December 31, 2019

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1720-P
P.O. Box 8013
Baltimore, MD 21244

Re: Medicare Program; Modernizing and Clarifying the Physician Self-Referral Regulations

Dear Administrator Verma:

The Physicians Advocacy Institute (PAI) appreciates the opportunity to provide comments on the Medicare Program; Modernizing and Clarifying the Physician Self-Referral Regulations proposed rule, published in the Federal Register on October 17, 2019.

PAI is a not-for-profit organization that was established to advance fair and transparent policies in the health care system to sustain the profession of medicine for the benefit of patients. As part of this mission, PAI seeks to better understand the challenges facing physicians and their patients and to also educate policymakers about these challenges. PAI also develops tools to help physicians prepare for and respond to policies and marketplace trends that impact their ability to practice medicine. PAI’s Board of Directors is comprised of CEOs and former CEOs from nine state medical associations: California Medical Association, Connecticut State Medical Society, Medical Association of Georgia, Nebraska Medical Association, Medical Society of the State of New York, North Carolina Medical Society, South Carolina Medical Association, Tennessee Medical Association, and Texas Medical Association, and a physician member from Kentucky. As a physician-based organization, PAI is equipped to provide comments and insight into many of the challenges facing the medical profession.

PAI is committed to helping physicians adapt to and succeed under the Medicare program, especially the Quality Payment Program (QPP) as well as alternative payment models (APMs) and other value-based arrangements (VBAs). PAI strongly supports the Department of Health and Human Services’ (Department’s) Regulatory Sprint to Coordinated Care (Regulatory Sprint) to remove regulatory barriers associated with four key laws and regulations: 1) the physician self-referral law; 2) the Federal anti-kickback statute; the Health Insurance Portability and Accountability Act of 1996 (HIPAA); and 4) rules under 42 CFR part 2 related to substance use disorder treatment.
Overview

The physician self-referral law was enacted in 1989 to help ensure that health care decisions be driven by patient choice and needs and not by physicians’ personal financial interests and profits. At the time, there was concern about the potential for overutilization of unnecessary, more expensive, and low-quality services. In response, the law prohibited physicians from making referrals for certain designated health services (DHS) to an entity with which either the physician or an immediate family member may have a financial interest. While exceptions exist that allow certain arrangements, the law is often considered a key obstacle to participation in integrated delivery models, alternative payment models (APMs), and other value-based payment arrangements. These care innovations demonstrate the evolution of medicine after the law’s 1989 enactment, which also merit its modernization.

The Centers for Medicare and Medicaid Services (CMS) has been encouraging physicians to bear more accountability for the total costs of their patients’ care, both through APMs involving two-sided risk and through the Quality Payment Program (QPP). These programs and opportunities help limit the concerns that gave rise to self-referral restrictions because these new payment model approaches discourage provision of low-value care. In order for these efforts to succeed, however, providers need not only appropriate incentives but also tools to coordinate their patients’ care and manage their illnesses and their health effectively and efficiently, including tools for communication and collaboration with other providers.

As described in greater detail below, the existing self-referral law inhibits the development of new financing and care delivery arrangements focused on care coordination and improving outcomes. Specifically, the law restricts certain types of practice arrangements and adds administrative complexity. Those factors can lead physicians desiring to pursue innovative approaches to seek employment in large health systems or closed referral networks. Additionally, they may prevent smaller practices from testing or adopting new and innovative approaches to care delivery. Without changes in the regulations governing self-referral, the result may instead be greater consolidation of physicians into large groups. The resulting reduction of competition in physician markets could raise costs for health care, reduce quality of care, restrict access to medical services, or some combination thereof.

In this comment letter, PAI echoes the recommendations and comments we submitted in response to the Anti-Kickback Statute and Physician Self-Referral Law Requests for Information (RFIs) last year, as well as the comments submitted in response to the Anti-Kickback Statute Proposed Rule. PAI believes that there should be as much alignment between the Physician Self-Referral Law exceptions and the Anti-Kickback Statute exceptions. Importantly, there should not be unnecessary complications and complexities due to potential conflicts between the two. We encourage the Department to provide increased and more uniform flexibilities across the Physician Self-Referral Law and the Anti-Kickback Statute that encourage participation in APMs and innovative payment arrangements. Lastly, modernization efforts also should ensure that the guiding laws and regulations at both the federal and state level are updated and keep pace with health care delivery system innovations and advancements to support improvements in quality and cost of care.
Proposed Definitions

CMS is proposing several new definitions to account for protected entities and activities. These include definitions for the following terms: Value-based enterprise (VBE); VBE Participant; Value-based Arrangement; and Value-Based Activity.

