

➤ Medicare, **Medicare** or... *Medicare*?

Introduction to Medicare & All Its Versions

KENTUCKY PRIMARY CARE ASSOCIATION – SEPTEMBER 30, 2026



SENIOR DIRECTOR

> Michael Ceballos

Ceballos leads Facktor's Managed & Value-based Care Practice.

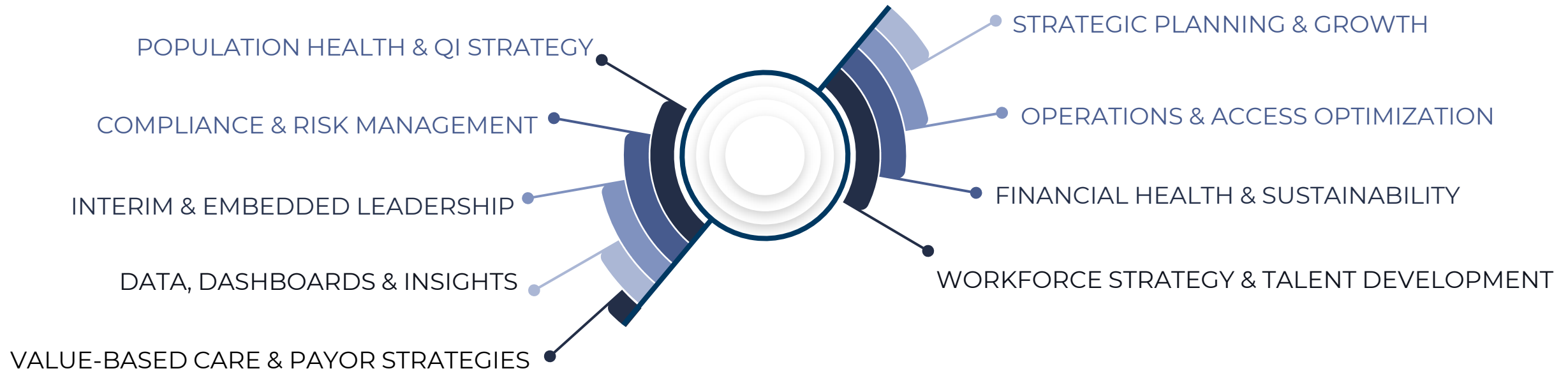
Select experiences:

- General Manager, MyCare Ohio, Buckeye Health Plan
- Chief Operating Officer, Mount Carmel Health Partners
- Head of New Markets & Implementation, Cityblock Health
- Head of Operations, Founding Team, Waymark



➤ Revolutionizing Community Health

Facktor partners with health centers and primary care associations to advance access, sustainability, and impact.





Session Goals:

- Educate audience on similarities and differences between Medicare and all its versions.
- Provide statistics on why health centers should care about Medicare.
- What initial steps health centers can take to understand their Medicare current state.



Medicare Options

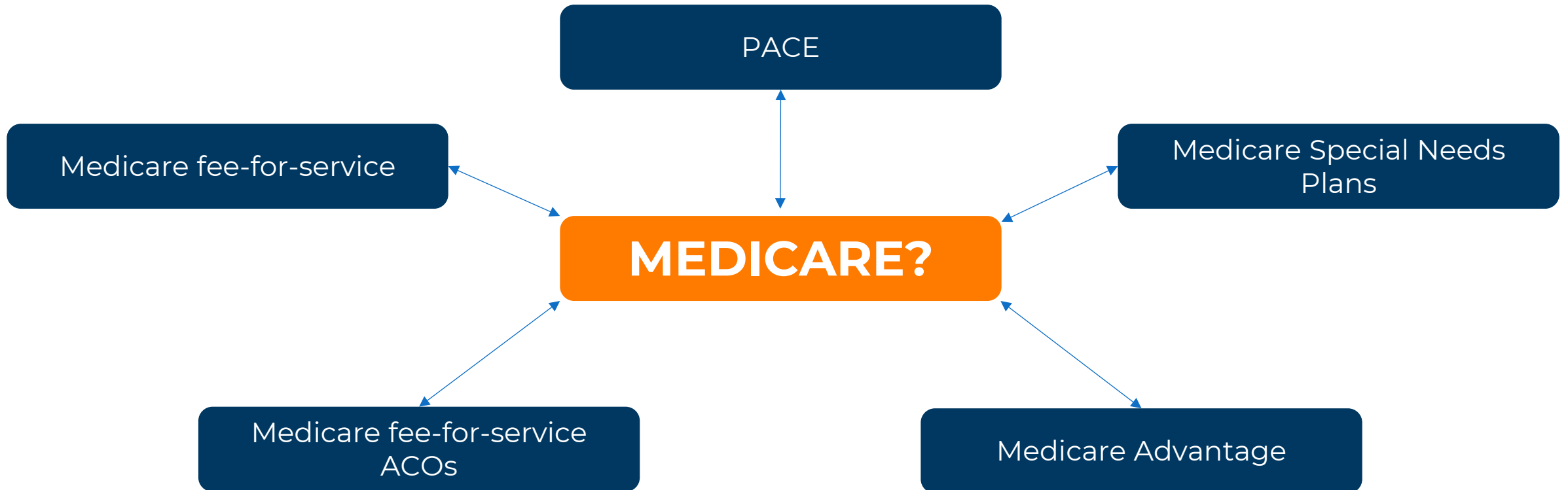
What is Medicare

Medicare is a federal health insurance program for people aged 65 or older. People younger than age 65 with certain disabilities, permanent kidney failure, or ALS, also known as Lou Gehrig's disease, may also be eligible for Medicare.

