PHYSICIANS FOR A NATIONAL HEALTH PROGRAM

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Medicare Direct Contracting: A Threat to Seniors and to Medicare's Future

Testimony before the:
Senate Finance Committee Subcommittee on
Fiscal Responsibility and Economic Growth

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President
Physicians for a National Health Program
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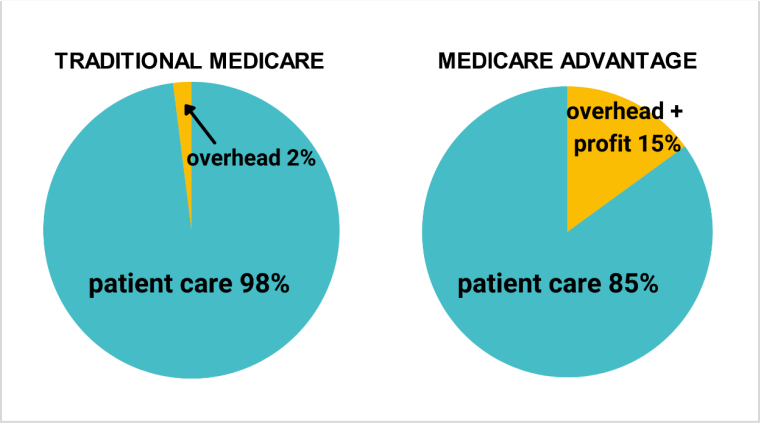
Part 1: The first phase of of Medicare privatization — Medicare Advantage

To understand how Direct Contracting works and why it threatens Medicare's future, it's important to understand the first wave of Traditional Medicare privatization through Medicare Advantage.

Traditional Medicare (TM) reimburses providers directly at a set rate for services provided to beneficiaries (fee-for-service); beneficiaries have free choice of any doctor or hospital. Because of TM's simplicity, the program spends 98% of its funds on patient care, with only 2% spent on administration.



In contrast, **Medicare Advantage (MA)** is a version of Medicare run mainly by commercial insurers for profit. MA insurers act as middlemen between Medicare and providers: Medicare pays MA insurers via "capitation," a lump sum payment per enrollee per month. MA insurers then pay providers a fee-for-service for enrollees' care, and keep what they don't spend on care as overhead and profit. Medicare requires MA insurers to spend 85%[1] of their revenues on care (called a "medical loss ratio"), keeping the other 15% as overhead and profit. **Because of MA insurers' profit and administrative waste, taxpayers spend $321[2] more per year to cover a senior through an MA plan compared to TM.**

Medicare Advantage is a highly profitable segment for commercial insurers. Gross margins for Medicare Advantage plans averaged $1,608[3] per enrollee per year between 2016 and 2018, nearly double the average gross margins for individual and group market plans.

Medicare Advantage insurers maintain these high profits in two ways: 1) maximizing the payments they receive from Medicare, and 2) minimizing what they spend on patient care.

First, MA insurers maximize payments from Medicare by making their enrollees appear sicker than they really are. Medicare's capitation payments to MA insurers are based on each enrollee's "risk score" — the sicker the enrollee, the higher the score and the payment. However, MA insurers engage in a kind of fraud called "upcoding[4]," exaggerating[5] and even fabricating diagnoses to inflate enrollees' risk

[1] https://www.kff.org/private-insurance/issue-brief/health-insurer-financial-performance-through-september-2020/
[2] https://www.kff.org/medicare/press-release/payments-to-medicare-advantage-plans-boosted-medicare-spending-by-7-billion-in-2019
[3] https://www.kff.org/report-section/financial-performance-of-medicare-advantage-individual-and-group-health-insurance-markets-issue-brief/
[4] https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2016.0768
[5] https://pubmed.ncbi.nlm.nih.gov/32925467/

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scores. Insurers use sophisticated AI software to scan patient records for upcoding opportunities, pay[6] doctors to document additional diagnoses, and even send insurer-employed nurses to seniors' homes[7] to upcode. Some MA insurers now buy provider practices[8] outright, allowing them to control the diagnostic coding process.

Note that risk scores and capitation payments do not account for the actual care provided to the patient, only the number and severity of diagnoses in a patient's record.