**Value-Based Enterprise (VBE)**

PAI is supportive of the proposed definition for a VBE, however, we request further clarification on the following: 1) responsibilities, requirements, structure, and composition of the “accountable body,” as well as requirements of the “governing document;” and 2) whether such requirements may be met through existing payer (including Medicare) contracts and agreements (i.e., a new contract or agreement would not be necessary if one already exists). For example, we seek clarification on whether the governing body must be exclusively providers and entities providing care, or if they can also include other third parties that are helping support the infrastructure and care delivery model in other ways. PAI also seeks feedback on the requirements necessary to certify a VBE for the purposes of these protections. PAI believes that a VBE should be perceived or be de facto “clinically integrated” under federal rules (including Federal Trade Commission (FTC) and Department of Justice (DOJ) rules) so that the entity and its participants can collectively enter into VBAs.

**VBE Participant**

PAI is supportive of the broad definition encompassing VBE participants. We believe that there is an array of health professionals that could benefit from participating in such entities, including those who have not realized the benefits of Stark Law exceptions to-date.

**Value-Based Arrangements (VBAs)**

PAI supports the proposed definition of VBAs but believes the definition should be expanded to also include Advanced, Other Payer, and MIPS APMs under the QPP, as well as state-based Medicaid initiatives, e.g., Patient-Centered Medical Home Models, and other state innovation models.

**Value-Based Activities**

PAI supports the broad definition of “value-based activity.” Furthermore, we support the provision that such activities will not be specifically required to improve the coordination and management of care.

**Value-Based Purpose**

CMS is proposing to define a value-based purpose as one of the following: (1) coordinating and managing the care; (2) improving the quality of care; (3) appropriately reducing the costs to, or growth in expenditures, without reducing the quality of care; or (4) transitioning from health care delivery and payment mechanisms based on the volume of items and services provided to mechanisms based on the quality of care and control of costs of care for a target patient population. CMS is also seeking input on how to define “improving quality of care” and “coordinating and managing care,” as well as input on different ways parties can demonstrate they are transitioning from health care delivery and payment mechanisms based on the volume of items and services provided to mechanisms based on the quality of care and control of costs of care.
PAI generally supports the definition of value-based purpose, however, we question the need for a “value-based activity” and a “value-based purpose,” and if such components can be embedded within a single definition to reduce administrative complexity in documenting VBA performance. Regarding comments solicited for quality improvement requirements, PAI believes that CMS should accept both efforts to improve quality, as well as efforts to maintain quality of care for the target patient population as this varies and is dependent upon the specific patient population.

Additionally, we believe that documentation demonstrating that care is being coordinated or managed should satisfy this requirement. This could be demonstrated through various services, e.g., care transition summaries or other continuity of care documents. If an entity has adopted or implemented care management systems or are using data to evaluate service provision and cost, that data could satisfy demonstrating the shift towards VBAs.

**Target Patient Population**

PAI has several concerns with the definition of a “target patient population” as defined within a VBA. First, we seek clarification that this would include patient populations that are retroactively attributed under VBAs (e.g., using a claims-based methodology). There are also concerns with patient populations that are of more transient nature (e.g., “snowbirds”) who may have different providers in different geographic locations responsible for their care at various times through the year. We believe that the “target patient population” definition consider these additional factors, and that the definition be more inclusive of non-health-related factors, aside from geographic characteristics and payor status. VBAs are most effective when tailored to the varying socio-economic and socio-cultural barriers that effect care access among underserved communities. Thus, PAI believes this definition should be more inclusive of such factors and must take into consideration and protect against underutilization of medically necessary services.

**Exceptions for Full-Risk Models**

CMS is proposing an exception for remunerations between a VBE and VBE participants pursuant to a VBA that assumes full financial risk; that is, assuming full risk for cost, on a prospective basis, of all patient care items and services covered by the applicable payor for each patient in the target patient population for a specified period of time. Specific to Medicare, CMS would interpret this as all items and services covered under Parts A and B. CMS verifies that the financial risk must be prospective; however, this is not limited to just a capitated model. CMS is soliciting comments on other models that may be included in this exception.