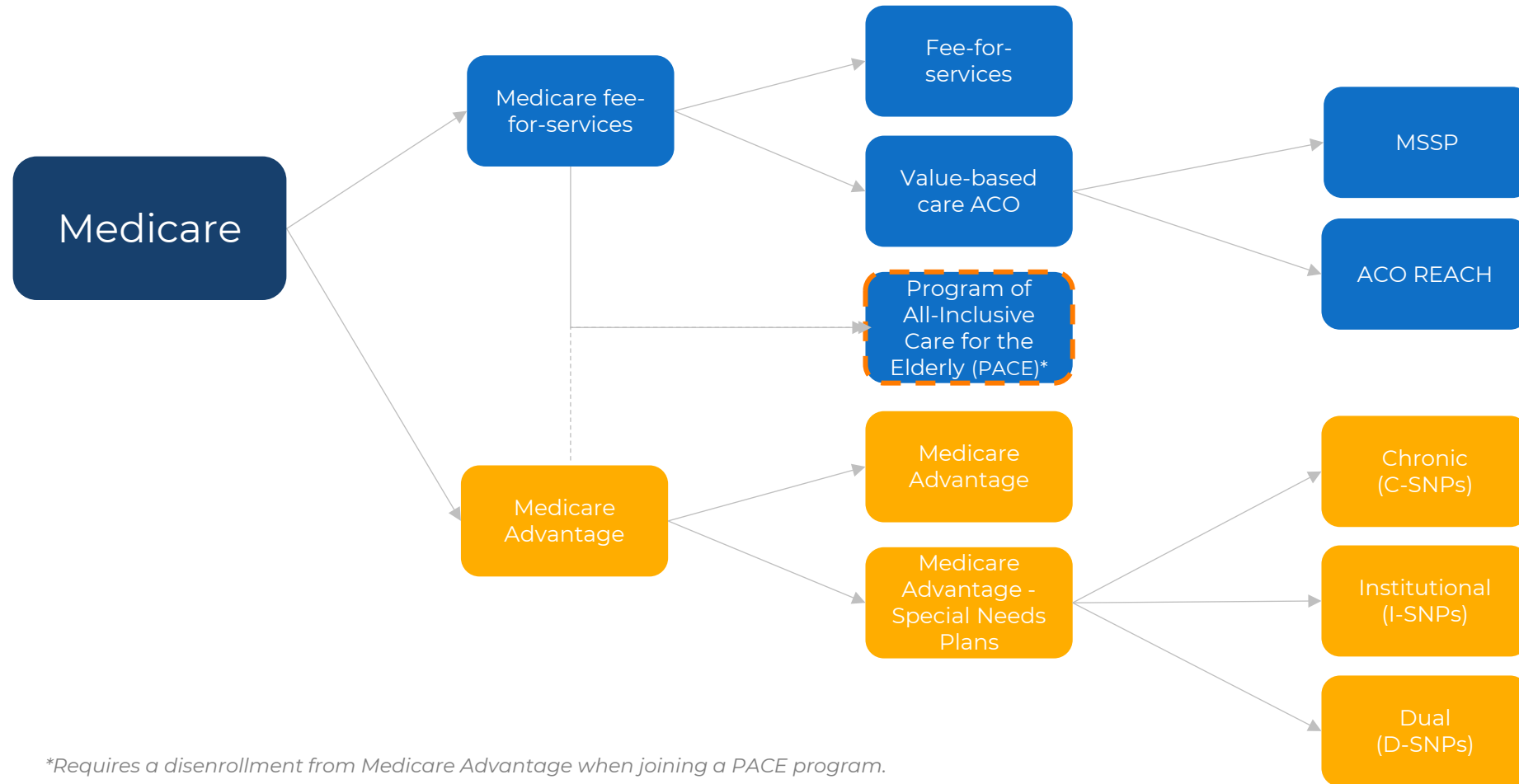
The program helps with the cost of health care, but it doesn't cover all medical expenses or the cost of most long-term care. Patients have choices for how you get Medicare coverage.



➤ All Signs Point to Medicare?



