Rethinking Medicare Advantage, February 15, 2024

David Burda:

Welcome to the 4sight Health Roundup podcast, 4sight Health's podcast series for healthcare revolutionaries, outcomes matter customers count and value rules. Hello again, everyone. This is Dave Burda, news editor at 4sight Health. It is Thursday, February 15th. I will qualify for Medicare a year from this April. Yes, I know it's hard to believe with my youthful voice and appearance, but it's true. It's also true that I will choose traditional Medicare, not a Medicare Advantage plan, assuming traditional Medicare makes it another year. It's strictly part A, part B and part D for me. It's not that I love traditional Medicare or that I love being old enough to sign up, it's that I'm not too fond of Medicare Advantage Plans. Is the bloom off the rose for Medicare Advantage? That's where we're gonna talk about on today's show with Dave Johnson, founder and CEO 4sight Health, and Julie Murchinson, partner at Transformation Capital. Hi Dave. Hi, Julie. How are you guys doing this morning, Dave?

David W. Johnson:

Well, the Super Bowl is over hail to the conquering chiefs. Pitchers and catchers report this week for spring training, and that's where my attention's focused on baseball means spring. And that makes me very happy.

Burda:

Yeah, you're a big baseball fan. Thanks, Dave. Julie, how are you?

Julie Murchinson:

Well, my household is definitely still licking its wounds from the Super Bowl, so I can't say that it's great, but you know, I enjoyed the Taylor [Swift] and Travis [Kelce] coverage. That was fun.

Burda:

<Laugh>, if your team loses, it only makes you stronger. That's what I, I say to myself,

Murchinson:

<laugh>, tell yourself?

Burda:

<Laugh>. Now before we talk about all the stuff that's happening with or more

appropriately to Medicare Advantage, let's talk about President's Day, which is coming up on Monday. Dave, are you taking the day off or are you working

Johnson:

<Laugh> 16 tons. And what do you get? <Laugh> another day? Older and deeper and Debt St. Peter, don't you call me? 'cause I can't go. I owe my soul to the company store. Well, I owe my soul to getting

the final draft of gradually and then suddenly done. So I'll definitely be working Monday, probably Saturday and Sunday too.

Burda:

Yeah, I could have answered that question for you. <Laugh>. Julie, how are you sleeping in or getting up early? I think I know the answer to this one too.

Murchinson:

Yeah, Transformation Capital does recognize President's Day, so that's great. But, you know, the working mom's job is never done, So be getting up early.

Burda:

<Laugh>, I hear you. Yeah, I'll be working too with two kids at a school in the third away at college. I'm out three excuses to take the day off. Plus I'm sure my wife doesn't want me underfoot, so I'll be exactly where I am right at this moment. Working. Okay. Let's talk about Medicare Advantage certainly been in the news a lot these past few weeks. Let me run down a few of the big events and then I'm gonna ask you what they mean for the market. In January, Cigna agreed to sell its Medicare Advantage business to HCSC, the big blues parent for more than $3 billion. And the same day in January, CMS proposed a slight cut to the base rate paid to Medicare Advantage Plans for 2025. That would be before CMS adjusts the rate for enrollee risk. Earlier this month, Cano Health, a primary care provider filed for bankruptcy. Its main line of business, was Medicare Advantage. Also, earlier this month, CMS sent a memo to Medicare Advantage plans, telling them that they can't use algorithms or artificial intelligence to make enrolling coverage determinations. You have a reported rash of hospitals and health systems terminating their payer contracts with Medicare Advantage plans, and I just read before we and on this morning that private equity investment in Medicare Advantage plans is dropping. Dave, as Vince Lombardi said, what the hell's going on out there? What do you think of the slight pay cut in the contract terminations, and what is the market saying?

Johnson:

I'll start with your last question first. What's the market saying? Two things you can run but you cannot hide. And secondly, accountability is a bitch. You know, David Kani, the Cigna CEO, basically said as much at his press conference when they announced the sale of their MA business to HCSC when he said the business wasn't worth the money they needed to invest to maintain it. Honestly, the writing has been on the wall with MA for quite a while. Two events sort of a year and a half ago were the early indicators. The first was the two part series by Don Berwick and Rick Gellan in Health Affairs, where they basically said payers were ripping off the government on Medicare Advantage gaming the risk factors, risk adjustment factors for their own benefit. And then the second was, and I think this is a real telling indicator partly of what's going on now was the was the battle between Mayo Clinic and United when Mayo announced that they would no longer provide care other than emergency care to out of network, United Healthcare Group MA members. And there are a lot of 'em, and I don't know if you remember that, but it settled pretty quickly. I don't think United thought Mayo would cancel the contract. And they came back to the table pretty quickly. So this fault line between private administration of government funded benefits is there, and it's real, and it's starting to manifest it itself in the marketplace today.

