Briefing Note, 10 April 2021

Centene take-over of GP surgeries

The facts surrounding the take-over by Centene Corporation of some four dozen GP surgeries and hubs in London, and the associated lack of openness and transparency, and even misrepresentation, under cover of the pandemic, has been widely reported, locally and nationally. For more information see the letters sent to the Secretary of State by NHS campaigning organisations and ourselves on 22 February 2021 and by leading councillors from 12 London boroughs on 19 March 2021. Both letters call for the Secretary of State to require the Care Quality Commission to investigate as provided by section 48 of the Health and Social Care Act 2008.

This briefing note focuses on the following 5 issues:

(1) How the take-over was made possible: the APMS contract

(2) Risks for primary care when services are provided by for-profit companies

(3) Risks for primary care when services are provided by US health companies

(4) Transfer of patient data outside the UK

(5) The white paper and the government's forthcoming Health and Social Care Bill

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(1) How the take-over was made possible: the APMS contract

There are now some 70 GP practices and hubs around England in the hands of Centene Corporation, a giant US health company with revenues last year totalling US $111 billion – NHS England's total budget for 2019-20 was £123.8 billion.

The majority of these are held under Alternative Provider Medical Services (APMS) contracts. APMS contracts are the creation of NHS administrators and law firms under ministerial directions. They were not created by Parliament, but they have a statutory basis under section 83(2) of the NHS Act 2006. They can be made with any person, including companies limited by shares. They have been described by a health industry lawyer as "the private sector's gateway to providing primary health care to NHS patients".

This is because when Parliament created the two main GP contract types - General Medical Services (GMS) contracts, and Personal Medical Services (PMS) agreements – it ensured that the private sector was not eligible to hold them. It allowed companies limited by shares to hold these two types, but imposed restrictions on the identity of their shareholders. In summary, only companies with GPs, regulated health professionals and (for PMS agreements) NHS trusts and foundation trusts, as shareholders can hold them.

Major companies awarded APMS contracts are reported to have failed: e.g., UnitedHealth for the Camden Road surgery in 2008 (where PR was a patient), which no longer exists; Atos pulled out of St Paul's Way medical centre in Bow in 2011; Serco pulled out of its out-of-hours contract in Cornwall in 2013, after a damning Select Committee report; and The Practice Group, a majority-owned Centene company, pulled out of the Osler House surgery in Harlow, Essex in 2018, according to the Daily Mail.

According to NHS Digital, there were 180 APMS practices in England in 2019-20, covering just over 1 million (and 1.8% of) registered patients. These can be seen on this map compiled by Dr Paul O'Brien.

The government's proposed Bill on NHS reform would be an opportunity to end APMS contracts, or at the very least to impose restrictions similar to those applying to GMS contracts and PMS agreements.

(2) Risks for primary care when services are provided by for-profit companies

The risks to services when for-profit companies provide services under contracts are well established.

It is impossible for all elements of service provision and risks to be set out in a contract. Contracts are incomplete. This is because primary care services and care not easy to specify. The Quality and Outcomes Framework (which was supposed to incentivise care through funding) reduces care to the measurable and prescribable. It was deeply opposed by GPs because it failed to recognise the complexity of providing holistic care to patients. Moreover, commissioners do not have the resources and expertise to do effective contract monitoring, even if contracts were capable of being complete.

Reductions in and closures of services, loss of access to care, denial of care, reduced staffing and changes in skill mix, and erosion of staff terms and conditions are well documented both in the US health care system and in the UK. They are also well exemplified in long term care where 'quality shaving' is common.

When the state hands over control to monopoly providers with shareholders and investors, price gouging and cost inflation result. Shareholders need a return on their investment, and the model of care changes as providers are incentivised to minimise costs by denying care, carefully selecting patients and/or introducing referral mechanisms which reduce the power of GPs to refer to specialists without prior authorisation.

This is demonstrated by the specific strategy and practice of Centene in the NHS in 2019 and 2020, in their own words:

> "[T]he strategic exit of certain loss-making elements of our business has allowed the group to consolidate its contract base without compromising on profitability...It is expected that this [consolidation] will lead to cost reductions and drive improved profitability, which we have started to see during the year [2019].