PAI supports this definition of “full risk” models. However, we believe full risk arrangements are not specific to capitated payment and should be more inclusive of other types of arrangements including bundled or episodic payments. Additionally, clarification is sought on innovative ways to demonstrate “full-risk” arrangements, that are not strictly monetary and consider investment in technologies that enhance physician-patient communication.

Furthermore, PAI does not support the requirement for care coordination and management activities, as full risk models are inherently incentivized to perform these tasks and such documentation requirements will induce unnecessary administrative burden even though the
functions are required. PAI supports the alternative approach of basing remunerations on the value-based purpose, as opposed to the value-based activity, as this is more wide-reaching; therefore, this will permit more innovative care activities within the full risk model. We also support the proposal to allow remunerated activities to also benefit non-target patient population members (i.e., spillover effect) and we believe that records for remunerations should be maintained for three-years after the fact. Additionally, there should also be protections for ensuring that there is not an unintended consequence resulting in underutilization of certain services.

Exceptions for VBAs with Meaningful Downside Financial Risk to the Physician
CMS is proposing a physician-based exception for remuneration paid under a VBA where the physician is at meaningful downside financial risk—meaning the physician is responsible to pay the entity no less than 25 percent of the value of the remuneration the physician receives under the VBA.

PAI has concerns with defining “meaningful downside risk” and believes that the 25 percent threshold is too high. We recommend that the Agency decrease the threshold to 5 percent, so it is more closely aligned with the risk threshold in other programs (e.g., medical homes, Advanced APMs, etc.). Additionally, PAI recommends that the protection of services provided downstream, or by staff, of a protected physician participating in a VBA that is not globally active throughout the VBE, should be permitted. We are requesting further clarification about the documentation requirements for establishing VBE’s as well as VBA’s pursuant to such joint or downstream entities. PAI believes there are areas of duplicative and unnecessary administrative requirements between VBA and VBE certification/documentation.

Exceptions for General VBAs
CMS is proposing an exception for compensation arrangements that qualify as VBAs, regardless of the level of risk undertaken by the VBE or any of its VBE participants. This exemption would permit both in-kind (nonmonetary) and monetary remuneration; however, CMS is soliciting feedback on the potential of limiting this exception to in-kind remunerations only. CMS also proposes several requirements for such VBAs, including the conditions on which remuneration can be provided and documentation requirements.

PAI supports a general exception for VBAs, regardless of risk. We believe this exception will be most applicable for independent, small, and rural practices that may not have the financial safety to take on considerable risk, but still practice high-quality care and play a vital role for patients in certain geographic regions.

PAI agrees with the general requirements regarding medical necessity and financially conditioned referrals. PAI does not support the alternative requirement that remuneration is not conditioned on referrals of any patients to entity, as those activities are already permitted and expected as components of Clinically Integrated Networks support for VBAs.
Lastly, PAI questions the necessity of documenting both value-based activities and value-based purposes within such written agreements and believes this may produce duplicative work. Furthermore, restricting VBAs to a set of value-based activities when they are already pursuant to a set of defined value-based purposes may reduce the variety of quality services provided to patients. However, PAI acknowledges that from a monitoring standpoint (as later discussed) it makes logical sense to list and define value-based activities as well as value-based purposes. We request that CMS continue to consider alternatives to this requirement in a way that doesn’t unnecessarily increase administrative burden.

**Monitoring Compliance of VBAs**

CMS is proposing the following requirements regarding monitoring compliance of VBAs:

1. The VBE or the VBE participant providing the remuneration must monitor whether the value-based activities under the arrangement are furthering the value-based purpose(s) of the VBE; and
2. If the value-based activities will be unable to achieve the value-based purpose(s) of the arrangement, the physician must cease referring designated health services to the entity, either immediately upon the determination that the value-based purpose(s) will not be achieved through the value-based activities or within 60 days of such determination.

For compliance purposes, PAI understands the necessity to track an activities performance pursuant to a value-based purpose. However, as stated previously, we request that the Agency continue to consider additional ways to meet the written and reporting requirements in a way that reduces duplicative work and doesn’t unnecessarily increase administrative burden. Additionally, there should be a greater grace period after such determination is made (i.e., more than 90 days) to allow for changes in workflows, processes, staff, etc.

**Contribution Requirement**

CMS is also considering a ”contribution requirement” of 15 percent for nonmonetary remunerations for VBAs under such exceptions. Specifically, CMS is considering that the 15 percent contribution is made: 1) within 90 calendar days of the donation if it is a one-time cost to the donor; and 2) at reasonable, regular intervals if the donation is an ongoing cost to the donor.

