# Medicare

## Medicare Advantage & ACO/REACH

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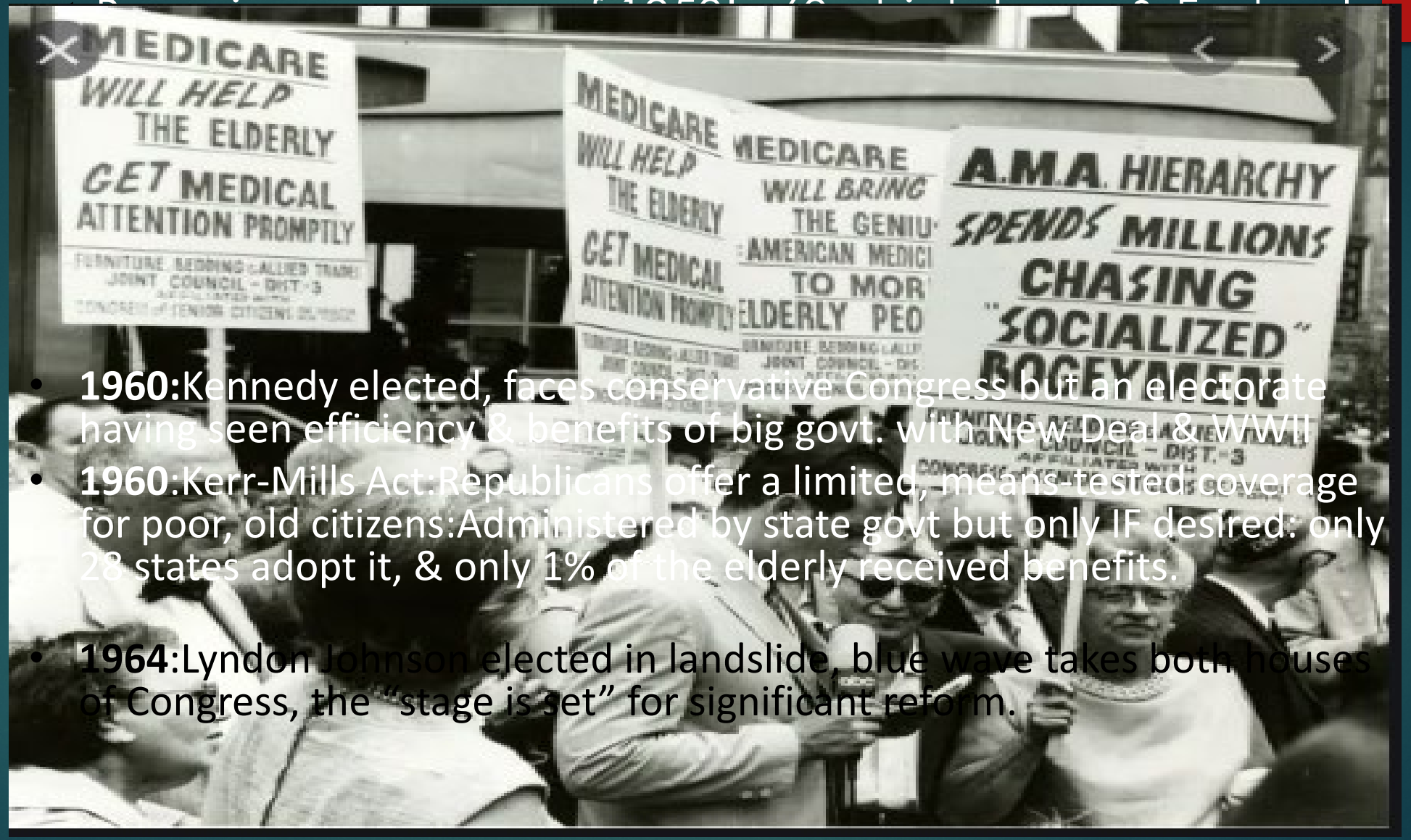
# Those Falling Between the Cracks within "The Other America"


- JFK elected 1960 - has vision for natl health care

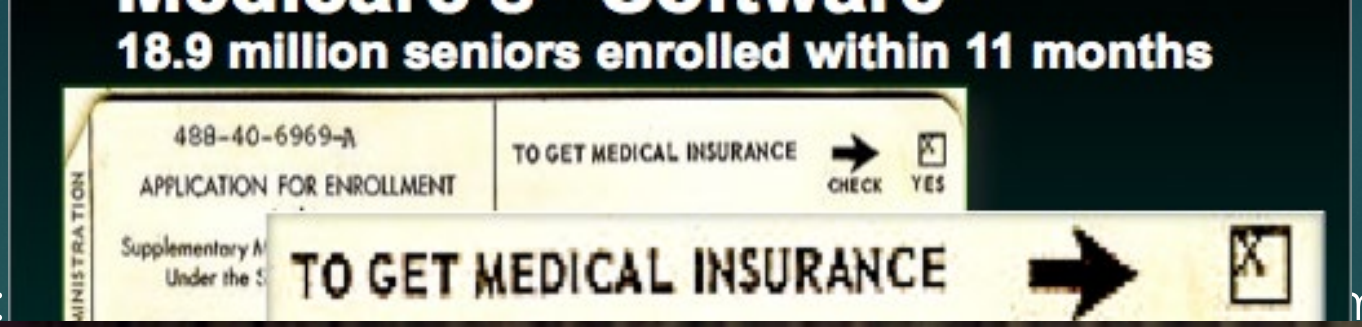
  1962: Michael Harrington, "The Other America" - Poverty in the US"

  The 40-50 million socially invisible Americans have low wages or are living in poverty within an "Affluent Society", most of whom have minimal health coverage
- **1964:** 50% of Elderly have no insurance for hospitalization, 25% of seniors go w/o any health care due to cost issues

# The fight for Medicare 1957-65



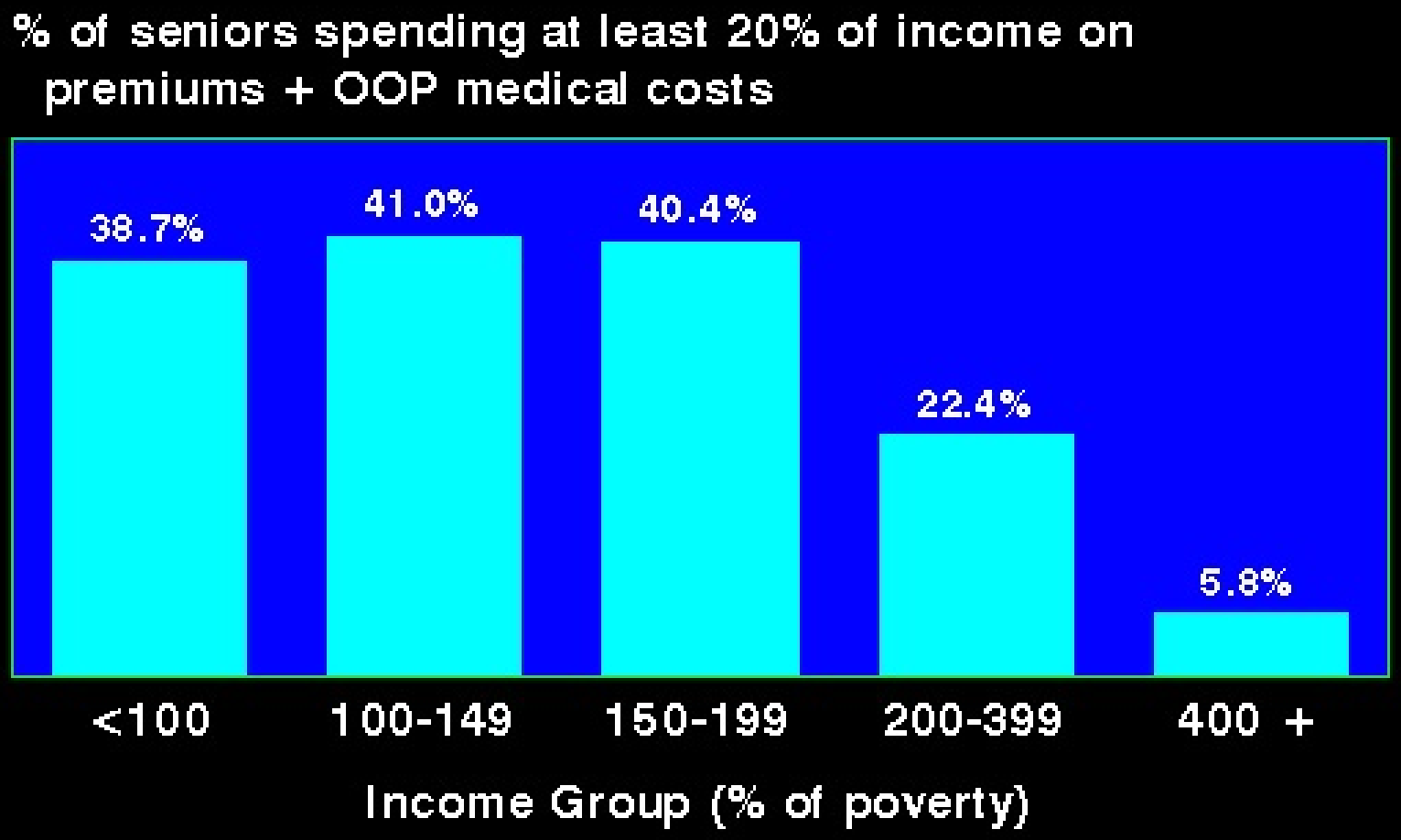

- **1960:**Kennedy elected, faces conservative Congress but an electorate having seen efficiency & benefits of big govt. with New Deal & WWII
- **1960**:Kerr-Mills Act:Republicans offer a limited, means-tested coverage for poor, old citizens:Administered by state govt but only IF desired: only 28 states adopt it, & only 1% of the elderly received benefits.
- **1964**:Lyndon Johnson elected in landslide, blue wave takes both houses of Congress, the "stage is set" for significant reform.