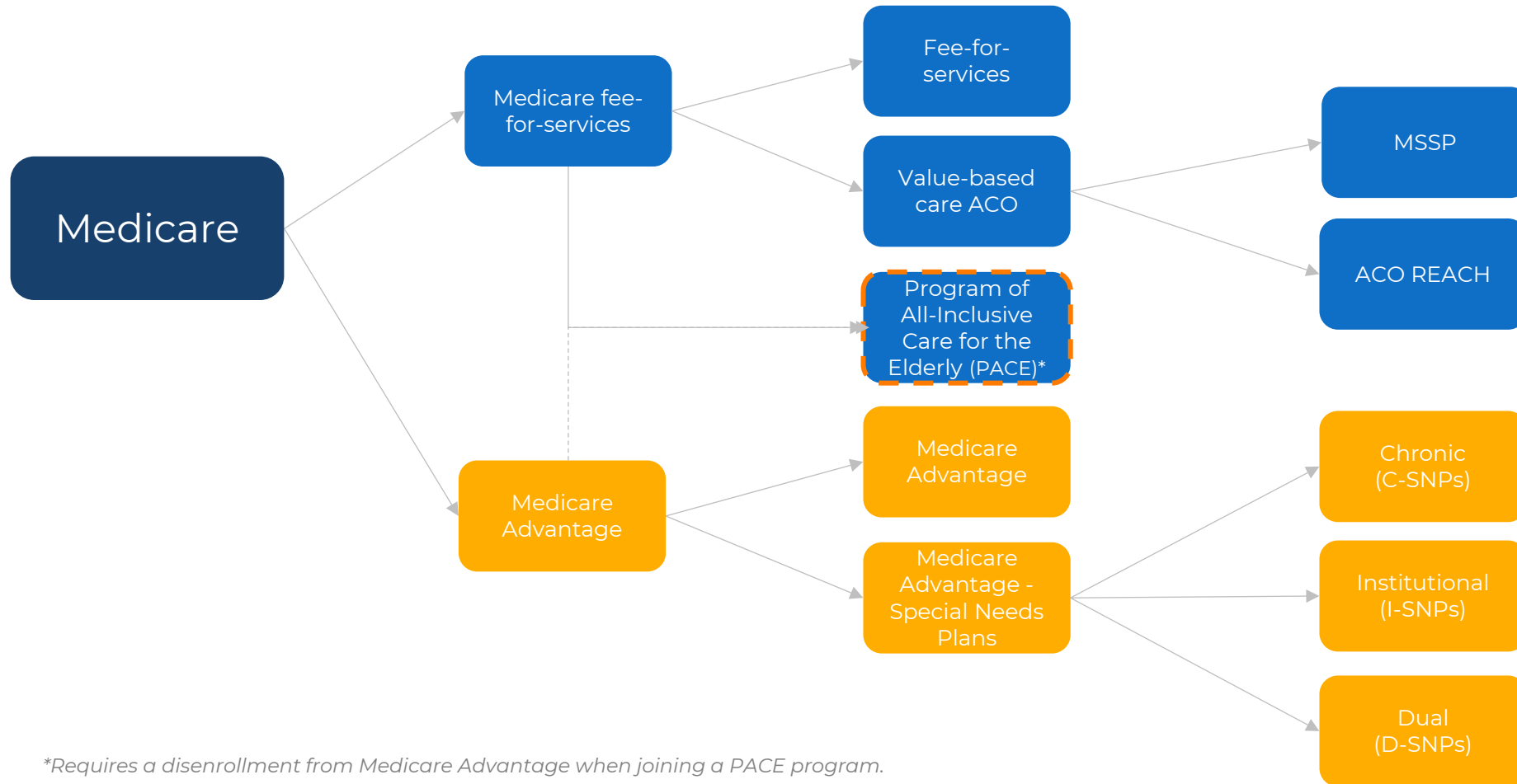
Medicare Variations



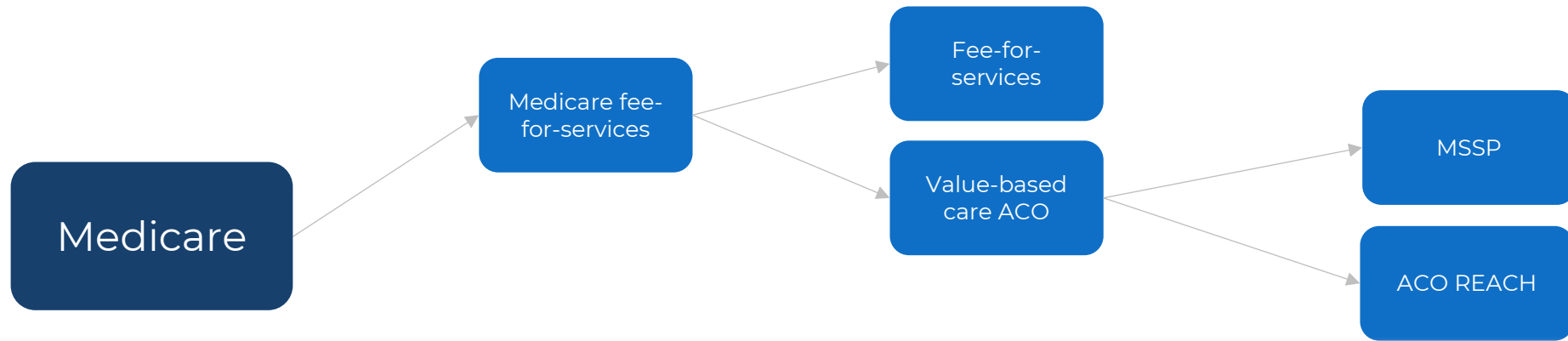
Medicare Variations

Medicare Type	High-Level Summary	Key Considerations
Medicare fee-for-service	Traditional Medicare where providers are paid per service without care coordination incentives	Not an accountable relationship; CMS has declared it wants all Medicare beneficiaries in an accountable relationship by 2030
Medicare fee-for-service, MSSP ACO	A voluntary program where providers form an Accountable Care Organization (ACO) to improve quality and share in savings or losses.	• Low-to-high stakes value-based care. • Must join an MSSP ACO • Patients may not know part of a program
Medicare fee-for-service, ACO REACH	A value-based model where providers take on higher financial risk and reward for managing Medicare beneficiaries' total cost of care.	• High stakes value-based care. • Must join a REACH ACO • Patients may not know part of a program
PACE	A fully integrated, community-based program providing medical and long-term care services for frail seniors who qualify for nursing home care.	• PACE program become patient's Medicare and Medicaid provider • Patient must qualify
Medicare Advantage	A private insurance alternative to traditional Medicare that bundles Part A, B, and usually Part D with extra benefits and managed care.	• Patient selects and pays for Medicare Advantage • Primary care provider added to ID card
Medicare Advantage, C-SNP	A tailored MA plan for beneficiaries with specific chronic conditions, offering specialized care coordination.	• Patient selects and pays for Medicare Advantage • Patient must qualify
Medicare Advantage, I-SNP	A specialized MA plan designed for individuals living in nursing homes or requiring institutional-level care.	• Patient selects and pays for Medicare Advantage • Patient lives in a long-term care facility
Medicare Advantage, D-SNP	A managed care plan integrating Medicare and Medicaid benefits for people who qualify for both programs.	• Patient selects and pays for Medicare Advantage • Patient must qualify

Medicare Variations



➤ Medicare Variations – Fee-for-Service



Patient is 65+

Patient qualifies for Medicare, made no decisions or selections. Paid for all care delivered.

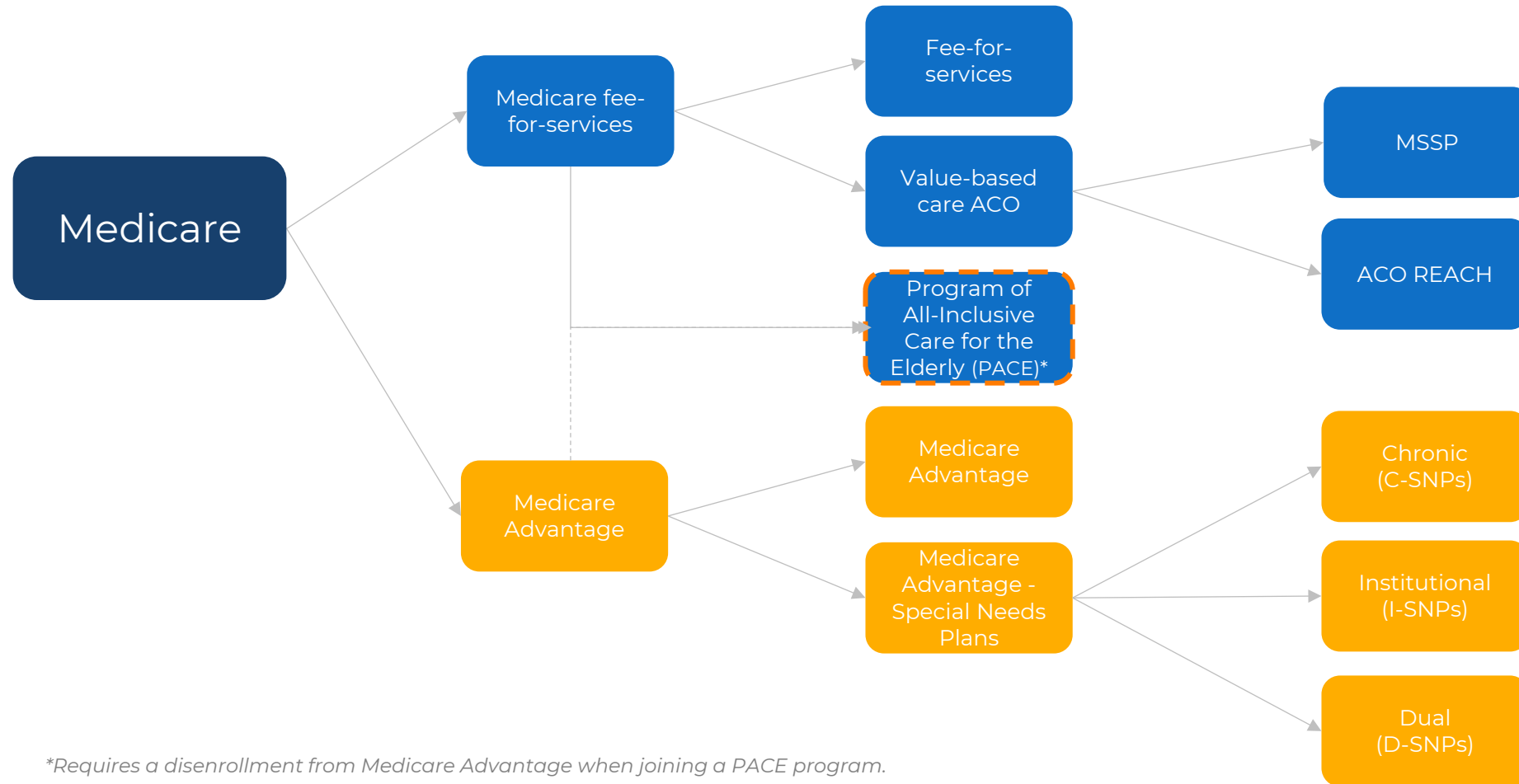
Provider determined. Decision usually made based on philosophical approach on how to practice.