Example of patient record, before upcoding

Condition	SCORE
Baseline for Age: 76 yo female	.45
Obesity	0
Type 2 Diabetes	.104
Major Depression	0
Congestive Heart Failure	.323
Asthma	0
Ulcer (unspecified)	0
Cong. Heart Failure*DM	.154
TOTAL RISK SCORE	**1.03**
Payment to MA insurer	**$9,000**

Example of patient record, after upcoding

Condition	SCORE
Baseline for Age: 76 yo female	.45
Morbid Obesity	.273
Type 2 Diabetes **w/ retinopathy**	.318
Major Depression, **single ep, mild**	.395
Congestive Heart Failure, **Class 3**	.323
COPD	.328
Ulcer, **Stage 3**	1.204
Cong. Heart Failure*DM, **COPD**	.154, .19
TOTAL RISK SCORE	**3.63**
Payment to MA insurer	**$32,000**

Fraudulent upcoding caused risk scores of patients in MA plans to be 19% higher[9] compared to those in TM; as a result of upcoding, researchers estimate that **Medicare overpaid MA insurers by more than $106 billion**[10] from 2010 through 2019.

Next, MA insurers retain revenues by avoiding payment for costly care. First, MA insurers aggressively market their plans to healthier (i.e., less costly) seniors with perks like gym memberships that would not benefit older or sicker beneficiaries, often called "cherry picking" enrollees. Then, MA insurers reduce medical expenses by restricting patients to narrow networks of specialists, imposing thousands of dollars in hidden fees for costly care like chemotherapy, and limiting care through pre-authorizations and denials. These barriers to care often force beneficiaries to switch from MA plans back to TM when they require costly or complex care. This type of "lemon dropping" causes a large percentage of dying patients to switch from MA to TM in their last year of life.

[6] http://medpac.gov/docs/default-source/reports/mar21_medpac_report_to_the_congress_sec.pdf#page=410
[7] http://medpac.gov/docs/default-source/reports/mar21_medpac_report_to_the_congress_sec.pdf#page=410
[8] https://www.healthaffairs.org/do/10.1377/hblog20210927.6239/full/
[9] https://www.npr.org/sections/health-shots/2021/11/11/1054281885/medicare-advantage-overcharges-exploding
[10] https://khn.org/news/article/medicare-advantage-overpayments-cost-taxpayers-billions-researcher-says/

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Part 2: The next phase of Medicare privatization — Direct Contracting

A majority[11] of seniors and disabled Americans choose Traditional Medicare (TM) over Medicare Advantage (MA) because they value the free choice of providers and the power to manage their own care. However, under the Medicare Direct Contracting (DC) pilot program, millions of beneficiaries who actively chose TM are being automatically enrolled into third-party Direct Contracting Entities (DCEs) without their full knowledge or consent.

Even though DC represents a radical change to TM, most beneficiaires — and, until recently, most members of Congress — have never heard of the DC program, and for good reason. The program was created by the Center for Medicare and Medicaid Services (CMS) "Innovation Center[12]", which was established by the Affordable Care Act in 2010 to test and implement health payment models *without* Congressional approval.

Direct Contracting business model

The DC pilot program was developed in 2019 during the Trump Administration to further privatize Traditional Medicare using some of the same elements as Medicare Advantage, such as capitation payments, risk scores, and a profit-based incentive model. Instead of paying doctors and hospitals directly for seniors' care, Medicare gives DCE middlemen a monthly capitation payment to cover a defined portion of each beneficiary's medical expenses. DCEs are then allowed to keep what they don't pay for in health services, a dangerous financial incentive to restrict and ration seniors' care.

There are different models of DCEs, but they all assume some level of "risk sharing," meaning they keep as profit some or all of what they don't spend on care, or take as a loss some or all of what they spend beyond the capitation payment. The DC payment model is similar to MA in that it **incentivizes DCEs to both increase capitation payments by "upcoding" diagnoses, and to decrease expenses by spending as little as possible on patient care.**

The opportunity for profit is much higher in the DC program compared to MA, where insurers are required to spend 85% of their revenues on patient care (called a "medical loss ratio"), and are allowed to keep up to 15% of Medicare's payments to them as profit and overhead. However, DCEs don't have such guardrails on health spending. In fact, former CMS officials estimate that **DCEs have an "implicit but irrelevant" medical loss ratio requirement of approximately 60%**[13], meaning they are expected to keep approximately 40% of what Medicare pays them as profit and overhead.