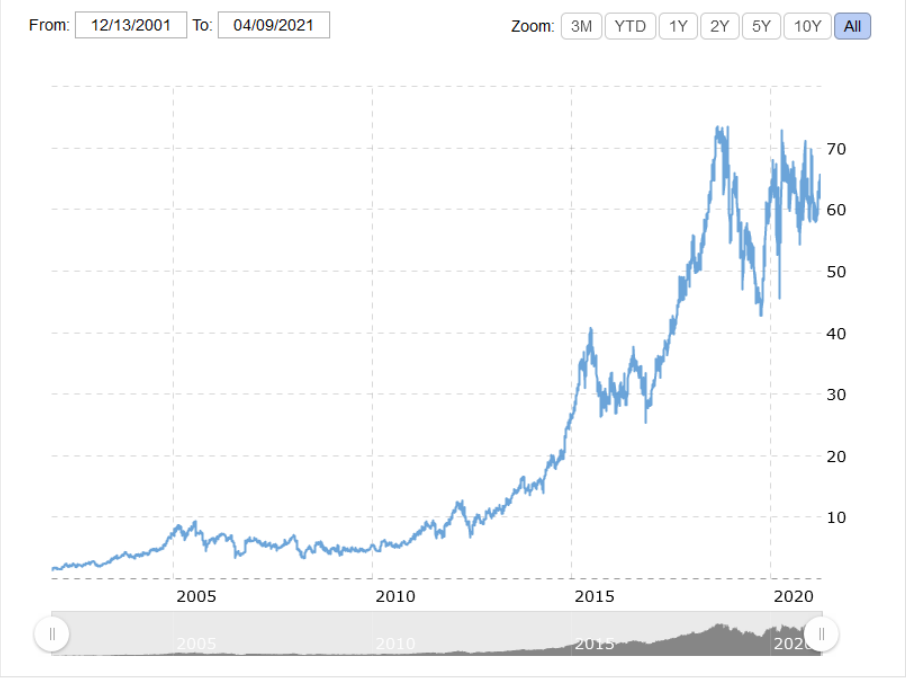
> Rationalisation of our business activities...has been a key feature of our strategy through 2019 and has continued into 2020, as the business seeks to divest of activities that have not met profitability targets. As a result, on 31 March 2019, Operose Health Limited exited the Surrey Borders Partnership NHS Trust CAMHS contract, on 30 June 2019 Operose Health Limited exited the Surrey Borders Partnership NHS Trust CFHS contract, and on 1 July 2019, Operose Health (Group) UK Limited divested its complex care service division, including the contracts and related assets."

Systematic fraud is another risk through gaming of prices resulting in overcharging, under-treatment, over-treatment and loss of preventative measures.

When the state hands over control there is also a loss of public scrutiny and public accountability, and the new proposed procurement rules for providers (see below), which will remove or reduce competition in the awarding of contracts, are a key cause for concern. Competition is essential for markets to at least function.

(3) Risks for primary care when services are provided by US health companies

The U.S. managed care industry is one of the most highly profitable industries in the US with executives being among the most highly paid. Centene, the parent of Operose, has been one of the most successful. Centene's CEO has made over $25 million USD in some years. Since the passage of the US Affordable Care Act, called Obamacare, in March 2010, Centene's stock price has risen exponentially:



Centene stock price 2001-2021, https://www.macrotrends.net/stocks/charts/CNC/centene/stock-price-history

Its profits have been fueled by taxpayer supported care provided to the poor via state Medicaid plans, and to the elderly patients in Medicare, via so called Medicare Advantage plans, which are largely Health Maintenance Organizations, and are paid on a capitated fixed sum basis per patient depending on risk. Each state runs its own Medicaid program. There is only one national Medicare program. 40% of US Medicare patients are in the HMO programs which utilize extensive and expensive advertising to enroll them.

In the State of Texas, Centene provides care to the state's Medicaid population and to over 30,000 foster children, an especially vulnerable population. Centene's subsidiary in Texas is called Superior Health Plan. Centene provides care to Medicaid patients in many states.

It became the subject of an extensive 5-part investigative report by the Dallas Morning News in 2018. The reports themselves are now blocked behind a firewall but have been summarized by the aging center faculty of Florida State University.

The most dramatic example of questionable care involved a disabled foster child who needed round the clock nursing care to maintain his airway, and when that care was denied, suffered respiratory compromise, brain damage and now is in a vegetative state.

Another significant problem reported was a much smaller than advertised network of mental health professionals available to care for foster children in Texas.

Centene has disputed these allegations and there are ongoing lawsuits about these contentions of negligent managed care.

Apart from Texas, Centene has been at the center of controversies about the quality of their care in states such as California, Iowa, and Washington State.

But this is not an indictment of Centene, specifically. It is a warning that the business model of US managed care companies involves many practices that threaten the quality and actual outcomes of patient care. Without a strong oversight system looking at actual outcomes and monitoring the actual processes of ordering and receiving ordered care, there can be serious adverse consequences.