Provider decision based upon risk tolerance.

Medicare Variations

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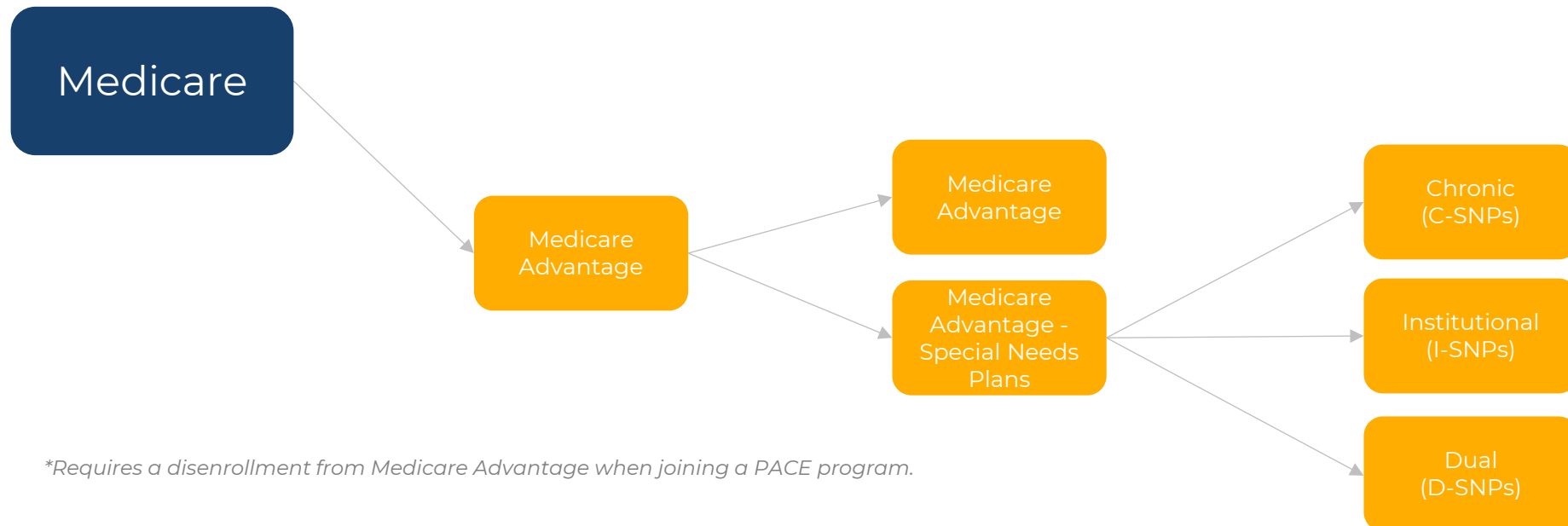
➤ Medicare Variations – Medicare Advantage

Patient is 65+

Patient qualifies for Medicare, makes a decision to enroll in Medicare Advantage.

Patient qualifies for a special needs plan, decides the benefits are better suited than 'traditional' Medicare Advantage.

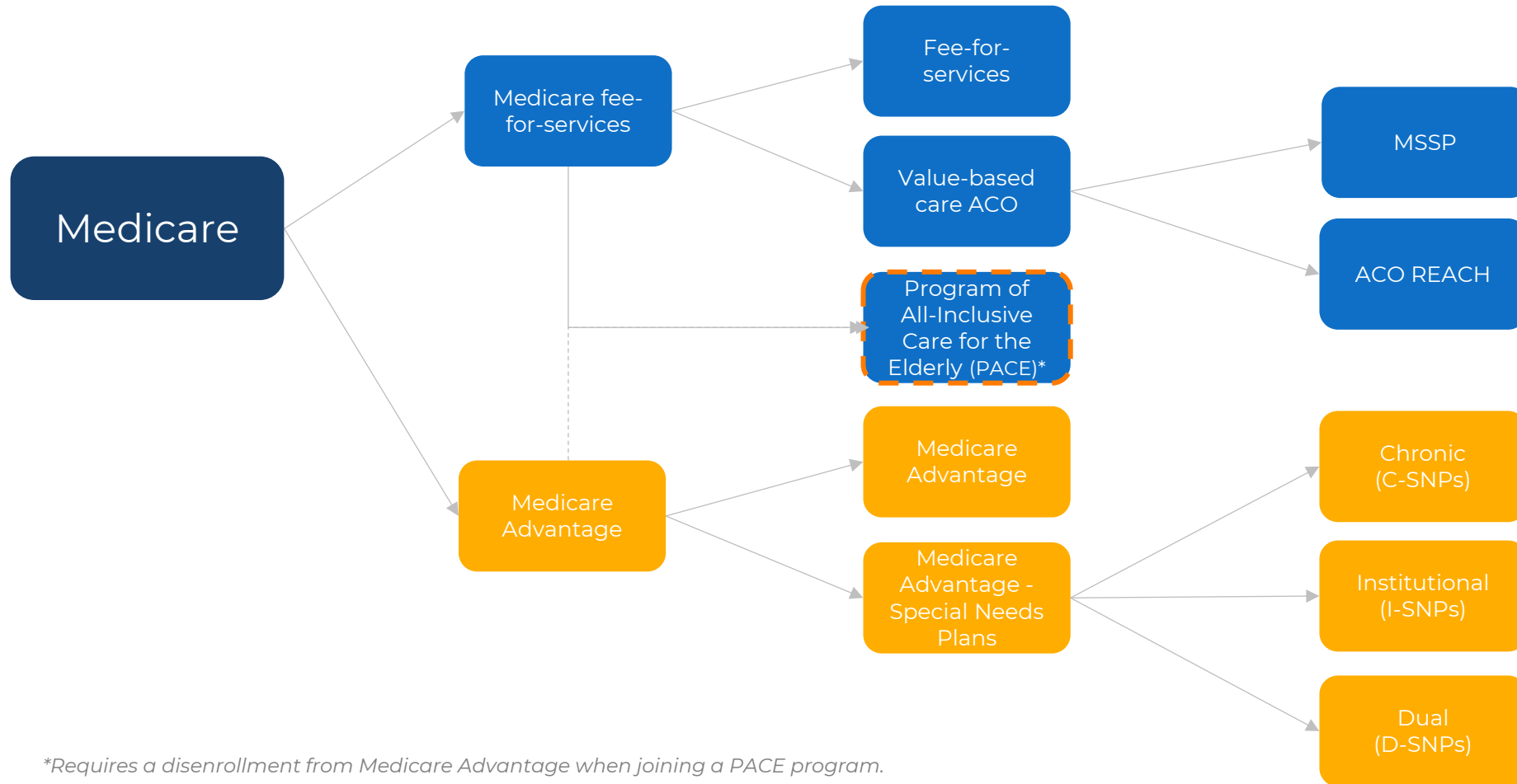
Based on disease condition, financial condition or home location.