- **Medicare:** me/medical

# Medicare Needs Improvement

## For Many Seniors, Medical Costs Consume More Than 1/5th of Income




Source: Commonwealth Fund May 12, 2017

# Medicare Coverage is inadequate

**Traditional Medicare exposes some to bankruptcy**

- 20% outpatient coinsurance
- $1,600 hospital deductible
- No limit on spending

**Option 1**

- Do nothing (risk of bankruptcy)

**Option 2**

- Purchase a Medicare Supplemental plan

**Option 3**

- Enroll in a Medicare Advantage plan

# 1982—First subcontracting to private plan

CMS initiates a (pilot) program: CMS makes a fixed monthly payment to a private plan which becomes responsible to fund all medically necessary care included in the Medicare benefit

Why?

# A Deeper pocket

1965---Private insurers happy to let government pay for care for the two most expensive groups: The elderly and the poor

1965 – 1985 stagnation in growth of private insurance: Amidst rising health costs, nearly everyone who could afford private insurance already had it

1980s—Private insurance reconsiders their strategy toward the poor and elderly, develops strategies to profitably cover these populations

Attracted to limitless deep pocket of federal government

# Ronald Reagan's First Inaugural Speech

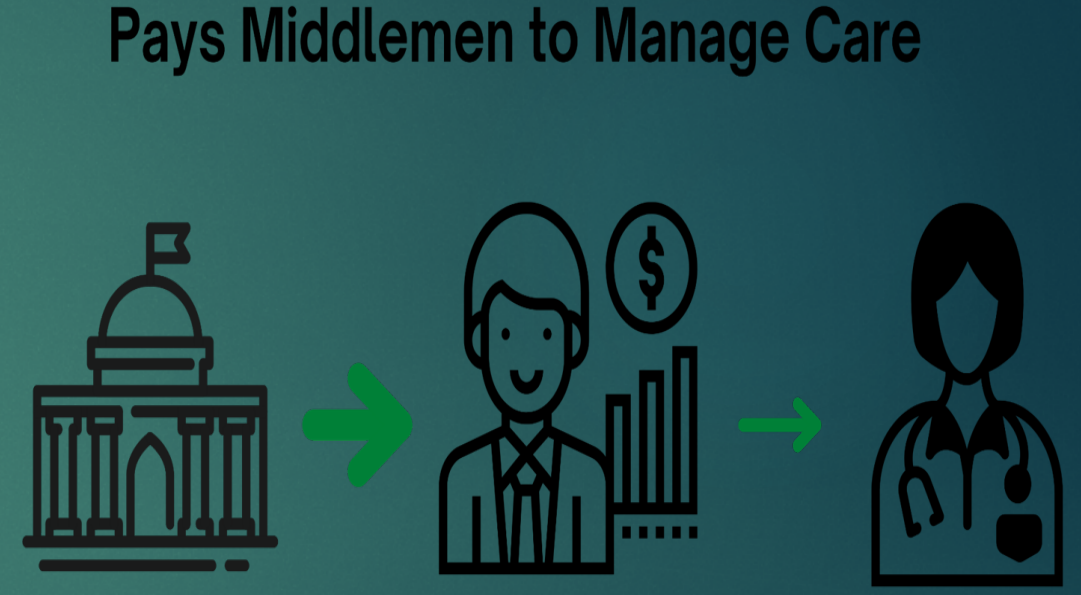

"Government is not the solution to our problems, Government **is** the problem

# Medicare + Choice

Regulations were developed, and the program was launched in 1985 as Medicare Part C.  Given the name "Medicare + Choice" in 1997

Growth was gradual through 2000 amidst unfavorable public view of Managed Care

Payment to participating insurers was 95% of average cost of Medicare beneficiary.  Age adjustment began in 1997



# Medicare Modernization Act of 2003

Medicare + Choice renamed "Medicare Advantage"

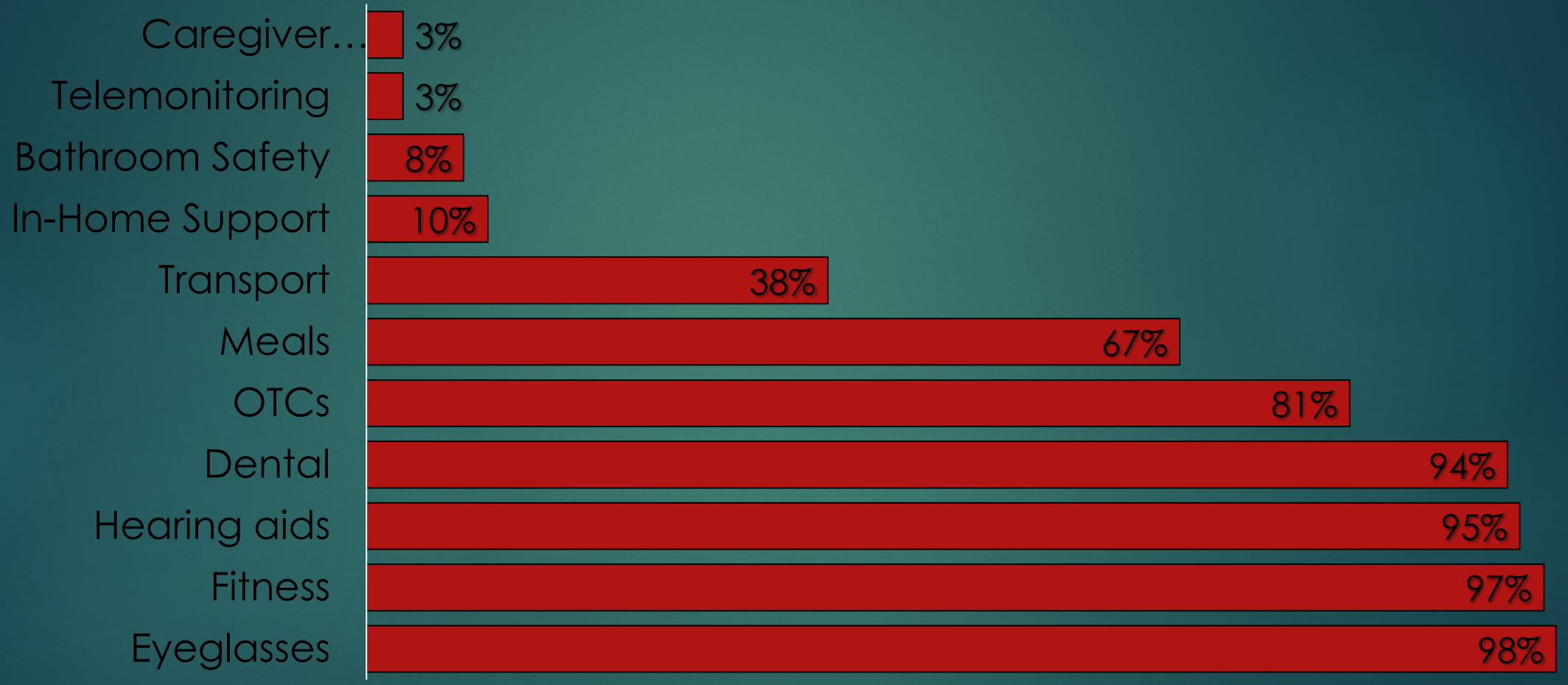
Called for implementation for risk-based payment system "Hierarchical Condition Coding" system  rather than universally abused 95% payment scheme

Within a year, vendors began marketing software to insurers to maximize reimbursements with new risk-adjusted coding system.

