Background Document on the Direct Contracting Entity program

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I am writing to request that the Vermont Medical Society go on record with a resolution to bolster traditional Medicare and to terminate the Direct Contracting Entity (DCE) program, as well as its recent rebrand as Accountable Care Organization/ Realizing Equity, Achievement, and Community Health (ACO/REACH) programs. This program grafts a new set of financial intermediaries onto traditional Medicare to impose a system of capitation on Medicare beneficiaries who sign up for traditional Medicare. The intermediaries who are implementing this program can be provider organizations (like health systems), primary care practices, clinics, health plans or other health care organizations. In reality, however, the current roster of DCEs—especially the largest—heavily represents managed care/insurance companies and private equity venture capital. [i] Many of the smallest DCEs are medical practices or combinations of practices. Given the relative small number of "covered lives" in such DCEs, the level of insurance risk such practice-based DCEs are taking on is worrisome (See below).

In its October, 2021 publication, "Innovation Center Strategy Refresh", CMS announced its intent to enroll 100% of Medicare fee-for-service enrollees into an "accountability relationship" by 2030.[ii] Enrollment in a Medicare Advantage (MA) plan—Medicare's managed care option-- will "count" as an accountability relationship, whereas enrollment in traditional Medicare with or without a Medicare Supplemental policy will not. It is this latter group that the DCE program is targeting.

Background

In this document, I define a managed care company as a private insurer that is intruding into medical care, questioning physician orders, requiring pre-authorization, and denying payment for care it deems to be unnecessary. I argue that the 35-year history of managed care in the United States has been a failure:

- Managed care is unpopular. Restrictive provider panels, denials of care, and hassle to physicians and other health workers have given it a distinctly unfavorable image to both the public and the providers of care. This has prompted frequent depictions in popular movies, some of which prompted spontaneous audience applause.[iii]
- Managed care is a key element of a system that has failed the public health, with the US lagging ever further behind the other wealthy nations in life expectancy, maternal and infant mortality, a higher level of mortality amenable to medical treatment[iv], and more recently, an ineffective response to the COVID pandemic.
- The most glaring failure of the managed care system is its dismal failure to control health costs. In 1980, health costs in the US were already higher than in any other developed nation. Since the managed care model took hold in the 1980s, the discrepancy in health cost inflation between the US and other developed nations has

widened ever further, making the US the ultra-expensive outlier, spending double the OECD average per capita.[v]

The Direct Contracting Entity (DCE) program was established in January, 2019 with the stated goal of creating an “accountability relationship” in fee-for-service (“traditional”) Medicare. In the model, DCEs recruit primary care providers to be part of their systems. While in theory, DCEs could be any private sector entity—for-profit or not-for-profit, the 99 organizations constituting the currently certified DCEs are largely for-profit insurers and private equity venture capital funded firms, which constitute virtually all the larger DCEs.

Medicare provides a monthly payment to DCEs based on the risk profiles of all of the DCE physician’s traditional Medicare patients using the same diagnostic coding system used for the Medicare Advantage program, the “Hierarchical Condition Category Coding” (HCCC). Since patients frequently switch primary care providers, or don’t have one, Medicare selects not the most recent primary care provider the patient has seen, but instead the PCP with whom the patient has had the most visits with in the previous two years. This has led to the “mis-alignment” of a substantial percentage of patients. Depending on the particularities of the contract they’ve signed, they may be paid in partial or full capitation, but additional types of payments may also occur: For example, physicians who sign up with the Clover DCE are given an extra payment each time they use the “Clover Assistant” (requiring approximately 5 minutes), Clover’s software that provides decision support and optimizes (= maximizes) the value of each patient’s diagnostic codes.

There is no available research demonstrating that DCEs save money for the Medicare program. Medicare regards the structure of ACOs and DCEs to be similar enough to extrapolate. And despite CMMI and the National Association of ACOs confidently stating that ACOs have demonstrated savings[vi], the actual research is fraught with a variety of biases, especially participation bias, and dubious selection of comparison groups. And even these studies reveal very mixed results [vii]

While provider capitation is optional in Medicare Advantage, and is not generally used, the DCE model requires the use of capitated payments. The model offers two types: primary care capitation and total cost of care capitation.