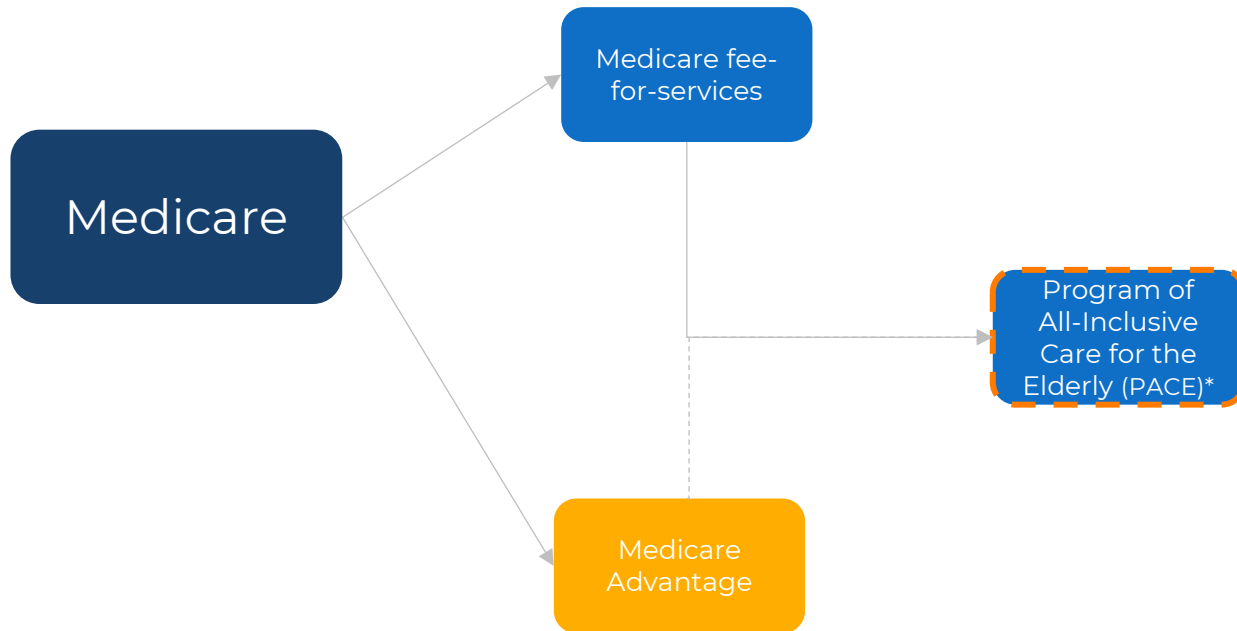
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Medicare Variations



➤ Medicare Variations – PACE



Patient is 55+

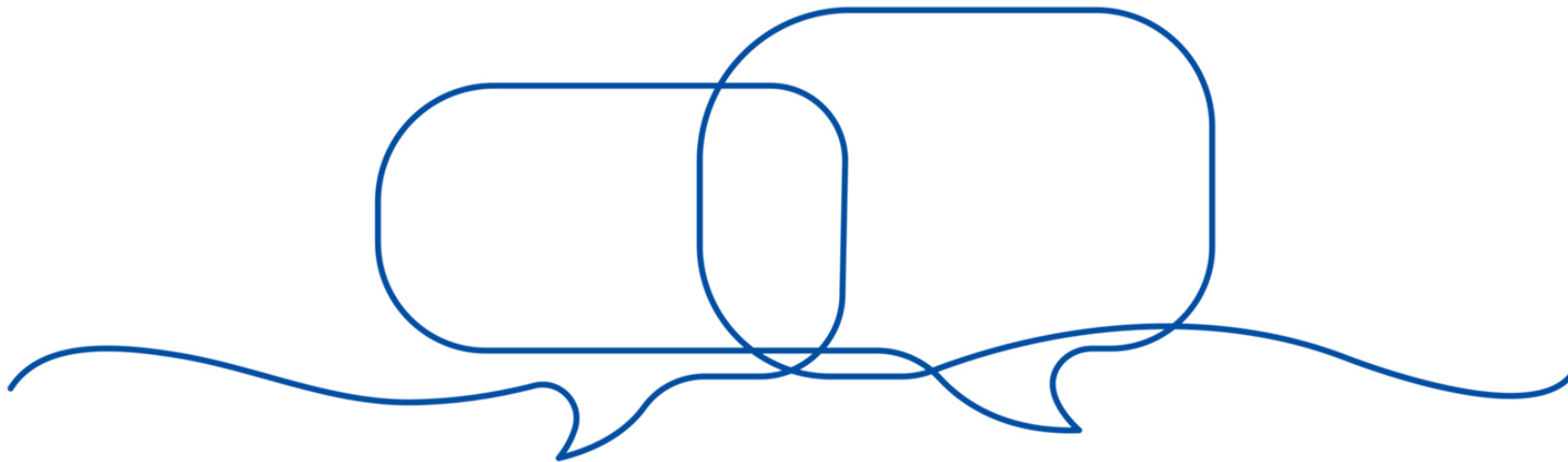
Patient makes the decision that they want to receive care from a Program of All-Inclusive Care for the Elderly (PACE) program