PAI does not support the proposed contribution requirement as it currently stands. PAI cautions the Agency against only using monetary value for meeting the contribution requirement. We believe that this could adversely impact small and rural practices pursing such agreements, whom should be extent from this contribution. Additionally, non-monetary contributions should be considered, as it is possible that they could be things that are important but not quantifiable, e.g., extended office hours, online health information, and basic and disease specific educational materials.

**Clarification for Indirect Compensation Arrangements**

CMS is proposing that when a physician is a direct party to a VBA that is also an indirect compensation arrangement (which has its own exception requirements), that indirect compensation would still qualify as a “VBA” for purposes of the proposed VBA exception. Alternatively, CMS is also proposing
a new definition for “indirect value-based arrangement” that would specify in regulation what exceptions would be available for such relationships.

PAI supports CMS’ clarification. PAI does not believe that it is necessary for CMS to establish a new definition for “indirect value-based arrangements” at this time, as this would likely add unnecessary complexity. CMS should instead continue to review stakeholder feedback on this issue as this rule is implemented and revisit the possibility of establishing a separate definition at a later date.

Price Transparency
CMS is seeking comment on how to ensure price transparency requirements within the current Stark Law exceptions proposed. Specifically, it is interested in comments regarding the following: availability of pricing information and out-of-pocket costs to patients; appropriate timing for the dissemination of information (e.g., at the time of the referral, the time the service is scheduled, or some other time); the burden associated with compliance with such requirements; and, if this requirement would reduce the potential for program or patient abuse.

PAI is supportive of price transparency. Additionally, we urge the Agency to ensure that the information to be made public first be shared with physicians and others to ensure that it is accurate, and that physicians have appropriate time to review and correct the information before it is made public. Furthermore, we believe that it is important to display and present the information with accuracy and in a manner that is helpful and not confusing to patients and others, with explanations for patient cost sharing.

Changes to Fundamental Terminology Requirements
CMS is proposing changes to several terms and standards including: commercially reasonable; volume or value standard; the other business standard; fair market value; general market value; and patient choice and directed referrals.

PAI has several concerns with the proposed changes to the terms and standards. Generally, we believe clearer and more direct guidance and education is necessary on the definitions and standards to ensure that physicians have a better understanding of the requirements. For example, we have concerns about these various standards, including the fair market value and general market value standards, given the difficulties in measurement for these standards and the arbitrary definitions that result from different interpretations. More specifically, we have the following concerns:

- For the volume or value standard we are concerned that the physician compensation must be set in advance and believe instead that this be relaxed to allow for the compensation to be set right at the onset or at a particular point in time correlating to the referral or the initiation of care or contact with the patient. Retroactive establishment of physician compensation is often required when cumulative performance impacts the return under VBAs.
- For the fair market value standard, we urge the Agency to ensure that when conducting this assessment, it and its consultants, understand and take into consideration the full spectrum
of factors that impact costs specific to that individual geographic market. These include costs of care, costs for medical liability, costs of equipment and staffing, certificate of need laws, provider and related taxes on health care services and centers, etc.

Technical Changes for Group Practices
CMS is proposing several technical changes for profits within group practices, including: special rules for profit shares for productivity bonuses; clarification of profit shares or productivity bonuses; and CMS’ interpretation of “overall profit” regulations.

Special Rules for Profit Shares and Productivity Bonuses
CMS is proposing new regulatory text that would allow for the distribution of profits from designated health services that are directly attributable to a physician’s participation in a VBE. Meaning, as stated by CMS, a group practice “could distribute directly to a physician in the group the profits from designated health services furnished by the group that are derived from the physician’s participation in a value-based enterprise, including profits from designated health services referred by the physician, and such remuneration would be deemed not to directly take into account the volume or value of the physician’s referrals.”

PAI supports this added flexibility. We believe that, by allowing group practices to individually allocate VBE-specific profits to members that independently participate in the VBE, this provision will improve overall participation within VBEs among the broader provider community. Furthermore, PAI requests clarification that distribution could be based on performance in quality metrics or engagement in VBEs, if such performance is related to both quality improvement and cost efficiencies.

