Administrator Chiquita Brooks-LaSure
The Centers for Medicare & Medicaid Service
7500 Security Blvd
Baltimore, Maryland

September 2, 2021

Dear Administrator Brooks-LaSure,

Congratulations on your confirmation as the Administrator of the Centers for Medicare and Medicaid Services. We are delighted to see CMS led by an individual with a well-established commitment to improving health care and health care coverage for everyone in America. And, we look forward to a very productive ongoing relationship with you and your team. We write today to urge you to honor people's choice of traditional Medicare and half or significantly limit the Trump Administration's Global Professional Direct Contracting (GPDC) experiment; we applaud the decision to halt the Geo Model.

We are deeply concerned that the GPDC experiment could lead CMS to auto-assign as many as 31 million people involuntarily in a Medicare-Advantage-type health plan that they specifically opted not to join when they signed up for traditional Medicare. For this reason, CMS should eliminate the six Insurer DCEs, controlled by insurers operating Medicare Advantage plans, and the 22 other Investor DCEs--for-profit non-provider entities--from the experiment. Further, we ask that the experiment go forward only with DCEs that are at least 75% provider-controlled, in keeping with the Accountable Care Organization (ACO) requirement.

The Insurer and Investor-driven DCEs present real threats to people with traditional Medicare and to the Medicare program. With Insurer and Investor DCEs in the program, maximizing revenues, not quality of care become the central focus. Vulnerable older adults are likely to face administrative barriers to care, restricted provider choice and inappropriate delays and denials of care. The GPDC model also is likely to undermine traditional Medicare's transparency, public accountability, and cost-effectiveness.

People who enroll in traditional Medicare do not want insurers and other for-profit middlemen managing their care or coming between them and their doctors, as they do in Medicare Advantage. The first priority for Investor DCEs, which are looking to be acquired by large insurers, and Insurer DCEs, is not patient health and well-being. The OIG has found **widespread inappropriate and delays and denials** of care and coverage in Medicare Advantage. Another **NBER study** found high mortality rates in some Medicare Advantage plans.

The Commonwealth Fund identified serious issues with the GEO DCE model that are at play in the GPDC model. It could exacerbate health and racial inequities. Without claims or encounter data, CMS will not have the tools to ensure that people assigned to DCEs receive appropriate care. CMS will be hard-pressed to detect fraud, inappropriate care and bad practices or evaluate quality of care. CMS has fewer tools at its disposal to evaluate quality of care than MedPAC, which has never been able to evaluate **quality of care in Medicare Advantage**.

Because of deep concerns about the risk the GPDC model presents to people with Medicare, US House Representatives, Mark Pocan, Lloyd Doggett, Katie Porter and Bill Pascrell sent CMS a **letter** on May 13, 2020 asking CMS to freeze the program.

Medicare Advantage should be the venue for all CMMI experiments that involve for-profit entities. Testing new MA models designed to rein in MA spending within MA could help bring down MA spending. Testing GPDC through traditional Medicare is likely only to drive up costs in traditional Medicare; Medicare Advantage has driven up Medicare spending by at least $143 billion in the last 12 years alone, along with costs for people with Medicare and taxpayers.

The Trump Administration created the DC model to shift all Medicare spending to private entities, likely driving up Medicare spending and effectively eliminating people's choice of traditional Medicare. Traditional Medicare has always been **more cost-effective than Medicare Advantage**. It also provides critical data on our health care system unavailable from MA plans and other corporate insurers.

In summary, we urge CMS to halt models involving insurers and investors in traditional Medicare. CMS should not test models in traditional Medicare that include intermediaries and complicate healthcare financing.

The appended materials provide a more detailed basis for these concerns.

With regard to the GPDC model, we recommend that CMS:

- Eliminate all Insurer DCEs and Investor DCEs from the GPDC model; if desired, test these private care models in Medicare Advantage, the private side of the Medicare program.

If CMS chooses to continue the GPDC model in traditional Medicare with Insurer and/or Investor DCEs, it should:

- End auto-assignments into Insurer and Investor DCEs
- Eliminate all DCEs from the GPDC model unless they are at least 75% provider-governed as per the existing ACO requirement
- Clarify that if a provider-controlled DCE is acquired by a non-provider-controlled entity it will lose its DCE contract
- Limit the size of DCEs to no more than 50,000 members each and do not allow DCEs to grow their provider networks
- Limit total additional DCE members to 350,000 for 2022

We further urge that CMS not permit under any circumstances:

- DCE risk-score gaming
- DCEs to profit from channeling members into MA Plans
    - Prohibit direct marketing to DC aligned members with elimination from the program as a penalty for violations
    - Make risk score of any DCE member converted to an MA plan .9 in perpetuity

Sincerely,

Diane Archer, Founder, Just Care
Alex Lawson, Executive Director, Social Security Works
Wendell Potter, Executive Director, Center for Health and Democracy
Julia Santos, Health Policy Manager, Indivisible
Jennifer Flynn Walker, Senior Director of Mobilization and Advocacy, Center for Popular Democracy
Robert Weissman, President, Public Citizen