Patient qualifies for BOTH Medicare and Medicaid, as well as meets nursing home level of care at home

Medicare Variations – Medicare Advantage

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Open Discussion



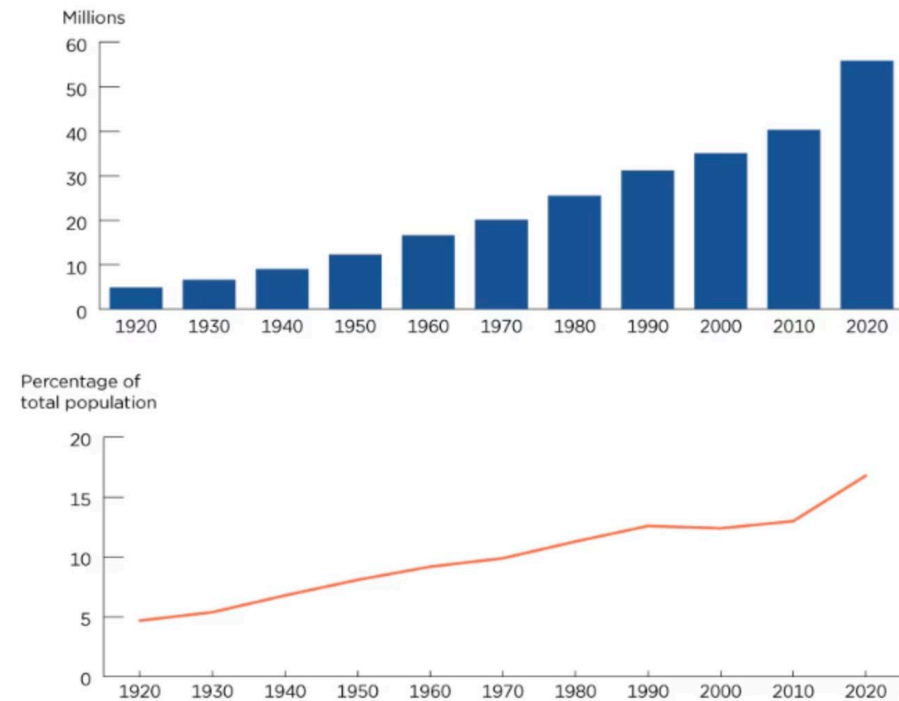


Medicare Growth

Senior Growth

U.S. Population +65 Over Time

Population 65 Years and Over by Size and Percentage of Total Population: 1920 to 2020

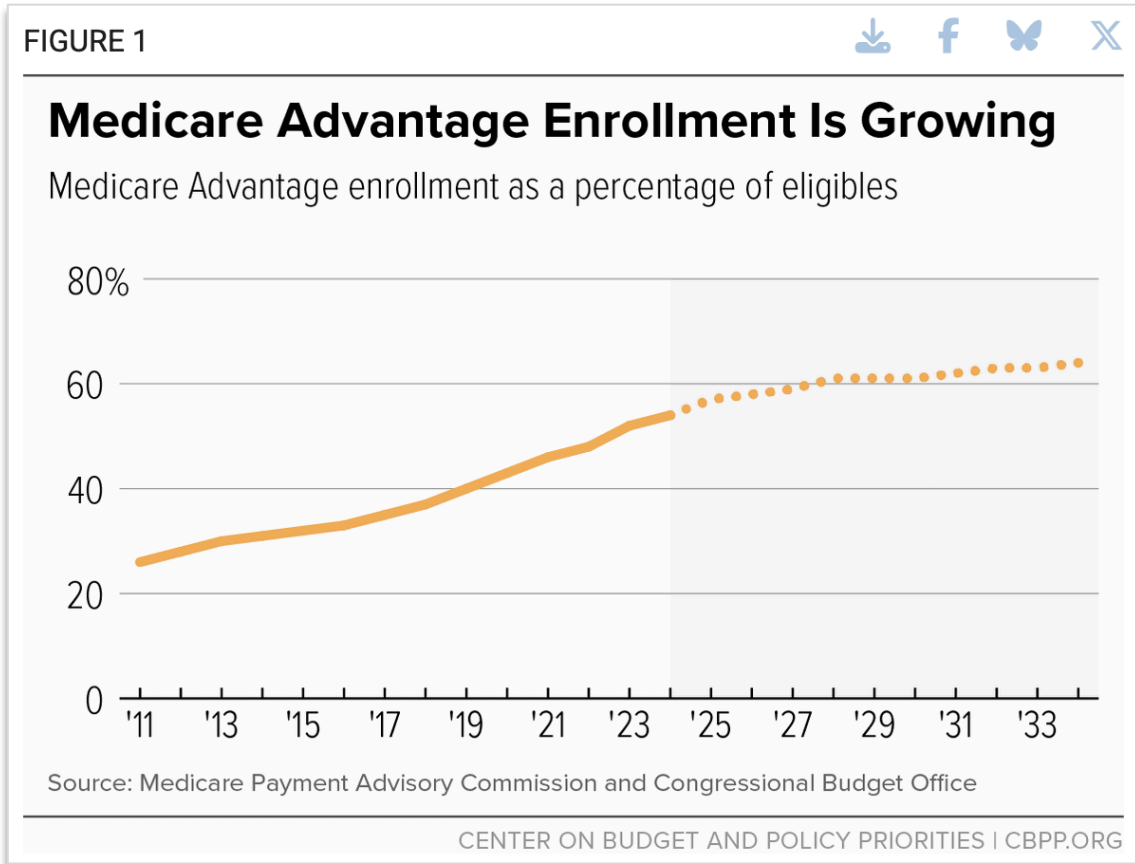


Note: For information on data collection, confidentiality protection, nonsampling error, and definitions, refer to <https://www2.census.gov/programs-surveys/decennial/2020/technical-documentation/complete-tech-docs/demographic-and-housing-characteristics-file-and-demographic-profile/2020census-demographic-and-housing-characteristics-file-and-demographic-profile-techdoc.pdf>.

Source: U.S. Census Bureau, Decennial Census of Population, 1900 to 2000; 2010 Census Summary File 1, and 2020 Census Demographic and Housing Characteristics File (DHC).