Clarification of Profit Shares or Productivity Bonuses
CMS is proposing that the profit share or productivity bonus is permissible but only if it does not directly consider the volume or value of referrals. Thus, profits derived from all the designated health services of the practice must be aggregated and distributed, with profit shares not determined in any manner that directly takes into account the volume or value of a physician’s referrals. CMS is proposing a revision that would deem the payment of a “productivity bonus” as not directly taking into account the volume or value of a physician’s referrals if the “services on which the productivity bonus is based are not revenues derived from designated health services and would not be considered designated health services if they were payable by Medicare.”

PAI supports CMS efforts to further clarify rules governing profit shares or productivity bonuses. However, we believe that in certain cases and under certain VBAs profit shares and bonuses may be appropriately based on volume of referrals because the volume is supportive of the VBA’s purpose. PAI recommends permitting these bonuses and profit-sharing arrangements to include volume of referrals—as long as the referral is necessary and appropriate and certain quality or other performance measures/standards are met, making sure that both overutilization and underutilization are evaluated or accounted for in the model.
CMS’ Interpretation of ‘Overall Profits’ Regulations

CMS is proposing to revise the definition of “overall profits” to be interpreted as the profits derived from all the designated health services of any component of the group that consists of at least five physicians, which may include all physicians of the group. If there are fewer than five physicians in the group, “overall profits” means the profits derived from all the designated health services of the group.

PAI is generally supportive of this definition, but believes it is problematic to base it on the number of providers given the variation across specialties and how they interact and work with other physicians and clinicians, including ancillary providers.

Decoupling the Physician Self-Referral Law from Other Laws

CMS is proposing to remove the requirement that the arrangement, in order to satisfy requirements of a Stark Law exception, must not violate the AKS or any Federal or State law governing billing or claims submission wherever such requirements appear.

PAI supports this proposed change. As stated in the proposed rule, we believe that compliance with Stark Law regulation infers compliance with AKS or other laws governing physician self-referral practices. However, we still encourage the Agency to streamline the requirements, as they mostly have done, across the two.

Changes to Technical Aspects of “Remuneration” Definition

CMS is proposing to remove the parenthetical that currently stipulates that remuneration does not apply to surgical items, devices, or supplies. Furthermore, CMS is instead proposing that surgical items, devices, or supplies would be excluded from the definition of “remuneration” when they are “used solely” to collect, transport, process or store specimens for the entity providing the items, devices, or suppliers, or to order or communicate the results of tests or procedures for such entity.

PAI supports CMS’ proposed change to eliminate the exception carve-out. Furthermore, PAI supports CMS’ proposal to loosen restrictions under the “used solely” requirement. We believe this rollback will reduce physician hesitancy regarding such remunerations and will reduce administrative work/time required.

Changes to the “Period of Disallowance”

CMS is proposing to delete rules relating to the “period of disallowance,” that physicians must follow to showcase a remedy of noncompliant practice. CMS clarifies that this in no way effects the general requirements of Stark Law, as well as prohibition against certain referrals that fail to meet requirements. However, CMS states that deleting the “period of disallowance” rule would eliminate the burdensome need to prescribe the particular steps or manner for bringing the period of noncompliance to a close.
PAI is seeking clarification on this proposed change. While we are generally supportive of eliminating burdensome steps and requirements, we seek clarification on whether physicians would have the opportunity to “cure” or would that physician be automatically “compliant.”

**Changes to Certain Ownership or Investment Interests**

CMS is proposing to extend the definition of the “titular” exemption. Specifically, this proposed rule would exempt “titular” ownership or investment interests—meaning an ownership where the physician does not have a right to the distribution of profits or the proceeds of sale, and, therefore, would not have a financial incentive to make referrals—from the restrictions placed on traditional cases of ownership and investment interests.

PAI supports this proposed change. We believe that physicians who do not realize any profits or proceeds of sale from ownership should be exempt from Stark Law restrictions regarding ownership and investment interests.

**Special Rules on Compensation Arrangements**

CMS is proposing to permit parties up to 90 days to satisfy the writing requirement of an applicable Stark Law exception. PAI supports this proposed change but recommends extending the time period to 120 days, as most small practices and parties require additional days to ensure compliance with all aspects of a compensation arrangement.

**Exceptions for Physician Recruitment**

CMS is proposing to eliminate the requirement that a physician practice sign writing documenting a recruitment arrangement between the recruited physician and the hospital in order to protect against program or patient abuse, when the physician practice is not receiving a financial benefit from the recruitment arrangement. PAI is supportive of this exception but is concerned that it may be used in anti-competitive ways and could disadvantage smaller and independent practices' recruitment efforts. Thus, PAI believes the exception should be expanded to be inclusive of recruitment efforts by physician practices to ensure a level playing field with hospitals and larger health systems.