Plans authorized to provide extra benefits

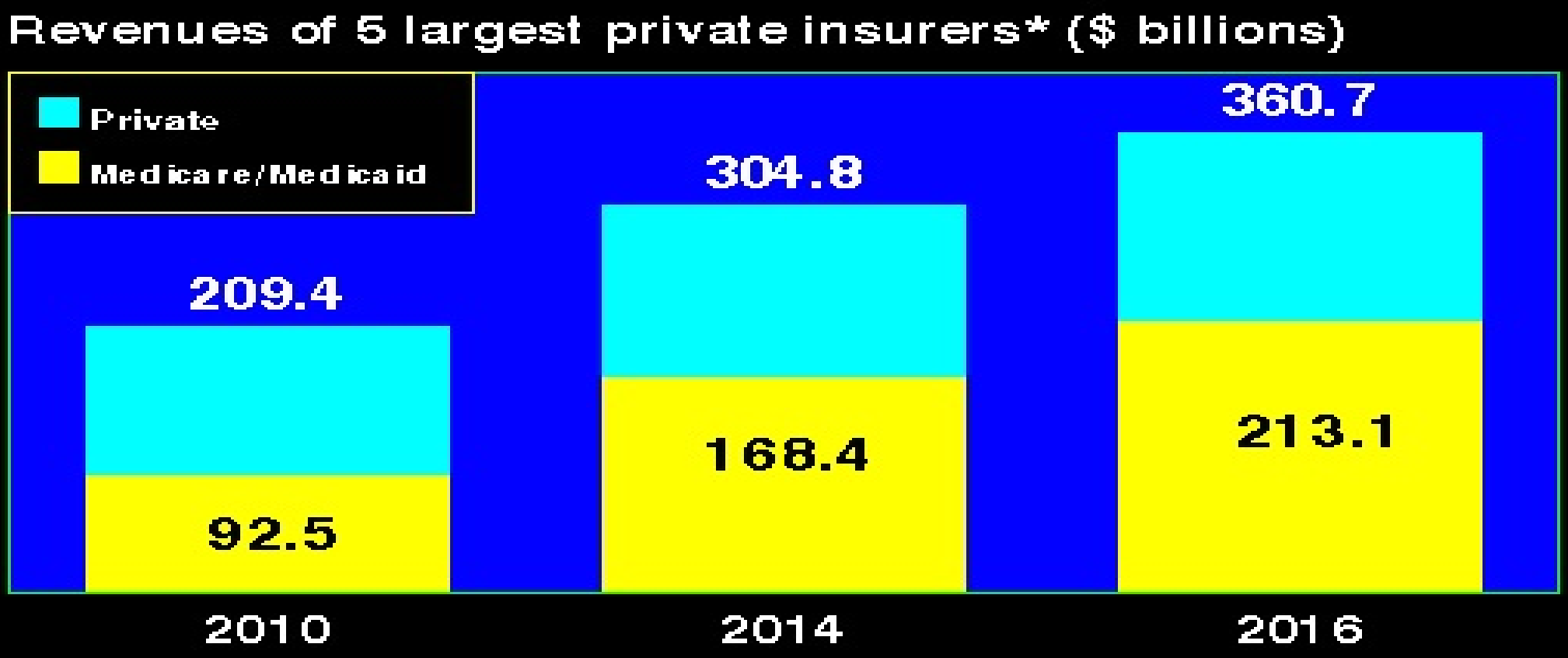

Cigna®

# MA Plans *Target* Their Extra Benefits



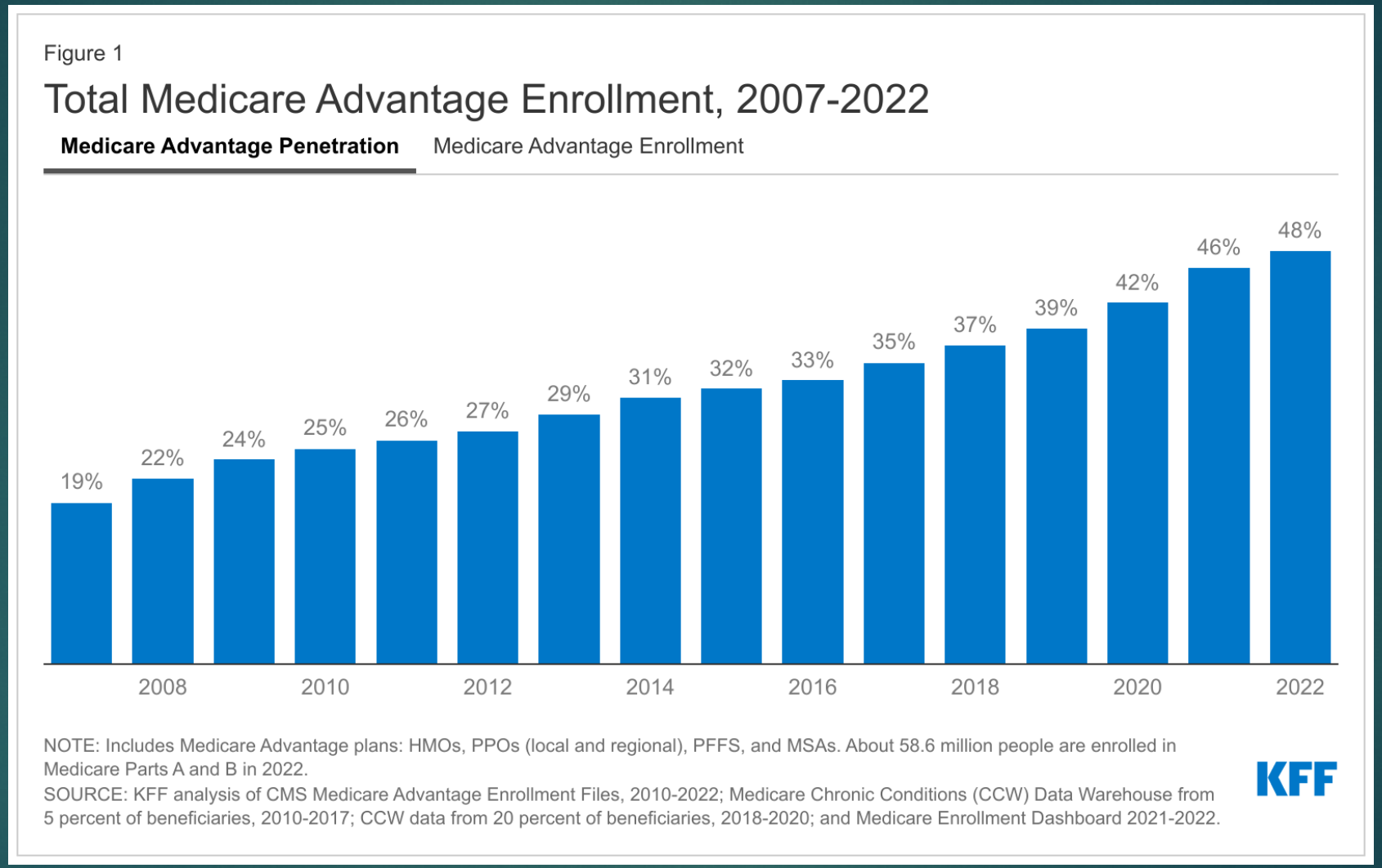

https://www.kff.org/medicare/issue-brief/medicare-advantage-2022-spotlight-first-look/ Accessed June 11 2022

# Medicare and Medicaid Keep Private Insurers Afloat




Source: Health Affairs 2017; 36:2185 - * Aetna, Anthem, Cigna, Humana, United Healthcare
Note: Figures exclude government payments for public workers' coverage

# Medicare Advantage continues to grow…




Source of data: https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2022-enrollment-update-and-key-trends/

Medicare Middlemen generate their profits by the

# Same Three Methods as *Any* Business

1. **Increase number of patients**
2. Maximize revenue per patient
3. **Minimize expenses** (actual patient care)

# 1. Increase Volume through Intense Advertising, paying brokers, gimmicks (“AARP United Healthcare”)

Highlight low premiums, extra benefits



Don’t mention copays, narrow networks, prior authorization, denials of payment

Three strategies to maximizing profits for investors in REACH

# 2. Maximize Revenues per Medicare Patient

Lobby for High "Benchmark" payments, Distort quality date (affects benchmark payments

## Upcoding and Risk Score Gaming

By making seniors look sicker than they are, Medicare Advantage plans receive far higher payments from Medicare, regardless of how much care patients actually receive.