In both models, Medicare Part A and B expenditures for the DCE’s aligned beneficiaries will be compared to the DCE’s benchmark to determine savings or losses. CMS will make a per-beneficiary-per-month payment to the DCE based on whether that DCE’s medical costs amount to more or less than the benchmark amount given the HCCC risk scores their submitted codes amount to. The DCE will in turn pay its contracted physicians and other providers using the payment scheme arrived at in the contract between the two parties based on their patients’ utilization pattern. It seems likely that this contract will have been formulated by the DCE, and not by its participating physicians.

For patients who are participating in these capitated systems, providers will still submit claims to CMS. However, CMS will zero out claims for these capitated services, and will not make fee-for-service payments to the physician for these claims. If the provider is also providing non-

capitated services (e.g. repair of a laceration), fee-for-service payments will be made, although this will be factored into DCE payments for physicians who are participating in the total cost of care capitation arrangement. Obviously, this is adding to administrative complexity in provider offices

While Medicare Advantage providers are required to maintain administrative expenses under 20% of total revenue, DCEs are allowed to retain as much as 40% of their capitated payments.

Under the ACO/REACH rebrand of the DCE program, DCEs will receive bonuses based on their number of minority enrollees. The quality of care provided specifically to this group will not affect CMS payment to DCEs.

CMS' outreach about the DCE program has been largely confined to policy researchers and insurance companies.

Congress has had no role in the establishment of the DCE program, and a team of physicians that met with four Congressional Representatives found that none of the four had heard of the program prior to this outreach.[viii]

Also based on personal interactions, I have found that the majority of physicians with whom I have spoken haven't heard of the program, and those who have are quite unclear about how DCEs operate. Furthermore, after reviewing the websites of the American Medical Association, the American College of Surgeons, the American Academy of Family Physicians, and the American College of Physicians, we can find no evidence that the DCE concept was developed or promoted by any of these organizations, and we've encountered no evidence that any other organization of practicing physicians was involved in the conceptualization and development of the program. Instead, these organizations' statements about the DCE program have been reactive. [ix] [x]

Critique of the DCE program:

To avoid the high out-of-pocket costs patients opting for traditional Medicare face—which average over $3000 annually[xi] and have no annual cap, the vast majority of patients elect to purchase Medicare supplemental insurance policies. Combined with the cost of one of the less expensive Part D drug costs, this will amount to approximately $2250 annually (2021 costs). It is unacceptable to impose a managed care arrangement onto patients who are spending over $2000 annually specifically to avoid managed care. Adding onto the travesty is that patients would be quite unlikely to learn of the DCE relationship prior to signing up with a particular primary care physician unless they specifically asked.

And patients are unlikely to ask, since the general public has been largely excluded from the creation and evolution of the program, as CMS has not sought media attention concerning the DCE program.

Furthermore, the only way patients can exit a DCE their primary care physician signs up for is to switch primary care provider. Given the shortage of primary care primary care providers

nationally, this is easier said than done. Furthermore, we should not be creating a health care system in which patients may wish or need to change primary care provider for administrative reasons. Changing physicians is simply not the same as switching brands of toothpaste.

Since physicians' compensation would be heavily determined by the composition of their practice, it is problematic that a high percentage of patients assigned to participating physicians don't actually regard that physician as their PCP or visit that physician. In this common circumstance, the physician will have no role whatever in determining such patients' health care utilization.

No other developed nation has resorted to converting their providers into mini-insurance companies, who lose money if their patients prove to be more ill than their associated diagnostic codes allow for. Given the proficiency of the DCE and MA sectors at upcoding patients who are not especially ill or complex, physicians are then put in a position in which they have a potentially potent incentive to avoid caring for patients who actually are very ill, complex, and time consuming to care for. So in spite of Medicare's risk adjustment effort, physicians paid under capitation will continue to fare best if they enroll large numbers of patients who aren't terribly ill, which would may have the effect of crowding out patients who require frequent visits and referrals.