**Exceptions for Payments by a Physician**

CMS is proposing to remain consistent with previous rules—maintaining that the “catch-all” exception for payments by a physician does not supersede other exceptions when applicable. Specifically, CMS states “the exception for payments by a physician is not available to protect any type of arrangement that is specifically addressed by another statutory exception at section 1877(e) of the Act, including arrangements for the rental of office space or the rental of equipment.” Moreover, CMS clarified that the “payments by a physician” exception would not include in-kind “payments” to an entity in exchange for cash from the entity.

PAI requests clarification from the Agency that this exception would permit physicians to assist their low-income patients through offering and providing them “discount cards,” for example, discount...
drug cards, or in practice dispensing of drugs or medical supplies (to reduce the patient’s overall or total expense).

**Exceptions for Fair Market Value Compensation Related to Rentals or Leasing**

CMS is proposing to extend exceptions for arrangements of fair market value compensations to arrangements for the rental or lease or office space that are less than 1 year. PAI supports expanding this exception, however, we caution the Agency about using a fair market value standard as this is difficult to measure.

**EHR Items and Services**

CMS is proposing similar amendments to EHR exceptions as found in the OIG proposed AKS rule. Specifically, the requirements for a deeming provision, information blocking, sunset provision, interoperability definition, etc.

PAI opposes the proposal related to the deeming provision which would provide certainty to parties seeking protection of the EHR safe harbor by providing an optional method of ensuring that donated items or services meet interoperable conditions by “deeming” the software to be interoperable if it is certified under the certification program. We believe it is critical to require interoperability be certified to further support the goal of VBAs and VBEs. We believe that the definitions and requirements for certification, as well as the terminology, should align and be consistent with existing statutory definitions, e.g., those established under the 21st Century Cures Act. PAI supports the OIG’s proposed changes to expand the EHR exception to protect donations of software and services related to cybersecurity; and to eliminate the sunset provision. PAI supports the elimination of a contribution requirement related to EHR donations for small or rural providers. We promote this exclusion to other safe harbors proposed within this rule that are proposing a contribution requirement, as discussed in other sections of this comment letter.

**Exception for Assistance to Compensate a Nonphysician Practitioner**

In acknowledgement of the role of Nonphysician Practitioner (NPP) patient services, CMS is proposing to extend the exception for remunerations provided for physician relocation to NPPs. PAI supports this proposed exception. NPPs serve a vital role in health care delivery, especially within rural regions. Extending the relocation exception to NPPs will improve health care service access in underserved areas facing provider shortages.

**Providing Flexibility for Non-abusive Business Practices**

CMS is proposing the following flexibilities for remunerations or arrangements provided that it deems as “nonabusive business practices:” arrangements involving the donation of certain cybersecurity technology and related services; staffing services, and arrangements for limited remunerations to physicians.
PAI supports these proposed exceptions, as well as definitions of “nonabusive business practices.” We request further clarification on what value threshold is used to determine “limited remuneration” designation. Additionally, we caution the Agency from allowing exceptions that could further bolster information blocking inadvertently. For example, hospitals sometimes cite cybersecurity as a reason for not complying with data sharing or other data access needs of physicians. Thus, we strongly encourage the Agency to take a holistic approach and consider unintended consequences of EHR-related exceptions that could result in further information blocking practices and prevent patient and/or physician access to necessary care information.

**Conclusion**

Overall, PAI supports the agency’s efforts to address the complexities and obstacles currently created by the physician self-referral law. We also support strategic use of exceptions to expedite those changes. The associations represented on the PAI Board of Directors welcome the opportunity to work with the agency to further modify existing policies and advance new policies. We look forward to exploring ways that allow physicians to provide higher quality, coordinated, integrated, and holistic care to their patients, while decreasing costs and increasing competition and choice in the health care market for patients and physicians. We reaffirm our belief that opportunities exist to improve the health care system and believe this should be done by enacting policies and modernizing antiquated regulations, which serve to foster innovative approaches to physician collaboration that will bring the benefits of competition to patients.

If you have any questions, please contact me at rseligson@ncmedsoc.org, or Kelly C. Kenney, PAI’s CEO, at k2strategiesllc@gmail.com.

Sincerely,

Robert W. Seligson, MBA, MA
President, Physicians Advocacy Institute