NRLN
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February 18, 2022

The Honorable Xavier Becerra, Secretary
Department of Health and Human Services
200 Independence Ave SW
Washington, DC 20201

The Honorable Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
7500 Security Blvd
Baltimore, MD 21244

Dear Secretary Becerra and Administrator Brooks-LaSure:

The good work of the Center for Medicare and Medicaid Innovation on Accountable Care Organizations (ACOs) to reduce the cost of healthcare and strengthening original Medicare should not be bastadized by Direct Contracting Entities (DCES) that were ill conceived by President Trump's political appointee.

As a December 13, 2021, op-ed in The Washington Post stated, "corporate interests and private equity investors, are lined up like pigs at the trough to get their hands on taxpayer dollars" through DCEs. Their incentive is the unjustified 40% not spent on medical services they can pocket, not an interest in providing quality healthcare for seniors and reducing costs.

DCEs are the failed Medicare Advantage (MA) plans on steroids. After 35 years and $400 billion in taxpayer rebates paid to healthcare insurers, $41 billion in 2021, rising to $100.8 billion in 2030, MA's 15% overhead has never been cost-effective with original Medicare's 2% Fee-for-Service (FFS) and never will be! There has been very little quality improvement by MA plans and MedPAC calls the 5-star rating plan illegitimate.

ACOs offer the best chance to contain costs, improve quality of patient care and to advance medical solutions. ACOs must be established as authentic non-profit models that reward clinicians, providers and administrators. ACOs must own original Medicare's centralized control of suppliers, including competitive bidding, and payment without artificial barriers or capitation payment obligations. CMS must restore the provider/supplier governance regulation from 25% back to 75%. The ACO model should be the litmus test for private plans.

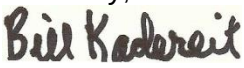
Financial incentives paid to for-profit organizations like insurance companies (MA plans) and corporate and investor-owned organizations (the DCE model) are propped up by taxpayer subsidies. Shared Savings Program (SSP) incentives are needed by ACOs that reward management, clinicians and suppliers for reduction of healthcare costs (measured in dollars/enrollee/service), and that support better quality care and innovation at the patient level.

Today, ACO provider networks are paid original Medicare FFS rates and receive "layered-on" financial incentives. Alternative Payment Models (APMs): Population Based (the current ACO model), Episode-Based and Advance Primary Care are all on trial.

ACOs are the only model that will achieve cost improvement and better care. Other strategies are perversely complex and cost taxpayers and Medicare more per enrollee.

Please contact me if you are interested in learning more about the NRLN's distain for MA and DCEs that is based on considerable research.

Sincerely,



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