depth and breadth of experience has helped an incredibly diverse range of healthcare industry leaders.

## Questions?


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14

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15