- 60 million seniors by 2020
- 17% of all Americans by 2020 (1 in 6!)
- 4.1 million Americans turned 65 in 2024
- 4.1 million Americans turn 65 in 2025
- 4.1 million Americans turn 65 in 2026
- 4.1 million Americans turn 65 in 2027
- **20% of all Americans by 2030 (1 in 5!)**
- Between 2022 - 2040, the number of people who are 85+ will more than double

➤ Medicare Advantage Growth

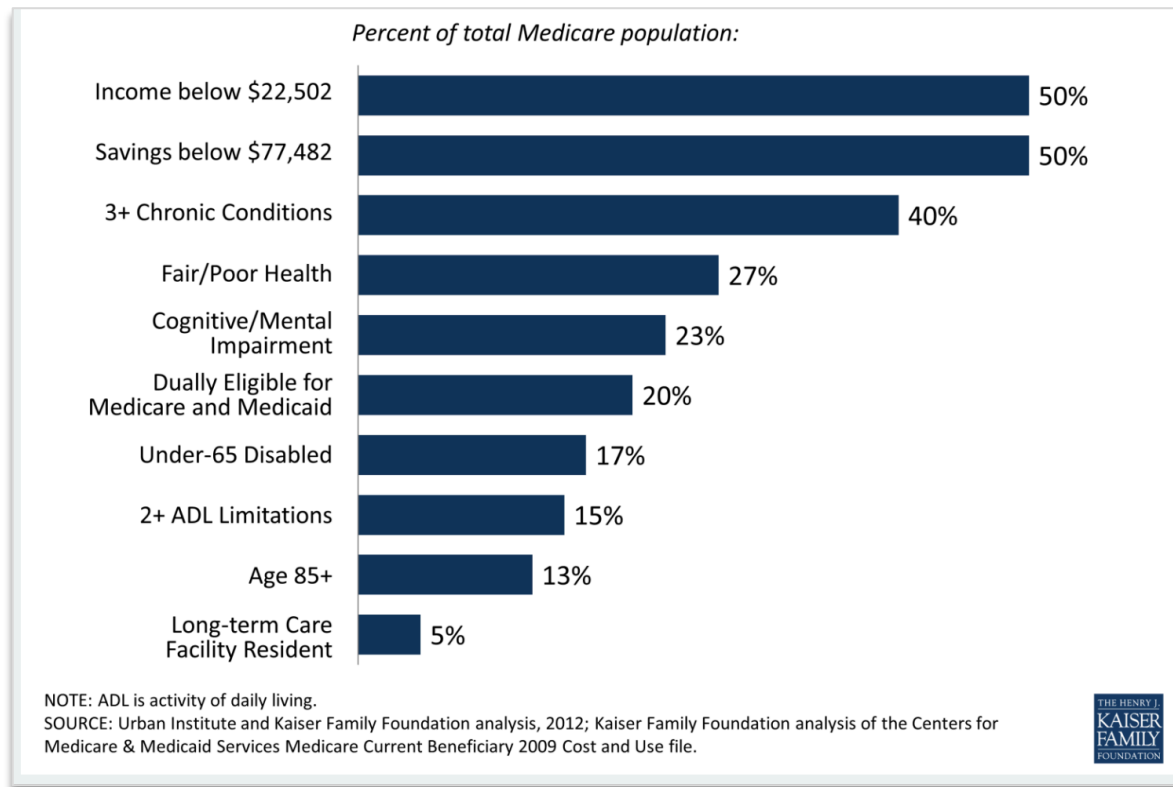


- Supplemental benefits
- Dental
- Transportation
- Gym memberships
- Care management
- Marketing
- *Can* have more engaged providers

<https://www.chartis.com/insights/mounting-headwinds-medicare-advantage-market-havent-stopped-growth>



➤ Medicare Beneficiary Profile (2012)



- Fixed income
- Co-morbidities
- Physical and cognitive impairments
- *Posit (due to pandemic and other trends) things have gotten worse*

Not cited (but known):

- Increased isolation & loneliness
- Food insecurities

➤ What Does This Mean? *Let's Discuss*





Where to start?

Where to Start?

3 initial questions:

1

How big is your Medicare attribution?

Understanding what percentage of your patient panel, as well as how many Medicare beneficiaries overall, is an important starting point. 10% or greater Medicare patients is a good starting point. Tennessee Medicare population is 17%.

2

Do you have any existing Medicare contracts or arrangements?

How many Medicare Advantage contracts are you currently participating in? Are you participating in a Medicare ACO? The answers to these questions will be instrumental in supporting Medicare infrastructure.

3

Are you engaged in population health?

Patient-centered medical home, population health, Comprehensive Primary care – various approaches to evolving operations to support longitudinal population health improvements.

Where to Start?

3 initial questions:

1 How big is your Medicare attribution? 

2 Do you have any existing Medicare contracts or arrangements?

3 Are you engaged in population health?

Understanding how many Medicare beneficiaries is an important starting point to understand if there is an opportunity for your health center to further invest in Medicare and Medicare-type services and activities.

Additionally, knowing what percent of your patients are Medicare may set the tone for a desire to diversify your revenues further into Medicare.

Where to Start?

3 initial questions:

1 How big is your Medicare attribution?

Review your current contracts to understand how many Medicare Advantage contracts or Medicare ACO arrangements you may have.

2 Do you have any existing Medicare contracts or arrangements?

Beyond the numbers just the numbers of contracts, start to research what existing incentive exist on the contracts? There could be existing money that is being left on the table for 2026.

3 Are you engaged in population health?

Commonalities, or differences, across contracts are important to call out.

Where to Start?

3 initial questions:

1 How big is your Medicare attribution?

2 Do you have any existing Medicare contracts or arrangements?

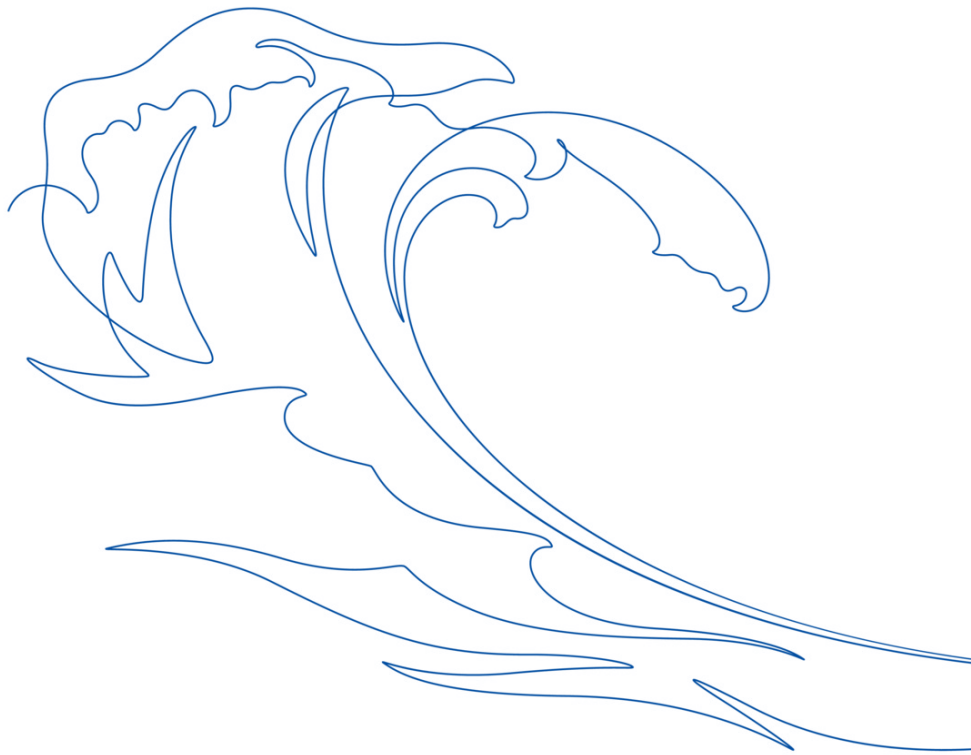
3 Are you engaged in population health?

What population health and / or patient-centered medical home (PCMH) activities is your health center engaged in?

- Annual wellness visits?
- Transitions of care?
- Clinical stratification?
- Addressing gaps in care?

If you are, it may be simple to deploy these practices for your Medicare population.

➤ Medicare Wave aka “Silver Tsunami”



Demographic growth – patients & workforce impacts



Care delivery impacts



Diversify revenues



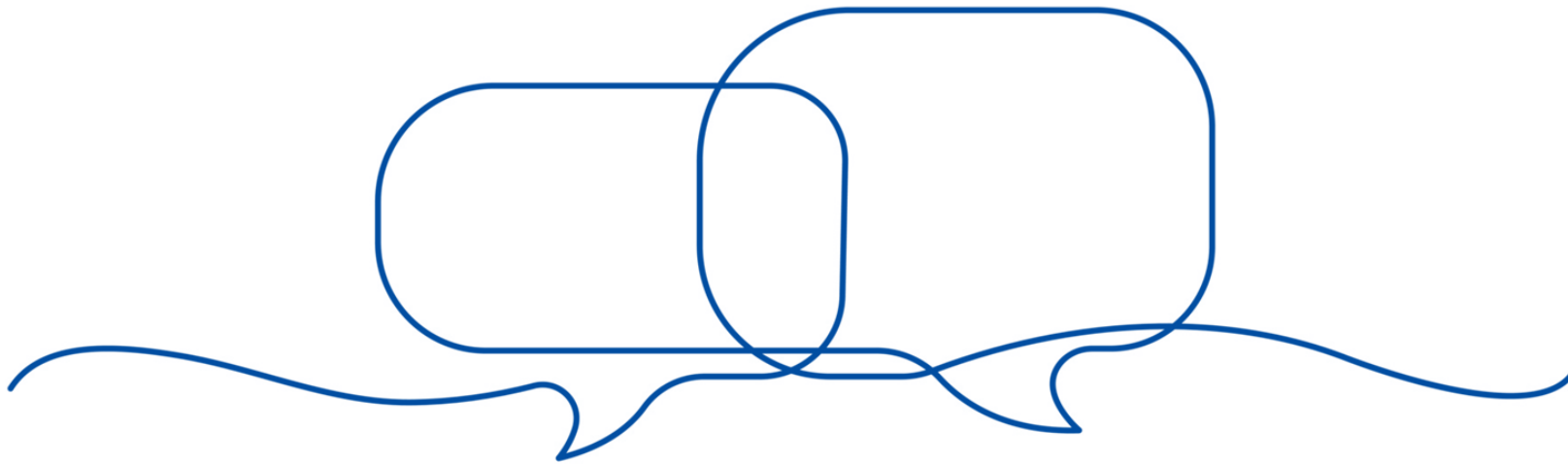
New ways to invest in workforce



Session Goals Check-in:

- ✓ Educate audience on similarities and differences between Medicare and all its versions.
- ✓ Provide statistics on why health centers should care about Medicare.
- ✓ What initial steps health centers can take to understand their Medicare current state.

➤ Open Discussion



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Appendix

Resources

- The Institute for Healthcare Improvement (IHI): Age-Friendly Health Systems Recognition
- NACHC:
 - Key resource topic, <https://www.nachc.org/topic/medicare/>
 - Meeting the Health Care Needs of the Aging (and Fastest Growing) Population at Health Centers
- Health Affairs, “Actualizing Better Health And Health Care For Older Adults”
- Cross Country, “Strategies for Supporting the Aging Population in Community Health Centers”

Keys to Medicare VBC Success



ANNUAL WELLNESS VISITS

Complete an annual wellness visit for all Medicare attributed patients. Complete all clinical documentation, close applicable gaps in care.



TRANSITIONS OF CARE

Complete a transition of care appointment within 7-days post hospital discharge, or 3-days for high-risk patients



CLINICAL DOCUMENTATION

Every time a patient engages with the health center, their burden of illness must be documented, fully. Look to document chronic conditions, as well as potential suspect conditions. Close applicable quality gaps in care.



SEE HIGH RISK PATIENTS MORE

Never let a patient leave without a follow-up appointment scheduled. Schedule higher risk patients more regularly, such as quarterly or even monthly.



ADVANCED CARE DIRECTIVES

All patients over the age of 65 should be engaged in advanced care planning and have their directives documented. This will prevent unnecessary and unwanted end of life care.



PREFERRED NETWORK(S)

Identify high quality, highly efficient specialists and post-acute providers and refer to these providers as frequently as possible.

Value Based Care Contracting



MEMBER ATTRIBUTION

Which patients do the providers have a relationship with?

- Claims-based
- Patient selection
- Geographic



BENCHMARKING

Look at three to five years of performance data to understand what the appropriate budget or annual benchmark spend should be.



QUALITY

Understand which quality metrics will support the contract; it is common for the financial performance to go through a quality 'gate' and / or have a quality threshold.



FINANCIAL RISK

How much upside / downside financial risk can / should the contract take? What is the appropriate glide path to downside risk?



PAYMENTS

Understand how the target medical loss ratio is calculated, when reconciliation payments will be distributed, are there any monthly or quarterly support fees?



INCENTIVES

What quality, coding, performance metrics are set in place to support the contract? How do the incentives make it to the frontline colleagues?