ACO REACH: The Hazards of Capitation for Traditional Medicare

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My Perspective

- Health Policy, Economics, & Services Research at UCSF (30 y)
- Analysis and advocacy for single payer / improved Medicare for All

Overview

ACO REACH Echoes Medicare Advantage

- Medicare Advantage
  - Private Health Plans marketed to beneficiaries, paid by capitation
  - Limit Care Access via formal constraints: Provider Networks, Prior Approvals, Denials
  - Overcharge CMS via risk adjustment gaming and adverse selection
- ACO REACH
  - Direct Contracting Entities (DCEs, rebranded as “ACOs”) = intermediaries paid by capitation
  - Take on cost risk for all patients of participating physicians
  - Seek savings / profit by incentivizing reductions in care
  - Informal constraints: lower referrals for specialists, tests, procedures
  - MD payment reflects this: Protect / grow income via lowering care

Medicare Advantage Access Problems

- Heavy reliance on provider networks, which often lack specialists and highest quality hospitals
- OIG (HHS Office of Inspector General) found 15 million incorrect care denials over 3 years
- 50% of MA enrollees in fair / poor health have trouble getting health care due to cost, or problems paying medical bills.
- MA enrollees likely to shift to Traditional Medicare at end of life

Medicare Advantage Overcharging CMS

- Aggressive (even fraudulent) diagnostic upcoding to raise capitation rates
- Inadequate CMS adjustment for known over-coding vs Traditional Medicare
- More expensive than Traditional Medicare
- Costs to CMS = $12 B in 2020 (MedPAC), $500 B 2023-2032 (Kronick)
- Increases Part B premiums (incl CalPERS reimbursements)

ACO REACH / DCEs & Financial Risk

- "Benchmark" Annual Cost (i.e., capitation) based on past spending
- Like MA, adjusted for diagnostic severity: More Diagnoses = higher benchmark
- Weak Limits (3% annual) on ACO Growth of Diagnostic Severity Once Program Starts
- "Static reference year" but only 2024-2026
- "Coding Intensity Factor" to control overall coding growth, but CMS failure to enforce limits in MA

ACO REACH Payment Structure

- Payment to DCEs at start of each month, provider payment after care → a "float" may yield several % investment returns (o/w would accrue to CMS)
- DCEs pay CMS 0-3.5% "discount" (offset by float)
- Then DCE keeps ALL savings (reductions in medical costs) up to 25%, + much beyond that. FAR higher than previous generations of ACOs.
- Thus, for DCEs to profit, they must incentivize less use of care.

Physician Payment Echoes & Enables ACO

- Physicians paid via fee-for-service, at lower rates than currently
- Share in savings under benchmark (details proprietary by DCE)
- Thus to maintain income (let alone gain), need to facilitate lower medical costs overall.
- Loss aversion is a very powerful motivator (as is raising income)

ACO REACH will use *informal* care constraints

- Fewer or slower referrals for specialists / tests / procedures
- Erodes trust between physician and patient – physician financial interests reside in *reducing* not facilitating care.
- Undercuts why seniors value Traditional Medicare.

Thus ACO REACH Poses Same Threats as MA

- Why privatize the public part of Medicare?
- CMS has stated goal of all beneficiaries in an "accountable relationship" by 2030.
- But little evidence that ACOs work, and no evidence that DCEs / ACO REACH works
- Should drop ACO REACH, let Traditional Medicare stay traditional; safest option
- At most, a *much smaller* pilot with ***very strict*** requirements for scale-up, eg superb access to care for sick enrollees

ACO REACH Ethical Issues

- Beneficiaries often don't know they're being enrolled (eg Sutter)
- Letter notifying of enrollment misrepresents, eg claims known benefits for clinical care, doctors requested this
- Finding a non-REACH provider is disruptive and difficult, no assistance. Represents coercion
- Doctor-patient relationship is compromised
- Ten ACO REACH DCEs have history of fraud within Medicare/Medicaid
- Medical experiment without human research oversight (as is MA, as is our insurance system).