[11] https://www.kff.org/medicare/issue-brief/a-dozen-facts-about-medicare-advantage-in-2020/
[12] https://innovation.cms.gov/
[13] https://www.healthaffairs.org/do/10.1377/hblog20210928.795755/full/

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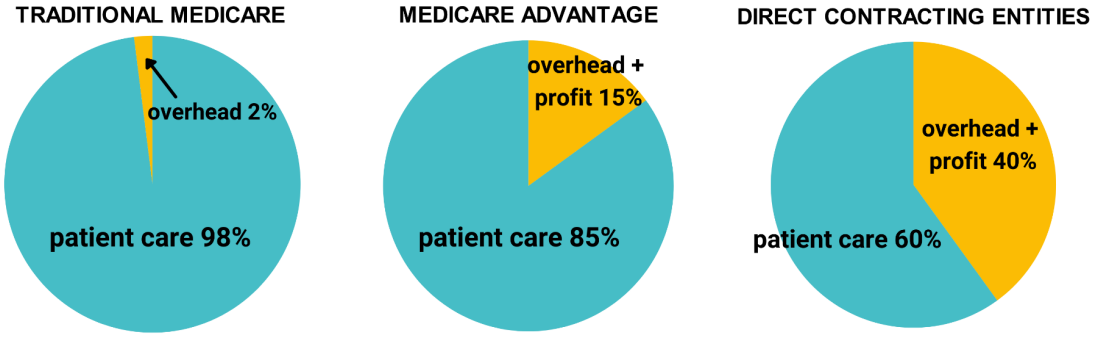

There are three types of DCEs: Geographic (GEOs), Professional Direct Contracting, and Global Direct Contracting.

1. **Geographic DCEs (GEOs)** are the most extreme of the three models, with the potential to fully privatize Traditional Medicare. Under the GEO model, every TM beneficiary living in a number of large geographic regions is *auto-assigned*[14] into a DCE, with no right to opt out. GEO DCEs assume 100% risk (profits and losses) for a beneficiary's medical services. *Under pressure from health care advocates, the GEO pilot was paused by the Biden Administration in early 2021.*
2. **Professional DCEs** assume a 50% risk-sharing arrangement with CMS, and can also participate in "primary care capitation[15]," receiving a monthly payment from CMS for primary care services only, at an amount determined by each enrollee's risk score.
3. **Global DCEs** assume 100% risk via two payment options from CMS: primary care capitation or total care capitation, for all services provided by the DCE and its contracted "preferred" providers.

Virtually any type of company can apply to be a DCE, including commercial insurers, venture capital investors, and even dialysis centers. Applicants are approved[16] by CMS without input from Congress or other elected officials.

At the end of 2021, the pilot involved 53 DCEs[17] in 38 states, D.C., and Puerto Rico, potentially covering 30 million[18] of the 36 million TM beneficiaries. Of the 53 DCEs, 39 are "Global" (100% risk sharing), and 14 are "Professional" (50% risk sharing). A majority of DCEs (28 of 53 total[19]) are controlled by investors — not providers. Of the investor-owned DCEs, six are owned by four different MA insurers, and are approved to operate in 19 states, with potential access to more than 20 million[20] TM beneficiaries.

[14] https://www.healthaffairs.org/do/10.1377/hblog20210928.795755/full/
[15] https://www.aafp.org/about/policies/all/capitation-primary-care.html
[16] https://innovation.cms.gov/media/document/gpdc-model-general-faqs
[17] https://innovation.cms.gov/media/document/gpdc-model-participant-announcement
[18] https://www.healthaffairs.org/do/10.1377/hblog20210928.795755/full/
[19] https://www.healthaffairs.org/do/10.1377/hblog20210928.795755/full/
[20] https://www.healthaffairs.org/do/10.1377/hblog20210928.795755/full/

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Experts predict[21] that MA insurers will dominate the DCE segment, given MA's national network and experience with capitation, risk-sharing, and upcoding schemes.