Hospice care for MA enrollees is paid for by traditional Medicare!!!! (mean of 87 days in Hospice = $17,400)

## Coding drives "Risk Scores"

# Risk Scores Drive Reimbursement

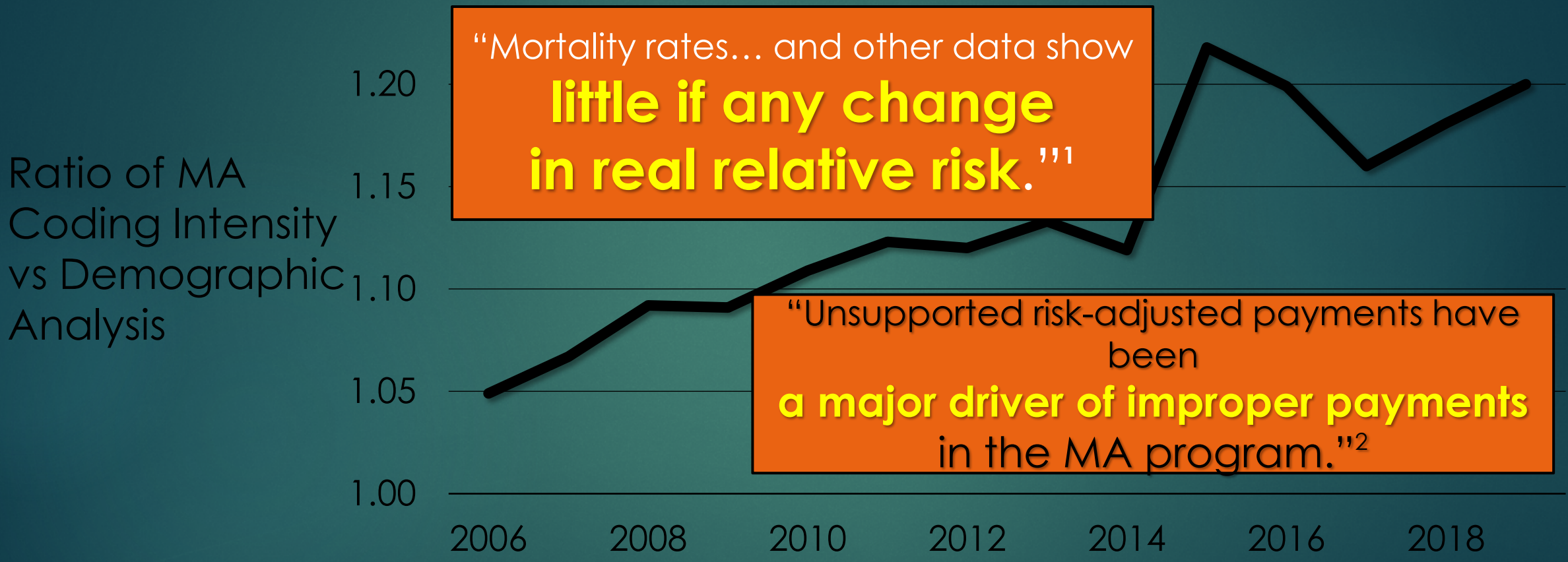
| Healthy 76F | HCC |
|---|---|
| Baseline for age | .45 |
| No extra codes | 0 |
| | 0 |
| | 0 |
| | 0 |
| | 0 |
| | 0 |
| | 0 |
| Risk Score = 0.45 | |
| **CMS pays insurer $4,000** | |

| Typical Coding | HCC |
|---|---|
| Baseline for age | .45 |
| Obesity | 0 |
| Type 2 Diabetes | .104 |
| Major Depression | 0 |
| CHF | .323 |
| Asthma | 0 |
| Ulcer, unspecified | 0 |
| CHF*DM | .154 |
| Risk Score = 1.03 | |
| **CMS pays insurer $9,000** | |

| Detailed Coding | HCC |
|---|---|
| Baseline for age | .45 |
| Morbid Obesity | .273 |
| DM w/ retinopathy | .318 |
| MD, Sing Ep, Mild | .395 |
| CHF, Class 3 | .323 |
| COPD | .328 |
| Ulcer, stage 3 | 1.204 |
| CHF*DM,COPD | .154, .19 |
| Risk Score = 3.63 | |
| **CMS pays insurer $32,000** | |

Source: https://downloads.healthcatalyst.com/wp-content/uploads/2019/04/HCC-coding.png

# Because Risk Scores are worth so much money, MA Plans Have Become Masters of Coding




https://deliverypdf.ssrn.com/delivery.php?ID=702000084013068001071103016064029065061037007020071061119065027014065123077103119101058020007125050109119005019118013112113015030071029038092097112009127010070001120062020054099019031091085026085014089000005003090089065127118099080016066025066065111112&EXT=pdf&INDEX=TRUE

1. https://www.healthaffairs.org/do/10.1377/hblog20200127.293799/full/
2. OIG report Sept 22 2021 at https://oig.hhs.gov/oei/reports/OEI-03-17-00474.pdf. Accessed Sept 22, 2021

## Risk Score Gaming
# Creates a Perverse Marketplace

The more **expensive** the MA Plan is to CMS

→ The better the benefits and the lower the costs for members

→ The MA Plan attracts more members and grows more quickly

→ Higher fees and more members = larger profits to the Plan

Higher coding = Risk Score Gaming

# A Suite to Optimize Business Results

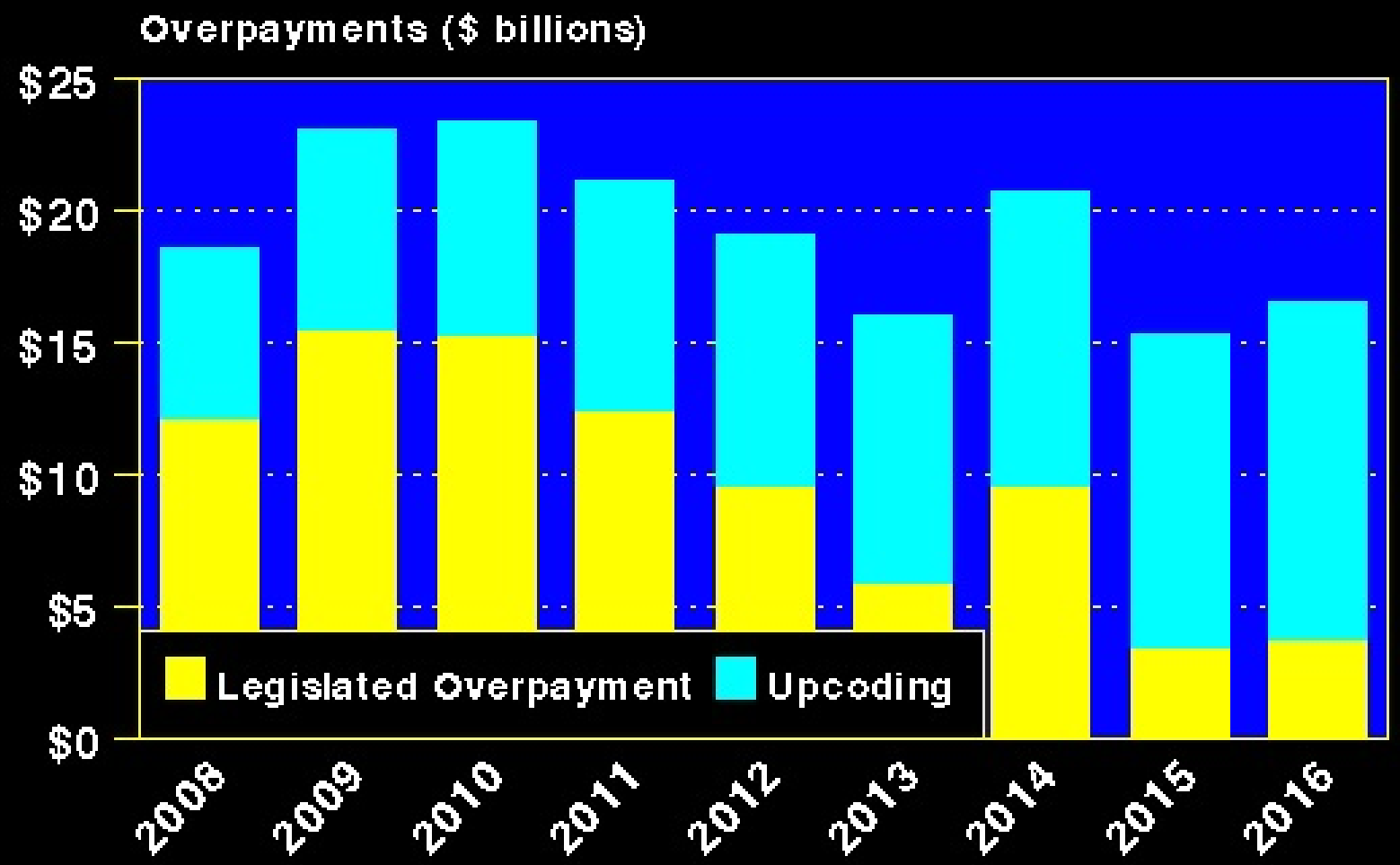
**Incessantly search for more codes**

- Home care visits, annual Wellness exams
- Data-mine electronic health records
- Software tools to "optimize" initial set of codes to maximize risk adjustment payments