In the UK that oversight of GP surgeries is provided in part by the Care Quality Commission.

Health care systems are always concerned about costs. They say they are concerned about quality but it is always the budget that politicians focus on. In the US, politicians at the state and federal levels have essentially off loaded the difficult patient care rationing decisions to the health insurance industry so they don't have to suffer the intense political heat when care denied goes bad and bad PR results as in a child with terrible hypoxic brain injury.

In the US, for profit managed care companies have a business model that focuses on the most vulnerable populations: elderly, disabled, poor, children, pregnant women, prisoners. These are also people who are often politically disenfranchised. Their care is paid through Medicaid, Medicare and other government programs using state and federal tax dollar.

Yet the oversight of these programs is weak in the US. Data on the actual outcomes of patients with chronic diseases like coronary heart disease, congestive heart failure, stroke, asthma, COPD, diabetes mellitus, and hypertension are hard to come by in managed care systems. Often only process measures are monitored rather than actual outcomes in sick patients.

Here is what any supervising governmental body and the UK public should understand about these for profit entities.

They exist to deliver profits to their shareholders. Their top executives made huge salaries + bonuses and stock options. The tactics they employ involve some or all of the following:

1. Policies and procedures that are confidential trade secrets;
2. Clinical guidelines and decision making that may be trade secrets;

3. Narrow networks of specialists;
4. Replacing more highly paid physicians with lower paid mid-level practitioners like Physician Assistants and Nurse Practitioners;
5. Replacing more experienced nurses with less experienced categories of nurses and assistants. Increasing the patient to nurse ratios which puts more pressure on nurses and may compromise care;
6. Burdensome prior authorization procedures for drugs, even generic drugs ordered; medical procedures; consultations; and hospitalizations;
7. Denying medical guideline appropriate care even when ordered by academic faculty at top medical centers;
8. Outcomes data that are proprietary and not easily accessible; US Medicare Advantage outcomes data are not readily accessible to objective researchers;
9. Intense lobbying campaigns directed at public oversight officials and legislators;
10. Revolving doors between public officials and managed care executives. This has been seen in the US Medicare program and also in state Medicaid programs. This effectively squelches effective public oversight of outcomes;
11. Cash rich managed care companies setting up charitable foundations to further sway public opinion and public officials;
12. Intense advertising campaigns in the cash strapped media such as newspapers which virtually suppresses critical/ investigative reporting;
13. Lobbying campaigns that result in governmental oversight that concentrates on dollars/pounds spent rather than actual patient outcomes. And the substitutions of process outcomes (eg who got a mammogram or had a BP taken) to actual outcomes like how did patients do with heart failure or severe coronary disease;
14. Gag clauses in contracts forbidding doctors to speak out about managed care policies that threaten appropriate patient care;
15. Contracts specifying that the medical director of the managed care company has ultimate authority over decisions of medical necessity;
16. Economic credentialing of doctors and other providers who face being fired if they order too many procedures or tests.

The sales pitch of US managed care will always be that they know the right way to practice medicine as opposed to the doctors who do unnecessary tests and run up the costs of health care. They will tell you that their networks of primary care doctors, specialists and hospitals are dedicated to the lowest costs and the most efficient care, and that their care is managed and coordinated by the best evidence.

But when they are sued in court for negligent care, we find that they have:

1. Failed to prevent a patient from being prescribed a deadly combination of three drugs each one of which had been discontinued because of adverse effects, and then re-approved one by one by the HMO with a resulting fatal outcome;

2. Failed to monitor a deadly combination of opiates and benzodiazepines in a young, decorated war veteran patient with severe sleep apnea who took his pills exactly as directed and died in his sleep;
3. Failed to schedule follow-up colonoscopies in 2 different patients with high risk polyps discovered by an initial screening colonoscopy both of whom went on to die of colorectal cancer;
4. Failed to appropriately treat high risk infections in a patient with severe prostatic hypertrophy;
5. Failed to monitor severe aortic valve disease;
6. Failed to train screening nurses to properly evaluate chest pain over the phone;
7. Cautioned doctors that if they admitted too many chest pain patients to the hospital they might be fired.

None of these examples are about Centene. They come from experiences with other large for profit US managed care entities in actual lawsuits. Only through the legal discovery process were the internal policies, procedures and contracts able to be accessed.

In addition to publicly traded US health care companies, there is also the threat of US private equity companies that are playing an increasing role in areas like nursing home care and high profit specialty care like dermatology, emergency medical care and anesthesiology.

