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

- **1957**: Forand & King’s modest House bill: coverage for elderly hosp. care, funded under preexisting SSI, (not "universal insurance")
- **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: federal health coverage for all >65, regardless of income/medical history.
  Part A hospitalization funded via SSA with 1.45% tax earnings ("FICA"); Part B, voluntary, for outpatient services (Dr’s fees) funded via premiums & general fed. revenue. Passage depended on an amendment demanded by the AMA that allowed Drs to set "reasonable charges" for fees, in lieu of govt regulating prices – a compromise, and a flaw.

• Medicaid: During reconciliation, at the last minute, conservatives accepted & added version of Kerr-Mills Act for low income coverage ("means-tested" based on Fed Poverty Level/state administered).

July 1965: Medicare law signed in Independence, Missouri with Harry S. Truman. Implementation required data processing and re-configuration of hospital policies nationwide – done on paper! (slide courtesy Dr W.)

• Many of this group (about 20% of the total in 2015) became "dual eligible" for both Medicare and Medicaid with the passing of the law. In 1966, Medicare spurred the racial integration of thousands of waiting rooms, hospital floors, and physician practices by making payments to health care providers conditional on desegregation.

[10]
Medicare Needs Improvement
For Many Seniors, Medical Costs Consume More Than 1/5th of Income

% of seniors spending at least 20% of income on premiums + OOP medical costs

| Income Group (% of poverty) | 38.7% | 41.0% | 40.4% | 22.4% | 5.8% |

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?
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

A Deeper pocket
“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
MA Plans Target Their Extra Benefits

- Caregiver…: 3%
- Telemonitoring: 3%
- Bathroom Safety: 8%
- In-Home Support: 10%
- Transport: 38%
- Meals: 67%
- OTCs: 81%
- Dental: 94%
- Hearing aids: 95%
- Fitness: 97%
- Eyeglasses: 98%

Medicare and Medicaid Keep Private Insurers Afloat

Revenues of 5 largest private insurers* ($ billions)

<table>
<thead>
<tr>
<th>Year</th>
<th>Private</th>
<th>Medicare/Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>209.4</td>
<td>92.5</td>
</tr>
<tr>
<td>2014</td>
<td>304.8</td>
<td>168.4</td>
</tr>
<tr>
<td>2016</td>
<td>360.7</td>
<td>213.1</td>
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</tbody>
</table>

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…

Figure 1
Total Medicare Advantage Enrollment, 2007-2022

Medicare Advantage Penetration

Medicare Advantage Enrollment

<table>
<thead>
<tr>
<th>Year</th>
<th>Enrollment</th>
<th>Penetration</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>19%</td>
<td></td>
</tr>
<tr>
<td>2010</td>
<td>22%</td>
<td></td>
</tr>
<tr>
<td>2012</td>
<td>24%</td>
<td></td>
</tr>
<tr>
<td>2014</td>
<td>26%</td>
<td></td>
</tr>
<tr>
<td>2016</td>
<td>27%</td>
<td></td>
</tr>
<tr>
<td>2018</td>
<td>29%</td>
<td></td>
</tr>
<tr>
<td>2020</td>
<td>31%</td>
<td></td>
</tr>
<tr>
<td>2022</td>
<td>32%</td>
<td></td>
</tr>
</tbody>
</table>

NOTE: Includes Medicare Advantage plans: HMOs, PPOs (local and regional), PFFS, and MSAs. About 58.8 million people are enrolled in Medicare Parts A and B in 2022.


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
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**

<table>
<thead>
<tr>
<th>Healthy 76F</th>
<th>HCC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline for age</td>
<td>.45</td>
</tr>
<tr>
<td>No extra codes</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>0</td>
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<tr>
<td></td>
<td>0</td>
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<tr>
<td></td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Risk Score = 0.45</td>
<td></td>
</tr>
<tr>
<td>CMS pays insurer $4,000</td>
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</table>

<table>
<thead>
<tr>
<th>Typical Coding</th>
<th>HCC</th>
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</thead>
<tbody>
<tr>
<td>Baseline for age</td>
<td>.45</td>
</tr>
<tr>
<td>Obesity</td>
<td>0</td>
</tr>
<tr>
<td>Type 2 Diabetes</td>
<td>.104</td>
</tr>
<tr>
<td>Major Depression</td>
<td>0</td>
</tr>
<tr>
<td>CHF</td>
<td>.323</td>
</tr>
<tr>
<td>Asthma</td>
<td>0</td>
</tr>
<tr>
<td>Ulcer, unspecified</td>
<td>0</td>
</tr>
<tr>
<td>CHF*DM</td>
<td>.154</td>
</tr>
<tr>
<td>Risk Score = 1.03</td>
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</tr>
<tr>
<td>CMS pays insurer $9,000</td>
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</table>

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

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

1. “Mortality rates... and other data show little if any change in real relative risk.”

2. “Unsupported risk-adjusted payments have been a major driver of improper payments in the MA program.”

103119101058020007125050191190650519118013112113015030071029038092097112091270100700111200620200504090190310910850
2608501408900005039008906512711809908001606602506606511112&EXT=pdf&INDEX=TRUE
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

Traditional Medicare
- Patient Care: 98%
- Overhead: 2%

Medicare Advantage
- Patient Care: 85%
- Overhead & profits: 15%
3. Minimize Medical Expenditures: Medicare Advantage Plans Often Deny Needed Care

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

- 50%
- 40%
- 30%
- 20%
- 10%
- 0%

Problems getting needed care

27%

Disenrollment reasons for 126 Medicare Advantage contracts with relatively high disenrollment, 2014

GAO Report 17-393 April 2017

Sicker Patients Leave MA Plans

Patient left:
- Traditional Medicare
- Medicare Advantage

Similar results with hospital or home care use

<table>
<thead>
<tr>
<th>No Nursing Home stay</th>
<th>Short term NH stay</th>
<th>Long term NH stay</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.5%</td>
<td>3.5%</td>
<td>3.0%</td>
</tr>
<tr>
<td>4.0%</td>
<td>9.0%</td>
<td>3.0%</td>
</tr>
<tr>
<td>0%</td>
<td>17.0%</td>
<td></td>
</tr>
</tbody>
</table>

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

Medicare Enrollment, Millions

- Traditional
- Advantage

Traditional Medicare has been an untapped opportunity for investors

Accessed Sept 22, 2021
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
2. Minimize healthcare spending

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

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)
“Direct Contracting” has been
Rebranded as REACH for 2023

2021
• 54 DCEs with 340,000 beneficiaries

2022
• 99 DCEs with 1.8 million beneficiaries
• Direct Contracting model ends 12/31/2022

2023
• REACH begins 1/1/2023
• 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.
The senior may get a form letter like this — which most of us would toss in the trash.
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 the promise of a 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

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