



January 17, 2023

The Honorable Xavier Becerra
Secretary
Department of Health and Human Services
200 Independence Ave., S.W.
Washington, D.C. 20201

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

Dear Secretary Becerra and Administrator Brooks-LaSure,

We write to you today to express our concerns about the Centers for Medicare and Medicaid Services (CMS)' ACO REACH program, a rebranding of the Trump administration's Direct Contracting Model. Direct Contracting Entities (DCEs), as they were called under the Trump program, are third-party middlemen approved to manage the care of Traditional Medicare beneficiaries. In November of 2021, we sent a [letter](#) to the Department of Health and Human Services outlining our concerns with the Direct Contracting program, along with a [petition](#) that amassed over 16,000 signatures calling for its end. In February of 2022, we [wrote](#) again, warning against making cosmetic changes to the program that had been suggested by an industry group and would not fix its core issues. Soon after, when the DCE program was rebranded as ACO REACH but kept largely in place, we wrote another [letter](#) with hundreds of other organizations opposing its continuation.

Our views on the program have not changed; we believe it presents a threat to the integrity of Traditional Medicare, and an opportunity for corporations to take money from taxpayers while denying care to beneficiaries. We continue to call for its permanent end. However, we write today not to simply reiterate our opposition to REACH, but to raise serious concerns about the entities being allowed to participate in the program.

As of February 2022, there were 99 DCEs operating in 48 states, D.C., and Puerto Rico, managing nearly [two million](#) Medicare beneficiaries. CMS stated that this group of DCEs would be allowed to continue in the ACO REACH model that will replace Direct Contracting on January 1, 2023, so long as they met the new model's standards for compliance. CMS has provided very little information about the [DCEs](#) aside from their legal names, websites, and states of operation; in many cases the DCE name obscures the ownership, making it difficult for advocates to understand exactly who is behind the entities managing the care of our most vulnerable patients.

PNHP's investigation of a small sample of current DCEs and their parent and affiliated companies uncovered instances of health care fraud — including Medicare fraud — or other malfeasance that should raise alarms for CMS, lawmakers, and the Biden administration at large.

It appears that in its selection process, CMS did not prevent the inclusion of companies with histories of such behavior. Given these findings, we are concerned that CMS is inappropriately allowing these DCEs to continue unimpeded into ACO REACH in 2023.

Twenty-two members of Congress shared our concerns, and asked CMS to remove actors with histories of fraud and abuse from the program, along with clarifying standards for entry.

As we have stated, PNHP believes that the REACH program threatens the integrity of Traditional Medicare and should be permanently ended. Whether or not one agrees with this statement, we should all be able to agree that companies found to have violated the rules have no place managing the care of our Medicare beneficiaries, especially when beneficiaries are being placed into these programs without their full knowledge or consent.

The care of our most vulnerable patients should be the absolute priority of the Biden administration. **We urge you to quickly act on these findings by ending the REACH program or, at a minimum, immediately barring companies that have violated rules designed to protect patients and taxpayers.**

Attached, please find a summary of PNHP's findings.

Sincerely,



Dr. Philip Verhoef
President, Physicians for a National Health Program

Direct Contracting Entities involved in health care fraud or other malfeasance

Parent company: Centene (primarily Medicare Advantage and Medicaid managed care insurer)

DCEs: 1) Complete Health Accountable Care, LLC (AL, FL); 2) Accountable Care Coalition of Direct Contracting, LLC (AR, CA, CT, DE, FL, GA, HI, IA, IL, IN, KS, MA, ME, MI, MS, NC, NH, NJ, NY, OH, PA, RI, SC, TX, VA, WA); 3) Accountable Care Coalition of Southeast Texas, Inc. (TX)

- **Overcharged the VA by nearly \$100 million:** In 2021, Centene subsidiary Health Net agreed to repay the Dept. of Veterans Affairs [\\$97 million](#) for inflated and duplicate claims it billed the agency while acting as a third-party administrator securing private care for veterans.
- **Overcharged state Medicaid plans by hundreds of millions:** Centene has faced a string of investigations stemming from its pharmacy benefit manager subsidiary repeatedly overcharging Medicaid for prescription drugs. The settlements include \$165 million in [Texas](#), \$88 million in [Ohio](#), \$56 million in [Illinois](#), \$55 million in [Mississippi](#), \$27 million in [Kansas](#), \$21 million in [New Hampshire](#), \$19 million in [Washington](#), \$15 million in [Arkansas](#), and \$14 million in [New Mexico](#), with reports of an ongoing investigation in [California](#) as of October 2022.

Parent company: Sutter Health (large California-based health system)

DCE: Sutter Preferred Direct Contracting, LLC (CA)

- Medicare fraud: In 2021, Sutter agreed to pay [\\$90 million](#) to settle allegations that it violated the False Claims Act (FCA) by “upcoding,” or knowingly fabricating patient diagnoses in order to increase Medicare’s payments to Sutter Health’s Medicare Advantage (MA) plans.
- Price gouging and anticompetitive practices: In 2019, Sutter agreed to settle with the state of California for [\\$575 million](#) to resolve allegations of anticompetitive practices that led to higher prices for patients. The settlement was given final approval by a federal judge in 2021. Secretary Becerra himself was involved in this case during his term as Attorney General of California.