Stepping back and I'll get your your question about what do I think about the government's payment adjustment? You know, Dave, you and I are real fans of Mad Magazine: Jaffe, Alfred E Newman you know, that old cartoon, you know what me worry, right? I <laugh> I think you know, snappy answers the stupid questions, a a anyway, I think part of what's going on here you know, the payers and providers are basically doing a version of Alfred E Newman, what me take risk? <Laugh>, they, you know, in the aggregates, not everybody, but in the aggregate, they treat patient risk, and the care management it acquire requires like a hot potato. Nobody wants to hold it. And you know, like you just said, I think the ma with the MA plans, the bloom is off the rose a bit. And, you know, no amount of marketing glitz can make up for a bad product. And so much of what drove MA sales were adding these incremental benefits with virtually no cost. Meanwhile, you know, they're making it all up on the risk adjustment factors. And that's, people are starting to see through that the providers are back in the game and have figured out, I think, how to force the payer's hands. Meanwhile, the government is tightening up rates as they should do. But all this begs the question of when is this country and its healthcare system actually gonna step up to the challenge of managing care for distinct populations? We talk about it all the time. Reminds me when I was in the Peace Corps volunteer in Africa, and I'd never heard so much talk about corruption and what to do about it and seen it so widely practiced. And we say we talk about value all the time, and yet so few really practice it. If payers and providers don't proactively embrace active care management and value-based delivery as I said, right at the top, you can run, but you cannot hide. And accountability is a bitch. And that's where we are right now. And it's showing itself in, in all this market activity related to Medicare Advantage.

Burda:

Wow. Thanks, Dave. You know, I'd love Jaffe's Snappy Answers to Stupid Questions. And the more I think about it that could describe what we do every week on this podcast, <laugh>,

Johnson:

We are snappy. We are definitely snappy.

Burda:

You're snappy, and I ask stupid questions,

Johnson:

And I'm snippy today. I'd say I'm snippy today too.

Burda:

I can tell Julie, be careful. Any questions for Dave?

Murchinson:

Dave, great observations. You know, what, everything that I have read and heard people talking about with these contract cancellations, it just feels to me like there's pain to be spread all around. Who do

you think gets hurt the most? Is it the health system long term, short term, long term, the health plan or the member?

Johnson:

at least in the short run per usual, the consumers are gonna be the ones that are probably hurt the most. Dave said it at the top of the broadcast where maybe a few years ago he would've thought about MA, but he's not going that direction now. And so I think consumers are gonna see the benefits cut probably, you know, the natural creep in in copays and deductibles, the way that happens up until we get companies that really partner with consumers to help them manage their real health and healthcare needs. And we've got some of those, you know, Julie, you're investing in some of these companies, but we need 'em to get bigger and grab a bigger share of the market so that the overall industry embraces these ideas.

Burda:

Got it. Dave, thank you Julie, it's your turn. What do you think of the Keano Health bankruptcy and CM S'S AI directive? What do they tell us about what's happening in the market?

Murchinson:

Well, I'm gonna take us down a little historical path, but if you wanna understand Cano health, you have to start with Leon Medical Centers. Leon was founded in 1996 in Miami, Florida. Like our friends at Cano, they provided primary care services, medical centers transportation, med management, and they did exceedingly well for years and made a lot of money in that business. They frankly did a lot of good for seniors in South Florida. I view Cano, which was, by the way, founded in 2009. By the way, ChenMed also located in Miami, right? A lot of juju here, but I think Cano is providing similar services plus NMA plan, and I look at it as kind of a lookalike, frankly, to Leon Medical Centers. And Cano quickly became a high flyer because of the MA component of what it was doing. And, you know, that caused it to be almost unicorn status that used that spac. Remember we talked about the SPACs to go public, right? Right. And it should have been able to make plenty of money just like Leon medical center, but the, the reliance on MA and its plan certainly had an impact. But let's talk about the SPACs. If you remember, the participants themselves that put the SPAC together made a lot of money, and they would often load the companies up with a lot of debt. And it's a very expensive way to go public, as we talked about for a long time. So here's Cano, they go public through a spac, public markets fall apart, and now it's bankrupt. It has more debt. I mean, an obscene amount of debt that it can't service. And let's just look at the stats as of July of last year, of the 860 SPACs that were issued between 20 and 22, 277 or 32% of those have liquidated. Wow. I mean, that's a huge percentage, a double the historical levels before 2020, but that doesn't really matter since SPACs were such a new thing. And separate stat bankruptcies of healthcare companies have been on the rise, as we know, and they hit a five year high last year. So, you know, we're seeing a lot of complement of issues here. So this story about Cano, I don't know, is it a story about MA and its reliance on MA revenue and the MA adjustments? Sure. I'm sure that's part of it. Is it about the fact that they went IPO through a SPAC and its impact on their, you know, their model? Or is it just inefficient operating models, which a lot of people say the founding CEO was not the best operator. So, you know, I don't know this whole, this Cano story can't all be blamed on MA. This AI directive. It annoys me. I'll say that just because CMS included the words algorithms and AI in its directive, and it did that because technology is just moving too fast and you can't put a label on these things at the moment,