- Direct financial incentives to primary care providers

# Medicare Overpays Private Plans

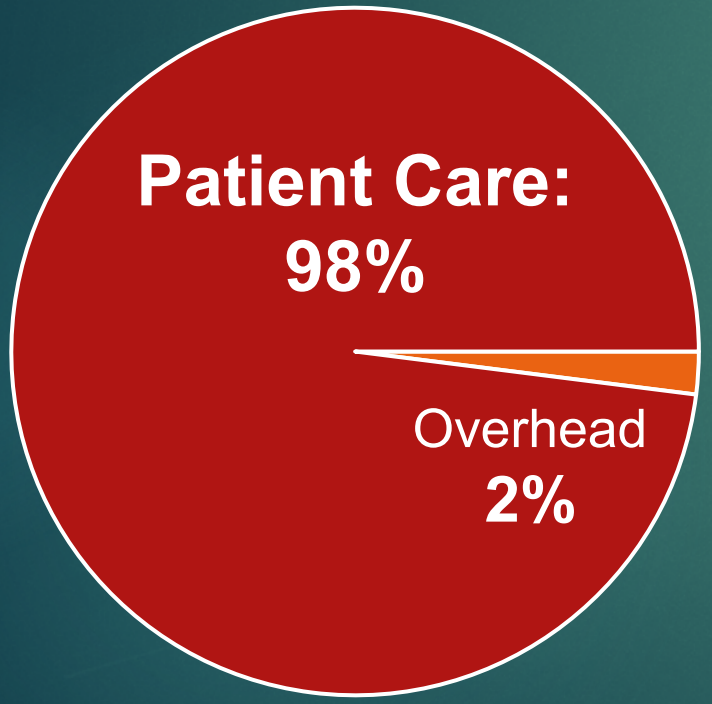
## Total Overpayments 2008-2016: $173.7 billion



