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Direct Contracting/REACH: A Backdoor Medicare Privatization Scheme

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Medicare is rapidly becoming a privatized, heavily subsidized public health insurance program through the use of private insurers in the Medicare Advantage (MA) program. Estimates of excessive payments to MA plans now are in the range of more than $20 B annually, rising to almost $100 B annually in 2030 and costing a total of over **$600 B** over the next 9 years. People in traditional Medicare cost taxpayers much less. CMS just announced that it will not change its approach to risk scores and therefore expects **MA revenue to increase 8.5% in 2023**. This increased subsidy will no doubt accelerate the rate of growth of MA even further.

The ACO REACH Program (formerly Direct Contracting or DC) opens the door for MA insurers, private equity and other for-profit startup firms to generate revenue from people in traditional Medicare. The REACH program operates as a hybrid of the MA and ACO models. Key features from both could accelerate the privatization of Medicare. These include:

- Automatic involuntary enrollment into REACH program based on PCP use
- Capitated payments unrelated to spending on medical and hospital care
- Provider networks to which patients are steered
- Modified risk adjustment opportunity
- No meaningful minimum medical loss ratio
- Broad marketing and sales activities
- No limits on program growth

DC/REACH is likely to drive up Medicare spending.

- Centers for Medicare and Medicaid Services(CMS) is paying REACH entities a capitated fee and allowing for upcoding, though less than in MA, more than in ACOs.
- REACH creates opportunity for MA plans, and MA-focused providers to drive members into MA plans despite CMS monitoring.
- **MedPAC** recently said that the MA payment model needs an overhaul. “[P]rivate plans in the aggregate have never produced savings for Medicare, due to policies governing payment rates to MA plans that the Commission has found to be deeply flawed.”
- Medicare Advantage has always cost more than traditional Medicare. Overpayments to Medicare Advantage plans, which exceeded **$106 billion between 2010 and 2019**, threaten to contribute to the Medicare trust fund’s insolvency. Overpayments are now projected to exceed **$600 billion between 2023 and 2031**.

REACH threatens health equity and quality of care in traditional Medicare.

- To maximize profits, REACH private equity and insurer entities could implement policies that lead PCPs to delay patient care and refer enrollees to low-cost/low-quality providers.
- Private equity can interfere in the practice of **emergency room** departments, **home health**, **nursing homes** and **for-profit PACE** programs to the detriment of enrollees.
- CMS requirement of health equity plan by REACH entities in 2023, with no specific directives and no health outcome requirements is effectively meaningless.
- CMS additional payments of $30 a month to REACH entities serving underserved communities will benefit REACH entities, but where is evidence it will benefit enrollees?
- **Ropes & Gray**: "[T]he re-designed cap on risk score growth … may impact current DCEs that have particularly high-cost populations. The extent of that impact warrants further financial assessment and review of health equity adjustment opportunities."

REACH eliminates people's choice of government-administered traditional Medicare.

- CMS is involuntarily enrolling people in REACH entities if their PCP is working for the REACH entity, without their permission.
- Enrollees cannot opt out of the program unless they give up their PCP and choose another PCP not in the program.
- REACH entities may get their PCPs to steer patients, through emails, to voluntarily enroll with them. After already attempting to influence patient choice, these emails advise that no one is allowed to influence their choice. This is a clear loophole that should not be allowed. CMS has not confirmed or denied that these emails comply with the REACH agreement that entities cannot influence people's choice.