And despite not resorting to these disturbing arrangements, the per capita health care spending among the other nations is half of what the US spends. This is likely because the number of procedures performed is not terribly higher in the US compared to other developed nations. Much more important causal factors leading to unusually high levels of spending in the US are the far higher fees for interventions and procedures, much higher costs for purchased items ranging from pharmaceuticals to joint prostheses, and vastly higher administrative costs than any other developed nation. Ironically, the entire DCE program actually adds to the US's already astronomic level of administrative spending by adding yet another program with particularly high administrative cost superimposed upon (and not replacing) all the rest of the administrative complexity of the US health care system.

When it comes to reducing taxpayer liability, despite CMMI's claim that they can reduce spending with this program, the response of Wall Street and the private equity sector to this new program speaks volumes: These firms are flocking into the program [xii], and have good reason to anticipate that they will profit handsomely. Gilfallan and Berwick characterize this system as a "Medicare Money Machine", operating at the expense of the Medicare Trust Fund.[xiii] The only way this could be otherwise is if the number of medical procedures the doctors stop ordering due to financial disincentives outweighs the profits Wall Street anticipates earning. This seems quite unlikely.

One impetus for the rebranding of the DCE program to ACO/REACH is that it will make extra payments to DCEs based on their ability to recruit more minority patients. Routing taxpayer money through these for-profit entities may be the most expensive way imaginable to reach such populations, and while it may engage them in primary care, access to specialty care may worsen due to the capitation arrangement itself. The entire purpose of the DCE program is to replace the fee-for-service system so that physicians have a financial disincentive to ordering

expensive specialty visits, tests and procedures. But minority populations have a history of underutilization of both primary and specialty care. So imposing disincentives on those providing care to underserved minorities is exactly the wrong reform for these populations.

A much more obvious method to improve minority access to care would be to expand the community health center and FQHC programs, which are specifically tailored to provide community-oriented care to such populations. These community-based programs are among the most cost-effective programs in the entire health sector. Furthermore, the extra payments to DCEs are only paying for enrollment of these populations, not for actually rectifying the disparities in access to health services or health outcomes these populations experience.

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[i] Global and Professional Direct Contracting Model Participant Overview Performance Year 2022—Update Feb 24, 2022. https://innovation.cms.gov/media/document/gpdc-model-participant-summary

[ii] Center for Medicare and Medicaid Services, Center for Medicare & Medicaid Innovation. "Innovation Center Strategy Refresh", October 2021, p. 14

[iii] Pendo, E. Images of Health Insurance in Popular Film: The Dissolving Critique. Spring 2004 37(2):267-314.

[iv] Organisation for Economic Cooperation and Development (OECD), Avoidable Mortality: Eurostat Lists of Preventable and Treatable Causes of Death: pp 1 – 21; Nov, 2019.

[v] Schneider EC, Doty MM, Shah,A, Tikkanen R, Fields K, Williams RD Mirror, Mirror 2021 –Reflecting Poorly, Health Care in the US Compared to other High Income Countries. Commonwealth Fund Report, pp 1- 39: August 4, 2021.

[vi] Highlights of the 2020 Medicare Program Results, no author listed. National Association of ACOs

[vii] McWilliams JM, Chen AJ; Understanding the latest ACO "Savings": Curb your enthusiasm and sharpen your pencils – Part 1. Health Affairs Forefront November 12, 2020.

[viii] Personal communication: Ed Weisbart, MD, December 1, 2021.

[ix] American College of Physicians Letter in response to Adam Boehler and Alex Azar RFI on Direct Contracting (DC) Model – Geographic Population-based (PBP) Option. American College of Physicians May 30, 2019.

[x] American Academy of Family Physicians Letter in Response to CMS RFI on Direct Contracting Entity Program. American Academy of Family Physician April 22, 2019

[xi] Kaiser Family Foundation Analysis of 2016 Medicare Current Beneficiary Survey, Center for Medicare and Medicaid Services, 2016.

[xii] King R; CMS Overhauls Direct Contracting Model to include new requirements on governance, health equity in 2023. Fierce Health Care Feb 24, 2022.

[xiii] Gilfillan, R and Berwick,DM; Medicare Advantage, Direct Contracting, and the Medicare 'Money Machine, Part 2: Building on the ACO Model. Health Affairs Blog, September 30, 2021.