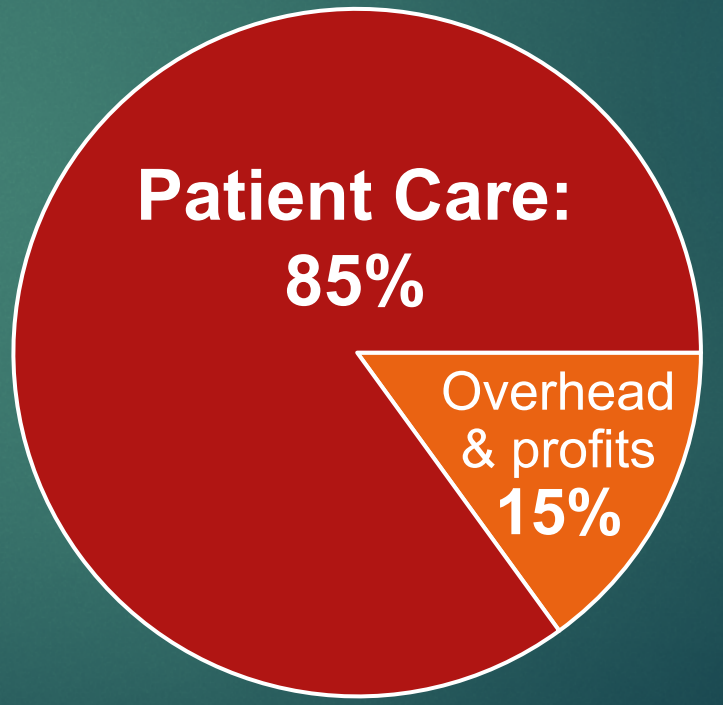

Source: MedPAC and Geruso and Layton, 2015

# 3. Minimize revenues spent on healthcare

Traditional Medicare




Medicare Advantage



# 3. Minimize Medical Expenditures:
## Medicare Advantage Plans Often Deny Needed Care

U.S. Department of Health and Human Services

**Office of Inspector General**

**Report in Brief**

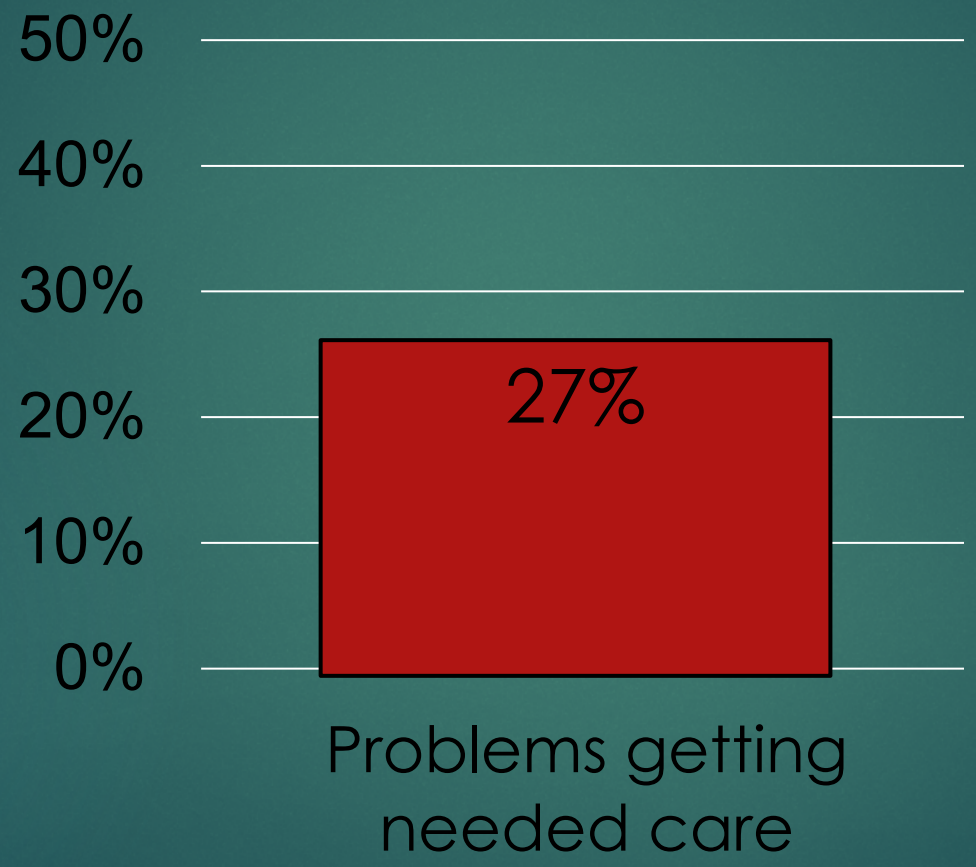
April 2022, OEI-09-18-00260

**Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care**

Source of data: https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf

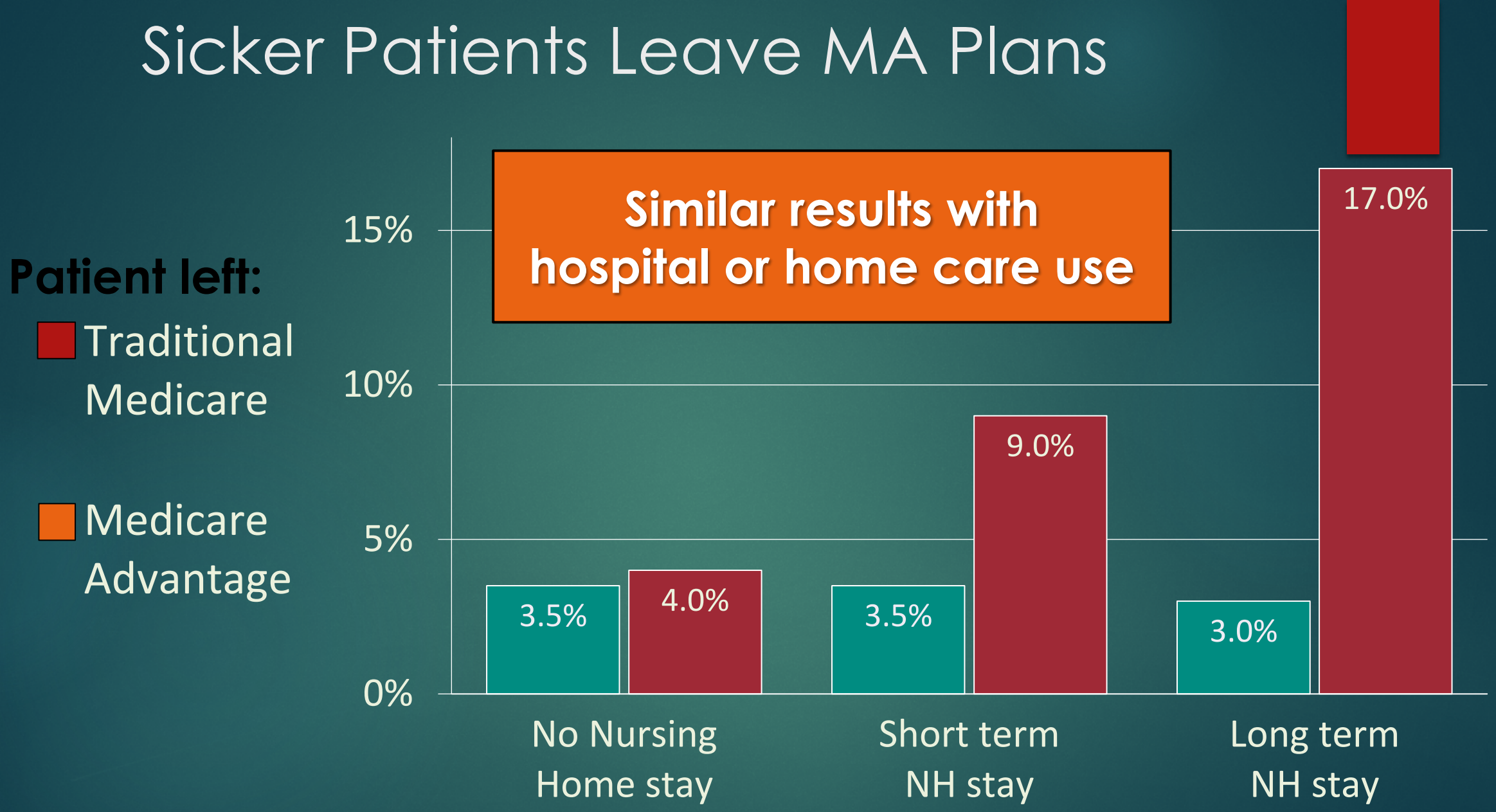
# Sicker Patients Leave MA Plans Because They Can't Get Healthcare

Patient reasons for disenrolling from MA plans




Disenrollment reasons for 126 Medicare Advantage contracts with relatively high disenrollment, 2014
GAO Report 17-393 April 2017
https://www.gao.gov/assets/690/684386.pdf Accessed Aug. 19 2017

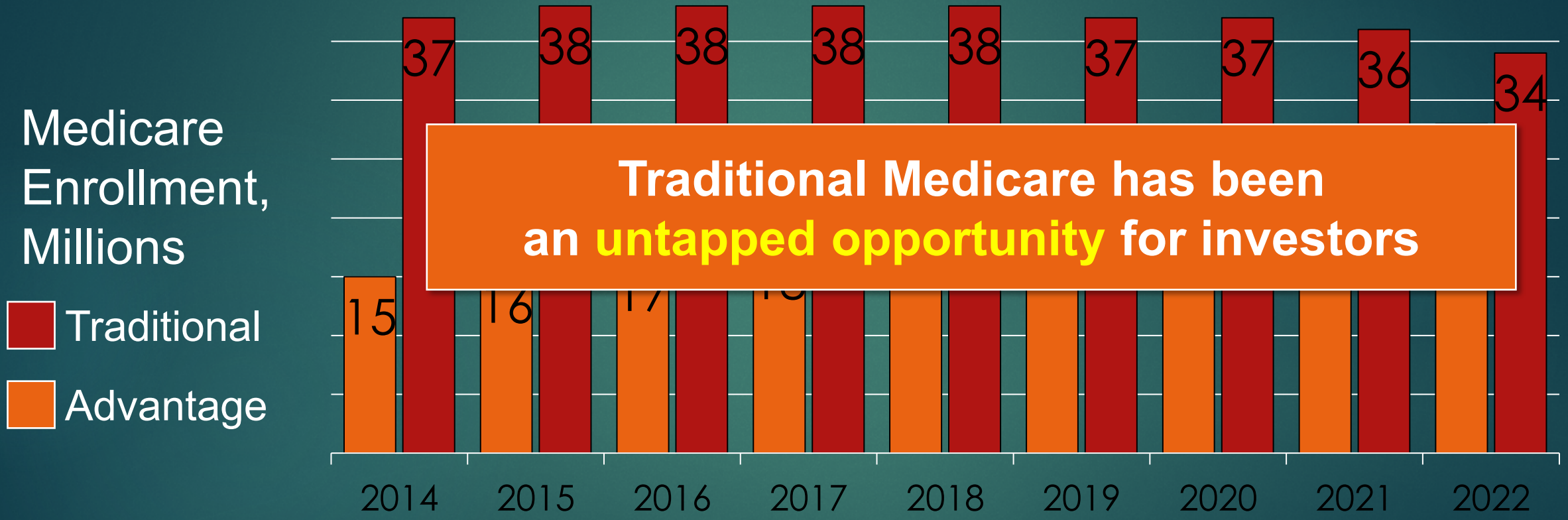
# Sicker Patients Leave MA Plans




Health Affairs 2015;34:1675. 2011 data.
Similar results for patients with hospital or home care use

## Medicare Managed Care ("Medicare Advantage") continues to grow, but

# Traditional Medicare Is Even Larger




https://www.kff.org/medicare/state-indicator/total-medicare-beneficiaries/?activeTab=graph&currentTimeframe=0&startTimeframe=10&selectedDistributions=original-medicare--medicare-advantage--total&selectedRows=%7B%22wrapups%22:%7B%22united-states%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7Dhttps://www.kff.org/medicare/state-indicator/total-medicare-beneficiaries/?activeTab=graph&currentTimeframe=0&startTimeframe=10&selectedDistributions=original-medicare--medicare-advantage--total&selectedRows=%7B%22wrapups%22:%7B%22united-states%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D
Accessed Sept 22, 2021

Landmark

Center for Medicare & Medicaid INNOVATION

**Adam Boehler** – a former roommate of Jared Kushner – ran CMMI when Direct Contracting was first proposed in 2019.

Prior to running CMMI, Boehler ran a startup called **Landmark Health**, which then became one of the first DCEs to contract with Medicare.

Boehler left CMMI in 2020

**Brad Smith** ran CMMI between Adam Boehler and Liz Fowler.

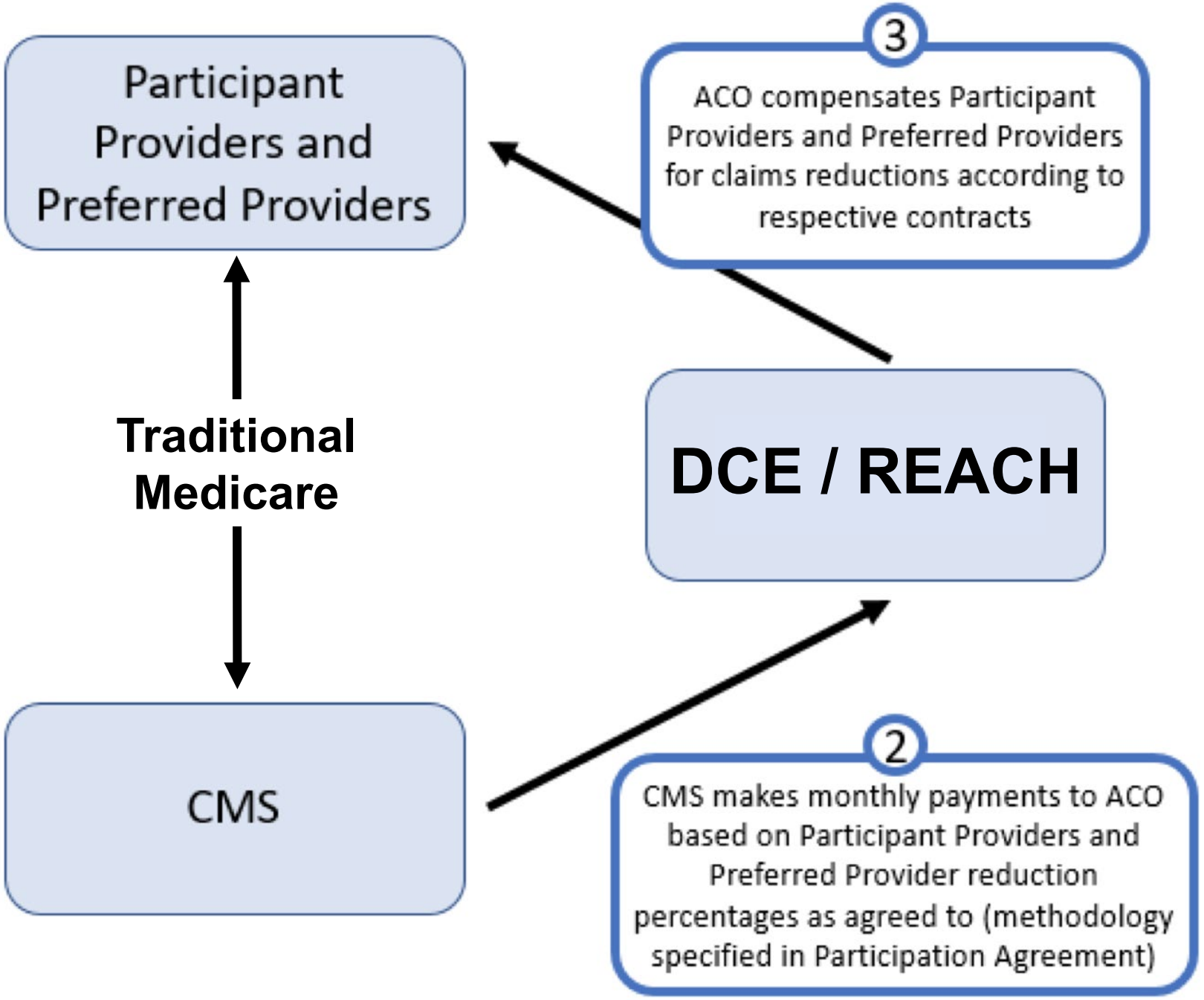
Before CMMI, Brad worked for the commercial insurer Anthem, which won a DCE contract through its “CareMore” subsidiary.