Parent company: Clover Health (primarily a Medicare Advantage insurer)

DCE: Clover Health Partners, LLC (AL, AR, AZ, CO, FL, GA, IL, IN, KS, MO, MS, MT, NJ, NM, NY, OH, OK, PA, RI, SC, TN, TX, VT)

- Fined by CMS for Medicare Advantage marketing: In 2016, CMS [fined](#) Clover for using “marketing and advertising materials that contained inaccurate statements” about coverage for out-of-network providers, after a high volume of complaints from patients who were denied coverage by its MA plan. Clover had failed to correct the materials after repeated requests by CMS.
- Department of Justice investigation: As of 2021, Clover was reportedly under investigation by the DOJ for at least 12 [issues](#), including possible kickbacks, marketing practices, and undisclosed third-party deals (Clover [responded](#) to the report alleging the existence of the investigation and acknowledged that it had received a request for information from the DOJ, but denied all wrongdoing). We do not know the status of the DOJ’s investigation.
- SEC investigation: In 2021, the Securities and Exchange Commission [launched](#) an investigation of Clover due to its failure to disclose the DOJ investigation with shareholders. We do not know the status of the SEC’s investigation.

Parent company: Bright Health (primarily an insurance company)

DCEs: 1) Physicians Plus (FL, IL, KS, MO, OH); 2) Physicians Plus ACO, LLC (CA, FL, TX)

- Fined by Colorado insurance regulator: After receiving more than 100 complaints from patients and providers, the CO Division of Insurance [fined](#) Bright Health \$1 million in 2022 for failure to pay provider claims, communicate with members, and process payments claims on time. If Bright Health improves its performance by April 2023, half of the fine will be waived.

In addition to PNHP’s own investigation, research done by members of Congress uncovered evidence of malfeasance by several other entities slated to participate in the REACH program. We have included those details below.

Parent company: AdventHealth (health care system)

DCE: AdventHealth Senior Care, Inc. (FL)

- Inappropriate payments and coding: In 2015, AdventHealth (then called Adventist Health System) paid [\\$115 million](#) to settle allegations of “improper compensation arrangements” with physicians who referred patients to their services. The company financially rewarded physicians for referrals in violation of federal law. Advent was also accused of submitting bills to Medicare with improper coding modifiers which resulted in greater reimbursements.

Parent company: Humana (private insurer and Medicare Advantage insurer)

DCE: Humana Direct Contracting Entity, Inc. (CA, FL, GA, IL, LA, NC, NJ, NV, NY, SC, TN, TX, WA)

- Improper coding: In 2021, a federal audit by the HHS Office of Inspector General alleged that Humana improperly collected almost [\\$200 million](#) from Medicare by overstating the sickness of patients. Humana disputed the findings of the audit.

Parent company: Vively Health (home-based care provider)

DCE: Vively Health (AL, AR, AZ, CA, CT, FL, GA, IL, LA, MD, MI, MN, MS, NC, NE, NJ, NM, NV, NY, OH, OK, PA, SC, TN, TX, VA, WA, WI)

- Creating drug wastage for Medicare reimbursement: In 2015, Vively (then called DaVita Healthcare Partners) paid [\\$450 million](#) to settle claims that the company “violated the False Claims Act by knowingly creating unnecessary waste in administering the drugs Zemplar and Venofer to dialysis patients, and then billing the federal government for such avoidable waste.”
- Improper billing of federal health programs for medication: In 2017, DaVita paid [\\$63.7 million](#) to settle claims that the company improperly billed health care programs for “prescription medications that were never shipped; that were shipped, but subsequently returned; and that did not comply with requirements for documentation of proof of delivery, refill requests, or patient consent.”
- Submitting inaccurate information for inflated Medicare payments: In 2018, DaVita subsidiary Healthcare Partners, a Medicare Advantage provider, paid [\\$270 million](#) to settle claims that the company submitted inaccurate information to receive inflated payments from Medicare. The DOJ reported that the company voluntarily disclosed practices, including that it had “disseminated improper medical coding guidance instructing its physicians to use an improper diagnosis code for a particular spinal condition that yielded increased reimbursement from CMS.” The settlement also resolved claims from a whistleblower that Healthcare Partners engaged in “one-way” chart reviews, looking through patient records for diagnoses to add to its coding forms while ignoring inaccurate codes that should’ve been deleted.

Parent company: Cigna (managed care and insurance company)

DCE: CareAllies Accountable Care Solutions, LLC (AZ, TX)

- Risk score gaming: In 2020, the Department of Justice filed suit against Cigna based on allegations that it created a program to game risk scores in its Medicare Advantage subsidiary for higher capitation payments. Based on a search of court records in PACER, the case is ongoing as of January 2023.