Appendix

Concern 1: Insurer DCEs

Unless CMS ends insurer DCEs, more than 20 million individuals who chose not to enroll in MA could be automatically put into an Medicare Advabtage-like healthcare plan: Insurer DCEs are very similar to MA plans. As in Medicare Advantage:

- They have the option to receive full capitation from CMS.
- They will have the opportunity to engage in inappropriate claims denials.
- They will have a defined network.
- They will create incentives for people to be steered into these networks.
- They will have an opportunity to benefit from Risk Coding, albeit more limited than they do in MA.
- While not established yet, they could in the future create requirements for network providers to pre-certify services
- They have the opportunity to offer additional benefits.
- People will have the opportunity to go outside the DCE network – as they do in MA PPO and PFFS programs, but it is not clear whether they will know, whether providers will see them or whether they will face financial barriers. Some providers will be paid by CMS, others by the DCE. This potential confusion could be worse than in MA, where the MA plan pays all bills.

We believe that vulnerable older adults and people with disabilities who chose not to enroll in MA coverage should not be automatically assigned into an MA-managed care environment and left to their own devices to find their way through it. Many people will not even know the significance of being enrolled in a DCE. They may not be aware of the claims activity, referral activity or network direction going on behind the scenes. They most likely will not be aware of the impact these activities could have on their health and healthcare. Many who are concerned may not opt out for fear of angering their physician, or because they may not know the ramifications of raising their concerns. Many others will simply not understand whatever communications are provided and not realize they have the option to opt out or seek care from other providers.

Unless CMS ends insurer DCEs, they are likely to increase CMS costs without demonstrating improvement in quality:

For over 35 years, privatized Medicare has cost CMS more, not less. Whatever efficiencies MA plans have created (a significant part of which result from denying/downgrading claims) have never translated into lower costs for CMS. Plans have consistently found ways to cherry pick different aspects of the program to get more revenue than is justified by the population's risk. Most recently Plans have manipulated the CMS 5 Star quality rating system and the HCC Risk Score adjustment systems to accomplish this. We cannot foresee all the mechanisms they will find or create to get overpaid in DC. The one thing that history has shown is that they will find a way.

Some Insurer DCEs are acting as if they will have similar Risk Score Gaming (RSG) opportunities in DC. CMS has reduced the opportunity for profiting from inflated risk scores in the DC program vs. MA. However, they still have several opportunities:

1. Insurer DCEs will benefit from driving their risk scores up to the maximum 3% cap. In doing so. they are likely to drive an overall high Coding Intensity Factor that will be used to adjust all DCEs' Risk

Scores. Less aggressive DCEs could end up seeing benchmarks up to 6% less than those of the Insurer DCEs as a result.
2. Some insurer DCEs have members with Medicare Supplemental coverage that would be eligible to enroll in their DCEs. These plans could potentially benefit by increasing the risk scores of these members before they enroll in the DCE. This is the approach taken today with 64-year old individuals when insurers and providers attempt to increase risk scores prior to their enrollment in Medicare.
3. It is unclear how CMS will include risk scores for voluntarily enrolled individuals in their first year.

As in MA, Insurer DCEs will be paying claims and will have their own arrangements with providers. Given the experience CMS has had trying to get complete and accurate encounter data from MA Plans, it seems unlikely that it will have good information on the actual cost of care from Insurer DCEs in the near future. **This experiment with Insurer DCEs has little chance of a meaningful evaluation based on the actual cost of delivering care.**

MedPac continues to say it cannot comment on the quality of care provided in MA Plans. After 35 years, CMS still does not have a solid methodology for measuring quality in privatized Medicare. How could CMS expect to be able to measure it any time soon in these new Insurer DCEs? **This experiment with Insurer DCEs has little chance of a meaningful evaluation based on quality.**

Insurer DCEs could significantly affect coverage choices for people with Medicare:

Insurer DCEs will be allowed to construct benefit differentials that could lead people to believe they do not need their supplemental coverage. Medicare Advantage plans offer supplemental benefits, such as dental and hearing, which often come with such high out-of-pocket cost that they are of little benefit to most enrollees. It is not clear whether Insurer DCEs will be able to offer similar benefits. There is concern that beneficiaries could decide to drop their supplemental coverage, which they would unable to get back in many states.

CMS says it will undertake significant auditing of DCEs. But CMS **audits of MA Plans are delayed for years** because of inadequate resources. It is hard to imagine CMS will have sufficient resources to audit these additional Insurer DCEs.

For all these reasons we believe that Insurer DCEs will either find ways to game the Direct Contracting model to make their profit targets. Or, they will simply use DC as a marketing vehicle to move people into their MA Plans. Either way they will cost CMS more, not less.
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Concern 2: The GPDC model should not be investor-driven

The ability of Medicare Advantage plans to increase risk scores has driven a dramatic influx of private investor funding into the MA space over the past several years. The introduction of Direct Contracting has poured fuel on the fire. And no one is expecting it to result in lower costs for CMS. Many of these investors are short-term investors that intend to benefit from the rapid increase in revenue driven by the DC capitation and acquisitions by insurers. Ultimate success in delivering better health and lower costs will be of no interest to these investors. They will focus on driving revenue higher and then exiting the market.