After CMMI, he now runs “Russell Street Ventures”, an investment firm that includes other CMMI alumni.

# Medicare Direct Contracting (& ACO/REACH)

- For each PCP who has signed a DCE contract, CMS *automatically* “aligns” each of that PCP’s Medicare patients to that DCE
- CMS searches the past two years of every beneficiary’s claims to assign a PCP
- Growth is driven by contracting with PCPs

- Patients are *not fully informed*
- Patients are *not asked for consent*
- Patients can only opt out by *finding a new primary care physician*




**With REACH, providers will need to track**

- 20% from patient or Medigap
- x% from CMS
- y% from REACH
- Incentives etc.

REACH 2022 RFA Figure 6.1 page 40
https://innovation.cms.gov/media/document/aco-reach-rfa Accessed June 9 2022

# 2. Minimize healthcare spending

| Gross savings/losses as a percent (%) of the Final PY Benchmark | ACO Shared Savings/ Shared Losses cap |
|---|---|
| Risk Band 1:<br>Gross Savings/Losses<br>Less than 25% | 100% of savings/losses |
| Risk Band 2:<br>Gross Savings/Losses<br>Between 25% and 35% | 50% of savings/losses |
| Risk Band 3:<br>Gross Savings/Losses<br>Between 35% and 50% | 25% of savings/losses |
| Risk Band 4:<br>Gross Savings/Losses<br>Greater than 50% | 10% of savings/losses |

**Risk corridors allow DCE/REACH to retain:**

100% of 1st 25% = **25%**

50% of next 10% = **5%**

25% of next 15% = **3.75%**

10% of next 50% = **5%**

Total opportunity = **38.75%**

DCE/REACH can retain ***all* of the first 25% "savings"** and potentially as much as **38.75% of their benchmark**

REACH 2022 RFA Table 6.5 page 35 (Example under Global contracts)
https://innovation.cms.gov/media/document/aco-reach-rfa Accessed June 9 2022

# "Direct Contracting" has been Rebranded as REACH for 2023

| | |
|---|---|
| **2021** | • 54 DCEs with **340,000** beneficiaries |
| **2022** | • 99 DCEs with **1.8 million** beneficiaries<br>• Direct Contracting model ends 12/31/2022 |
| **2023** | • REACH begins 1/1/2023<br>• No announced limits to expansion in REACH |
| **2030** | • *Every* Medicare beneficiary will be assigned to a program like DCE/REACH |

DCE/REACH middlemen generate their profits by the

# Same Three Ways as Medicare Advantage (and most business)

1. **Maximize total number of enrollees**
2. **Maximize revenue per patient**
3. Minimize expenditures (on medical care)

Three strategies to maximizing profits for investors in REACH

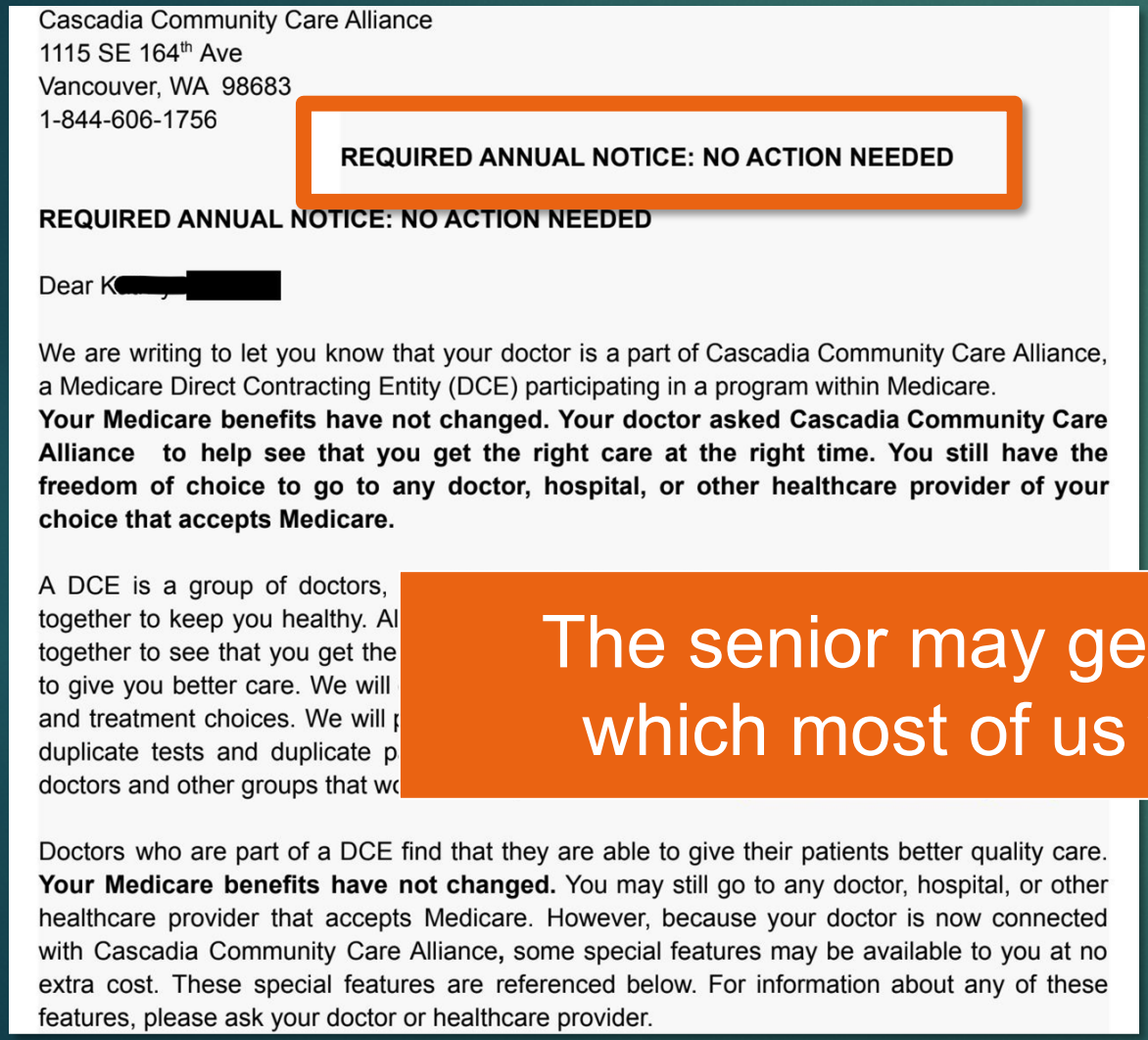
# 1. Increase Volume through “Alignment”


## TV Ads Not Needed

Medicare *automatically* “aligns” a senior into a DCE/REACH if with that middleman is affiliated with their primary care physician.