right? But the issue here is not whether sexy AI is doing something wrong, it's that we're automating decisions based on, you know, inferior or incomplete data training models. And we don't have the personalized data we need about the patient in question in all of these automated decisions. So if we think about what the word algorithm is, it's nothing more than an automated rule that a person would've had typed up in their how to do my job manual, you know, 15 or 20 years ago, right? These are blunt rules that are becoming more refined and nuanced with how technology is advancing. But look, I mean, co-morbidities create decision complexity in those things. Social determinants may not be fully absorbed into the decision intelligence. So here comes Congress and CMS, I mean, Senator Warren was like way outspoken on this issue. They're forcing insurance companies to prove the reliability on these algorithms and the AI black boxes that they're using in ways that may not be frankly, appropriate for the sophistication of how these technologies are getting to decisions. So I, I get the intent, but we're beginning to see cracks in our, you know, federal leadership's understanding of how these technologies work and how to trust them. So, you know, I frankly think this directive is gonna be the beginning of a much bigger discussion of how data is used in these kinds of decisions.

Burda:

Yeah, blunt force trauma. I, I get it. Thanks, Julie. Dave, any questions for Julie?

Johnson:

Great, great analysis. What, what I didn't hear in your answer, Julie, which is probably what motivated CMS in the directive, is their belief that there's some mal-intent on the part of payers to you know, use AI to increase denials, and again, in a pretty blunt way. So while I absolutely agree that, you know, having complexity in sort of sifting through and deciding what and what not to pay is probably beyond the reach of most models. It'll, they'll keep getting better at it. I do wonder about some level of, of mal-intent, and I probably argue on the other side, the providers are getting good enough at this, that they're playing the game better, which is sort of forcing the the payers to up their game. It's a little like arms control, you know, we need each side to step back from the brink.

Murchinson:

Yeah, I, you know I didn't want my comments to be construed as supporting the payer side necessarily, because I think you're right. And what I see every day in my role is really the fight over data. Like the arms race is the data race, right? And plans have been trying to get enough clinical data for years to do their job better, or well to do their job. And they still don't have enough clinical data. So hence these training models aren't robust enough. So I, you know, I don't disagree with you. I think there's obviously intent to manage the business for <laugh>, for the good of the shareholders, shall we say. But, you know, if providers… I would rather see the federal government recognize what some of the foundational issues are that help create a more fair system because that's really what it should be, you know, trying to help us do. And instead we have senators making statements about things that they don't really understand. That's my point.

Johnson:

Yeah. Yeah. Very fair. Very fair.

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Burda:

Thanks, Julie. And I think we all agree there is turmoil in the Medicare Advantage market, and as a soon to be beneficiary, I am very anti turmoil. So that's, that's my position. <Laugh>

Murchinson:

<Laugh>.

Burda:

Now let's talk about other big news that happened this past week. Julie, what else happened that we should know about

Murchinson:

Well, at the very end of last week we saw Walgreens go through a pretty major shakeup or kind of you know, resorting the decks a bit. They tapped former CVS strategy lead and Solara Health Executive Mary Langowski, who I know and love, and thinks she could do an incredible job helping Tim Wentworth really refocus what Walgreens is doing in healthcare. So, congrats, Mary.

Burda:

That's a good move for Walgreens. That's great. Dave, what other big healthcare news made your lineup this week?

Johnson:

For me, the, the big news really relates to my work with the HFMA. I'm chairing the Healthy Futures Task Force, and we are officially kicking off this week our first working group meeting, and we're setting ourselves up to try to solve what I'm calling the reverse tragedy of the commons and healthcare, which is our public good is investing in health. So primary care, integrated behavioral health prevention, health promotion, all those good things, chronic disease management. And yet nobody does it because the payment models don't work. So we asked 18 people to be part of the advisory board in some capacity or another, internal and external. Nobody said no, I'm not sure there's more important work than getting the payment and metrics right on how we fund and therefore incentivize the provision of health and healthcare services. Our show today was, you know, yet another exploration of the, you know, kind of stupid outcomes that were result from having perverse payment incentives, guiding business decisions. Let's get it right. So anyway, we're gonna try and do our part with the healthy Futures task force. Wish us luck.

Burda:

Alright, good luck. And you get what you pay for even in healthcare, right? All right, thanks Dave. And thanks, Julie. That is all the time we have for today. If you'd like to learn more about the topics we discussed on today's show, please visit our website at 4sighthealth.com. And don't forget to tell a friend

about the 4sight Health Roundup podcast. Subscribe now and don't miss another segment of the best 20 minutes in healthcare. Thanks for listening. I'm Dave Burda for 4sight Health.