We have seen this type of rapid, short term investment in PCP Practices and MSOs before. In the 1990's, for-profit, start-up Physician Practice Management Companies (PPMCs) similarly rolled up physician practices and signed capitated contracts with insurers, many of them focused on the privatized Medicare+Choice plans of that era. The most prominent of these companies were FPA, MedPartners, NAMM and PhyCor. After a quick runup in stock price, and hefty returns for the initial investors, each of these went bankrupt, leaving patients, providers, employers and insurers to deal with the unpaid bills. Some of the same individuals involved in those firms are active in the MA Risk-Score gaming industry today.

In the original ACO regulations CMS explicitly required ACOs to be 75% provider/supplier governed to avoid a recurrence of this experience; to keep traditional Medicare administratively simple and cost-effective; to ensure accountability for better care at lower costs from the providers delivering care; and to avoid some of the perceived negative aspects of for-profit managed care.

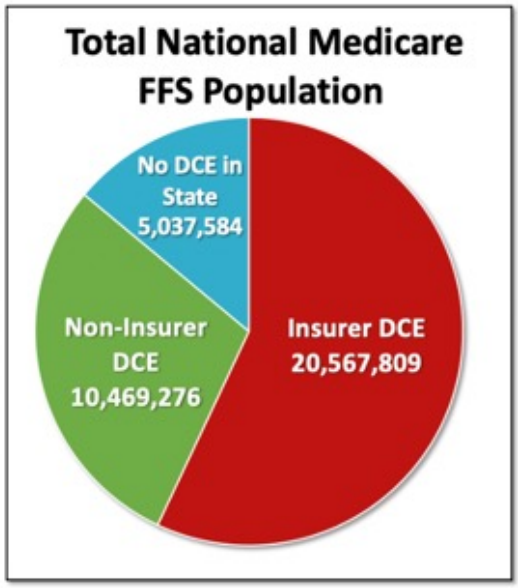
CMS, during the Trump Administration, eliminated the 75% governance requirement in the Direct Contracting Model, decreasing the requirement to 25%. As a result, in the first phase of the Direct Contracting model, CMS has contracted with the very MA insurers, and for-profit MA PCP-MSOs, most active in pulling more and more money out of the Trust Fund. While it is difficult to identify the owners of every DCE, it appears that investor-owned DCEs are almost 60% (32 of 53) of all DCEs and cover all of the 39 states in the Program. We do not know how many insurer and non-provider-governed DCEs are in the January 2022 deferred DCE group. In effect, the GPDC model replaces provider control with Wall Street control over the health care of millions of people with Medicare.

It's no secret that Wall Street entities are first and foremost in the business of profit-taking. The current wild investing shows that they see MA and now the GPDC model as a huge business opportunity. If they can't profit to the extent they believe they can from this model, they will use their marketing power to move the millions of people CMS auto-assigns to them into Medicare Advantage plans, where they are already profiting wildly through risk-adjustment gaming, at significant cost to taxpayers, people with Medicare and the Medicare Trust Fund. The one lesson we have from the last experience with PCP investor speculation was that if the investors cannot make money, they will simply declare bankruptcy and leave the mess for others to clean up.

The 75% provider-control rule clearly had meaningful effect in the ACO movement of ensuring provider control while at the same time generating reasonable investor interest in ACO-enabling organizations like Caravan, Aledade and Evolent Health.

The six Insurer Direct Contracting Entitities are operating in 19 states with

57% of the Entire National FFS Population



Insurer DCEs	
AZ	754,117
CA	3,532,451
DC	71,055
FL	2,313,674
GA	946,742
KS	414,059
LA	480,173
MO	704,258
NJ	1,071,026
NY	2,006,816
NV	312,285
NC	1,143,268
PA	1,494,508
RI	124,561
SC	719,660
TX	2,354,202
VT	153,228
VA	1,111,201
WA	860,525
Total: 20,567,809	

Non-Insurer DCEs	
AL	531,746
AK	101,577
AR	430,100
CT	362,521
DE	168,820
HI	143,741
IN	772,184
IA	475,291
MA	1,004,742
MD	895,195
ME	186,784
MI	1,062,400
MN	564,090
MS	435,301
OH	1,297,864
NH	233,000
NE	276,548
NM	253,073
PR	155,185
OR	455,753
WI	663,361
Total: 10,469,276	

No DCE in State	
CO	518,737
ID	212,815
IL	1,583,027
KY	542,181
MT	186,226
ND	127,656
OK	525,656
SD	162,026
TN	757,675
UT	239,612
WV	71,512
WY	110,461
Total: 5,037,584	

Medicare FFS enrollment data as of 4/21/2021

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