**This is done to seniors *without their consent.***

# How are patients informed?



Cascadia Community Care Alliance
1115 SE 164th Ave
Vancouver, WA 98683
1-844-606-1756

**REQUIRED ANNUAL NOTICE: NO ACTION NEEDED**

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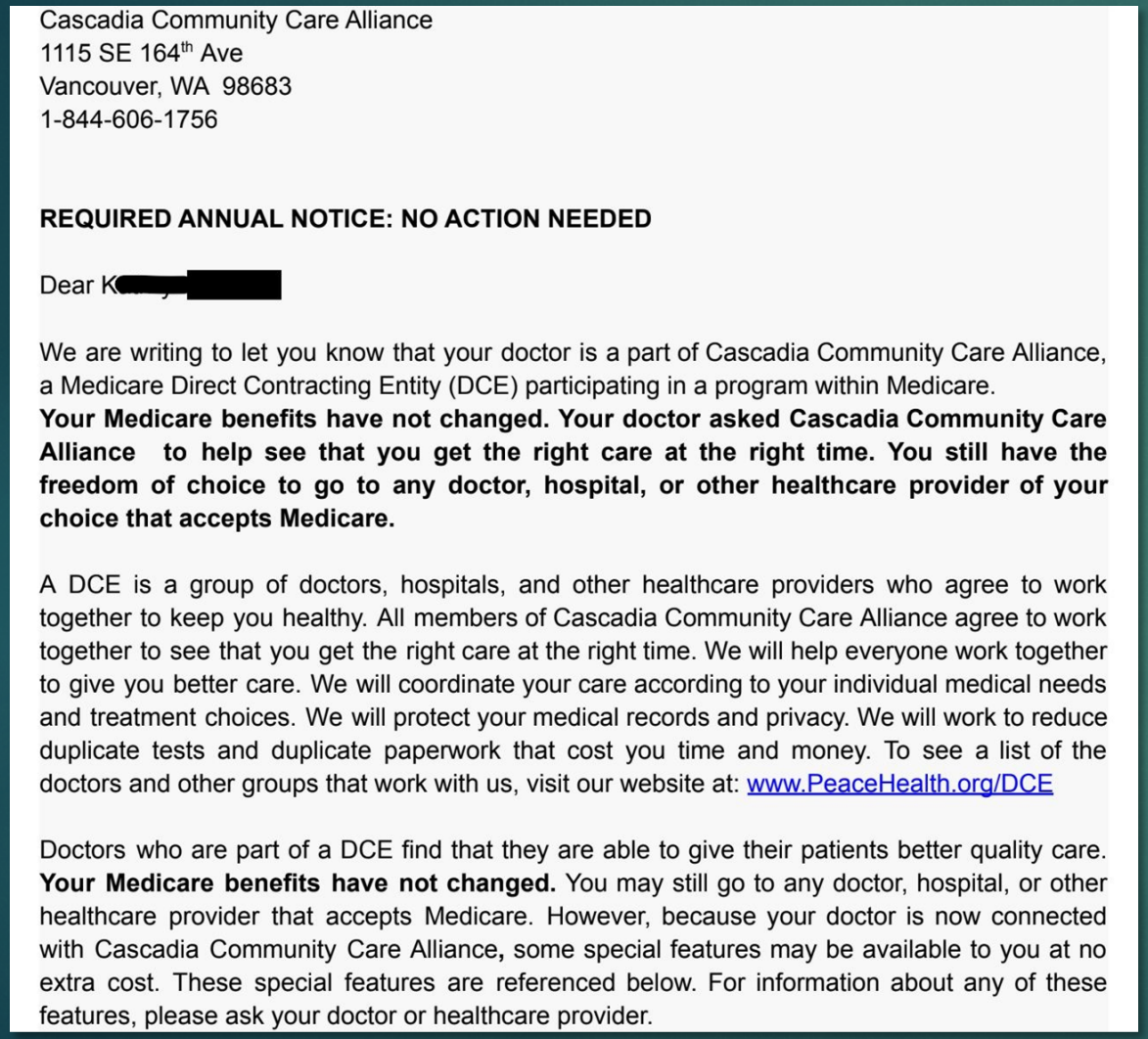
Dear K[redacted]

We are writing to let you know that your doctor is a part of Cascadia Community Care Alliance, a Medicare Direct Contracting Entity (DCE) participating in a program within Medicare.
**Your Medicare benefits have not changed. Your doctor asked Cascadia Community Care Alliance to help see that you get the right care at the right time. You still have the freedom of choice to go to any doctor, hospital, or other healthcare provider of your choice that accepts Medicare.**

A DCE is a group of doctors,
together to keep you healthy. Al
together to see that you get the
to give you better care. We will
and treatment choices. We will p
duplicate tests and duplicate p
doctors and other groups that wo

Doctors who are part of a DCE find that they are able to give their patients better quality care. **Your Medicare benefits have not changed.** You may still go to any doctor, hospital, or other healthcare provider that accepts Medicare. However, because your doctor is now connected with Cascadia Community Care Alliance, some special features may be available to you at no extra cost. These special features are referenced below. For information about any of these features, please ask your doctor or healthcare provider.

The senior may get a form letter like this — which most of us would toss in the trash.



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A DCE is a group of doctors, hospitals, and other healthcare providers who agree to work together to keep you healthy. All members of Cascadia Community Care Alliance agree to work together to see that you get the right care at the right time. We will help everyone work together to give you better care. We will coordinate your care according to your individual medical needs and treatment choices. We will protect your medical records and privacy. We will work to reduce duplicate tests and duplicate paperwork that cost you time and money. To see a list of the doctors and other groups that work with us, visit our website at: www.PeaceHealth.org/DCE

Doctors who are part of a DCE find that they are able to give their patients better quality care. **Your Medicare benefits have not changed.** You may still go to any doctor, hospital, or other healthcare provider that accepts Medicare. However, because your doctor is now connected with Cascadia Community Care Alliance, some special features may be available to you at no extra cost. These special features are referenced below. For information about any of these features, please ask your doctor or healthcare provider.

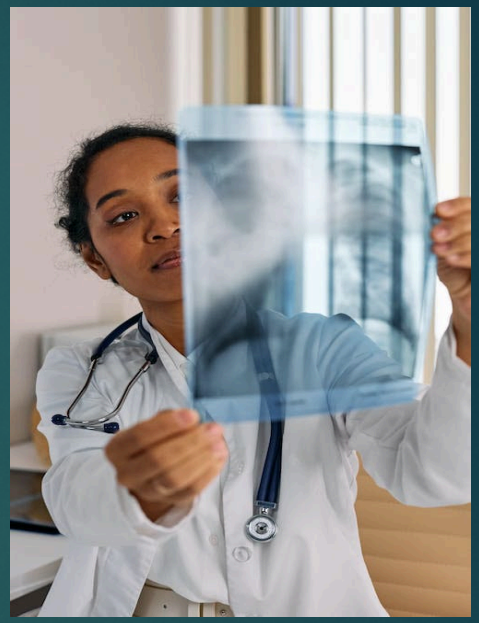
Once auto-aligned into REACH, your only way out is to **change primary care physicians.**

That's particularly difficult for seniors in rural or other underserved areas.

Suggesting seniors change PCPs undermines Traditional Medicare's promise of free choice in provider.

# 1. **Maximizing the number of enrollees—sign up more PCPs**

Will DCEs properly inform primary care providers of the risks as well as the potential upsides of signing up?



Primary care practitioners may be attracted to promise of fixed, minimum amount of revenue through capitation, and the lure of additional revenue for "keeping their patients healthy". (costly treatment of metastatic lung cancer in a patient who quit smoking around the time you met him)

The DCE may offer other incentives for PCPs (e.g. Use of the Clover Assistant, preventive care measures)

## 2. Maximizing revenue per patient

Just as in Medicare Advantage, upcoding is central to the ACE/REACH business model:

Getting Medicare to classify your patients as more complex than they actually are

# 3. Minimize Medical Expenditures
## "Capitation" and "Financial Risk" provide powerful disincentives

- In the contract with primary care providers, the DCE will attempt to build in disincentives: At the very least, capitate the PCP's primary care services
- Will likely confer additional risk onto the primary care provider—PCP would lose money the more medical costs his/her patients generate compared to a benchmark for that risk level

- Patients in traditional Medicare can see all providers credentialed within the Medicare program, however, the DCE contract may reward the primary care clinician to refer within the DCE's preferred network

https://innovation.cms.gov/innovation-models/gpdc-model Accessed Sept 18 2021

# Some of the issues with the ACO/REACH model

- **Middleman** between Medicare and providers
  - Deliver less care, retain higher profits
  - Can include private equity investors & commercial insurers
  - Can retain more than 25% as profit and overhead
- **Administratively complex–and financially risky--for physicians**
- **Perception (and reality) of conflict of interest for physicians**

# Downsides of ACO/REACH for patients

- **Automatic, involuntary enrollment**
  - Patients aren't able to choose whether to participate
  - Only way for patient to get out is to find a new PCP
  - Most patients will be paying $165/mo (= $2000/yr) for Medigap plan to avoid managed care
  - Patients are not properly informed

# Thank you

MARVIN MALEK, MD MPH
MMALEK66@GMAIL.COM