All of these corporate entities promise cost savings, efficiency and better quality. Often the reality is different from their promises of coordinated care, which is why governmental oversight of the quality of actual care in granular detail is necessary.

Whether in the US or in the UK, patients want doctors they can trust. They want a doctor they can call "my doctor" not someone who is more interested in saving dollars than saving lives.

(4) Transfer of patient data outside the UK

Specific concerns have arisen about the transfer of patient data to Centene in the US, and about the 'assurance' given on 3 December 2020 by AT Medics to South East London CCG, which led the due diligence process for all the CCGs.

Here is a screenshot from the assurance document of the confirmation that AT Medics was asked to give in this respect, and its response:

Confirmation of whether any personal data or other assets currently held by ATML will be transferred to any Group Company and in particular any Group Company outside the UK as a result of the change in control.	No patient data will be transferred outside the UK. Personal data that relates to employees and suppliers may, in certain limited circumstances, be shared with other Group companies including those outside the UK, for specific purposes such as invoice payments. No assets are transferred outside the UK.

AT Medics' website has its own privacy notice, which appears not to have been updated since the take-over.

Here are screenshots from Operose Health Limited's privacy notice dated 20 October 2020, which are not stated to cover AT Medics' surgeries (as the document preceded the take-over):

> **7. Disclosure of personal data**
>
> **Third party recipients**
>
> We may have to share your personal data for the purposes set out in in section 4 above with:
>
> i. those involved in your care, such as: doctors, clinicians and other health-care professionals, hospitals, clinics and other health-care providers healthcare professionals, NHS providers.
>
> …
>
> vi. any member of the family of companies.
>
> vii. our affiliate company Centene Corporation.
>
> …
>
> **Transfers of personal data outside the EEA**
>
> Your personal data may be transferred outside the UK and the EEA for the purposes set out above.
>
> For example, our Website is hosted in the US by our parent company Centene Corporation and your personal data may be transferred to the US as part of the operation of the Website.

It is concerning that AT Medics stated that no patient data will be transferred outside the UK, when Operose Health says the opposite for its surgeries before the take-over. At the very least an explanation for the difference needs to be provided.

(5) The white paper and the government's forthcoming Health and Social Care Bill

The white paper published in February contains a set of deregulatory, incomplete and incoherent proposals. A government Bill is expected to follow at the start of the next parliamentary session. It should be opposed by all those committed to a publicly provided, funded and accountable comprehensive NHS.

Under the guise of integration, innovation and flexibility, the government is proposing to give unprecedented power to statutory Integrated Care Systems to decide on health services. They will receive a single pot budget which will merge the budgets for general practice with acute and other services. They will take on the CCG and some NHS England commissioning functions.

Their boards will include representatives of NHS trusts, local authorities and general practice "and others determined locally" but without any required local links. General practices taken over by Centene, for example, would be included. No controls are proposed over whom the other board members may be. They could therefore include, for example, private hospital groups, nursing home

chains and the 67 companies awarded a £10 billion contract last November for NHS inpatient, day case, pathology and imaging services, urgent elective care, cancer treatment, and diagnostic services.

The white paper contains no proposals to address social care or for local accountability. ICS decisions will be taken far away from local authorities, and their power to refer service reconfigurations to the Secretary of State will either be removed or severely weakened. The local voice will be virtually inaudible and subsumed within a wider representative body, massively outnumbered by NHS and private bodies. The lack of accountability we have seen over the Centene take-over will be par for the course.

There is a proposal for a second body – a Health & Care Partnership – but this is not worked through, devoid of detail, and not 'where the action is at'.

Apart from the merging of NHS England and NHS Improvement/Monitor, there are two clear and genuine reversals of the 2012 Act: greater ministerial control over NHS England, and the abolition of competition rules, especially the "needless bureaucracy" of virtually compulsory tendering for clinical services.

The latter is welcome from the perspective of those of us who see no place for a market bureaucracy in the NHS. But far from needless, transparently competing for contracts is the check against corruption and cronyism within a market model. Contracts worth £10.5 billion were awarded directly without any competition during the pandemic to the end of July 2020. The bespoke provider selection regime, currently being consulted on, will not prevent this becoming common place.

Contributions: Professor Allyson Pollock and Peter Roderick wrote sections (1), (2), (4) and (5). Brant S. Mittler MD JD wrote section (3).

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This Briefing Note is based on written deputation requests made by AP, PR and BSM to a meeting of Camden Council's Health and Adult Social Care Scrutiny Committee meeting on 7 April 2021