Impact on patient choice

TM beneficiaries are "aligned" to DCEs in two ways. First, DCEs are allowed to proactively market to seniors, asking TM beneficiaries to voluntarily enroll. More commonly, Medicare will "auto-align" beneficiaries to a DCE based on the beneficiaries' existing relationship with a DCE-affiliated primary care provider. To auto-align beneficiaries, Medicare will annually conduct "prospective alignment[22]," automatically searching two years of each TM beneficiary's claims history — without their knowledge or consent — for any recent encounters with a DCE-affiliated provider. **TM members are allowed to opt out of having their data shared with the DCE (though few, if any, would know of their right to do this), but cannot opt out of being aligned into the DCE.**

If a senior is auto-aligned into a DCE, **their only way to remove themselves from the DCE is to change primary care providers.** Changing primary care providers is a difficult task for most patients, but is especially challenging for medically vulnerable patients and those residing in rural or other underserved areas. In addition, asking seniors to change providers undermines Traditional Medicare's promise of free choice in providers.

Currently, DCE-aligned patients are allowed to get medical care outside of their DCE's network (i.e., from a specialist); those out-of-network providers are then paid directly by Medicare at Medicare-contracted rates, and CMS ultimately reconciles those costs back to the patient's DCE. **Therefore, the DCE has a financial incentive to steer patients to specialist providers within the DCE's network, where the DCE has direct influence over the payment model.**

DCEs are expected to have a big impact on physician practices. Given that alignment into a DCE is determined by a TM member's primary care physician, DCEs are actively recruiting medical groups and physicians into their network. Researchers have documented[23] a quiet explosion of Wall Street investment in primary care practices, which historically produce little or no profit. But investors who understand the DCE model — including the upcoding game perfected by Medicare Advantage — know that **owning a DCE physician practice could result in massive profits over time**. And DCEs owned by commercial insurers may try to move enrollees into their MA plans.

Status of the Direct Contracting pilot program

The DC program officially began on April 1, 2021 and the Global and Professional pilots are scheduled to run for six[24] years. CMS also allowed an additional, previously approved cohort of DCEs to launch in

[21] https://www.healthaffairs.org/do/10.1377/hblog20210928.795755/full/
[22] https://innovation.cms.gov/media/document/dc-financial-op-guide-overview
[23] https://www.healthaffairs.org/do/10.1377/hblog20210927.6239/full/
[24] https://innovation.cms.gov/media/document/gpdc-model-general-faqs

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early 2022. The agency has — for now — paused acceptance of new applicants, but may open it up again for the 2022-23 cohort.

The CMS Innovation Center recently said[25] that, "All Medicare FFS [Traditional Medicare] beneficiaries will be in a care relationship with accountability for quality and total cost of care by 2030," signaling their intention to rapidly expand the DCE program to cover all TM beneficiaries in the next eight years.

Dr. Donald Berwick, a former Administrator of the Centers for Medicare and Medicaid Services, and Dr. Richard Gilfillan, former Deputy Administrator of the Centers for Medicare and Medicaid Services and Director of the Center for Medicare and Medicaid Innovation, together published a pair of articles for the journal *Health Affairs* explaining[26] the dangers of the DC program, prompting a national debate on direct contracting.

In recent months, a grassroots movement[27] of physicians, seniors, and community and health advocacy groups have called for an immediate end to the DC program. Advocates argue that, if left unchecked, DC could essentially privatize Traditional Medicare without the consent of its own enrollees, or even a vote by Congress.

In January, 54 members of Congress sent a letter[28] to Health and Human Services Secretary Xavier Becerra demanding an end to the DC program, stating that, "This model disrupts the sanctity of traditionally public Medicare benefits by giving control of beneficiary care to private interests."

Physicians for a National Health Program welcomes a robust debate not only on Medicare Direct Contracting but on the role of profit-seeking middlemen in any publicly funded health program. Medicare's other privatization project — Medicare Advantage — has demonstrated that injecting a profit motive into patient care doesn't save money or improve care; instead it leads to higher costs for taxpayers and more barriers to care for patients.

Traditional Medicare is our nation's most important and popular health care program; it has proven its value for more than half a century as a lifeline for America's seniors and younger adults living with disabilities. **Medicare is not a playground for Wall Street investors.** Instead of selling it off to the highest bidder through the MA and DC programs, we call on Congress to strengthen Medicare by improving its benefits, eliminating costs for beneficiaries, and expanding it to cover everyone in the U.S.

[25] https://innovation.cms.gov/media/document/cmmi-strategy-webinar-slides
[26] https://www.healthaffairs.org/do/10.1377/hblog20210927.6239/full/
[27] https://pnhp.org/direct-contracting-entities-handing-traditional-medicare-to-wall-street/
[28] https://jayapal.house.gov/wp-content/uploads/2022/01/Medicare-DCE-Letter.pdf