RESOLUTION TO ELIMINATE THE DIRECT CONTRACTING ENTITY (DCE)/ACO-REACH PROGRAMS

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Whereas, the Direct Contracting Entity (DCE) program was established by the Centers for Medicare and Medicaid Services (CMS) in January, 2019 with the stated goal of creating an "accountability relationship" in fee-for-service ("traditional") Medicare;[i] and

Whereas, 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; and

Whereas, 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); and

Whereas, the DCE model requires the use of capitated payments in which 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; and

Whereas, the experience with Medicare Advantage plans and the HCCC model shows that the incentive is for MA plans to "upcode" patients who are not especially ill or complex; and

Whereas with physician payment exclusively via capitation, physicians will have a powerful incentive to forego ordering expensive tests, treatments, and referrals, and generally avoid including patients with complex illness who require a great deal of time and expense into their patient panels; and

Whereas the DCE program includes no plan to compensate physicians who may experience large financial losses if their patient panels incur high health care expenses; and

Whereas, the imposition of capitation onto traditional Medicare in the form of the DCE program, and its implementation by private equity firms and large for-profit insurers, is a drastic change and should have been widely publicized and discussed with physician organizations, public officials, patient advocacy groups, as well as relevant Congressional committees before it was authorized and especially before a decision was made to enroll all traditional Medicare beneficiaries into the program by 2030;[ii] and

Whereas, physician practices are too small to absorb the risk imposed by capitation onto primary care, and the impacts of social determinants of health are far more powerful predictors of health outcomes than the provision of even the highest quality medical care;[iii] [iv] and

Whereas, a high percentage of DCE patients are likely to be "aligned" to the wrong primary care provider, which adds to the unfairness to physicians participating in the DCE; and

Whereas, clinical decision-making about ordering the most expensive tests and treatments is not actually under the control of primary care providers, but rather made by specialists caring for patients with complex illnesses; and

Whereas, imposing the DCE program on traditional Medicare beneficiaries who are paying over $2000 annually for supplemental and prescription coverage demonstrates lack of transparency, accountability and choice for patients; and

Whereas, it is inappropriate to impose a system of care in which the only way to opt out of the managed care/DCE program, with which one's primary care team is contracted, is to change primary care providers, which is often impossible to do; and

Whereas, no other developed country has adopted capitation and managed care to control costs; and

Whereas, the US spends twice per capita on health care compared to the other 24 developed nations, [v] due to high pharmaceutical and medical device costs and high administrative costs in the US, and the DCE program adds yet more administrative costs; and

Whereas, CMS will make extra payments to DCEs based on their ability to recruit more minority patients, not by actually rectifying the disparities in health access, by, for example, expanding the highly effective community health center and FQHC programs; and

Whereas a key goal of capitation is reduce health care utilization, and minority populations underutilize most types of health services including both primary and specialty care, [vi] meaning that the central goal of the change to capitation and creating disincentives to provide care for this population will be especially harmful to these populations; and

Whereas, the Medicare Advantage program is a major factor leading to the depletion of the Medicare Trust Fund, which is taxpayers' money, and the DCE program will likely further deplete the Trust Fund given utilization of the same faulty risk-based coding system;[vii] [viii] therefore be it

RESOLVED, that the Vermont Medical Society will advocate to the Center for Medicare and Medicaid Services and the Vermont Congressional delegation to eliminate the Direct Contracting Entity/ACO-REACH programs and other attempts to impose managed care intermediaries onto traditional Medicare.

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[i] The Direct Contracting Entity (DCE) program, was recently rebranded as the "Accountable Care Organization/ Realizing Equity, Achievement, and Community Health (ACO/REACH)" Program; this resolution will continue to refer to the DCE program as this is the more widely known name. There continues to be publicized critique of the new ACO REACH model; see for example, https://revcycleintelligence.com/news/organizations-urge-cms-hhs-to-terminate-new-aco-reach-model and https://www.fiercehealthcare.com/payers/house-progressive-push-cms-end-newly-rebranded-aco-reach-model

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

[iii] Daniel H, Bornstein SS et al; Addressing Social Determinants to Improve Patient Care and Promote Health Equity: An American College of Physicians Position Paper. Annals of Internal Medicine April 17, 2018

[iv] Clements DS; Social Determinants of Health in Family Medicine Residency Education. The Annals of Family Medicine March 2018 16(2):178

[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] Williams TR, Rucker DR; Understanding and Addressing Racial Disparities in Health Care. Health Care Financ Rev 2000 Summer, 21(4):75 - 90

[vii] Gilfillan, R and Berwick,DM; Medicare Advantage, Direct Contracting, and the Medicare 'Money Machine, Part 2: Building on the ACO Model. Health Affairs Blog, September30, 2021.

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