May 25, 2018

Mr. Adam Boehler
Deputy Administrator for Innovation and Quality
Director, Center for Medicare & Medicaid Innovation
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Request for Information on Direct Provider Contracting Models

Dear Deputy Administrator Boehler:

The Physicians Advocacy Institute (PAI) appreciates the opportunity to provide comments on the Center for Medicare and Medicaid Innovation (CMMI) Request for Information (RFI) on Direct Provider Contracting (DPC) models. We believe CMMI has a vital role and timely opportunity to expand the options for physicians to participate in innovative arrangements to care for patients. This RFI signals CMMI’s willingness to work collaboratively with the physician community to address issues and advance solutions, which are foundational to PAI’s mission, to advance fair and transparent policies in the health care system to sustain the profession of medicine for the benefit of patients.

PAI is a not-for-profit organization whose 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. PAI and its affiliated state medical associations are pleased that CMMI has heard the concerns expressed by physician organizations about the need to address various barriers to physician-led health care and believe CMMI must now effectively advance changes through its model design work.

**Barriers**

PAI believes there are multiple macro-level barriers that exist and are supported by the current health care system to independent private practice physician participation in APMs. We believe CMMI should address these existing barriers through its model design work, including:
• Developing physician-led models that improve patient access and care across a wide range of geographies, settings, and communities, including underserved communities, and ensuring that models incorporate a risk adjustment model that better addresses health status, frailty, socioeconomic factors, social determinants of health, etc.;
• Revising federal payment policies that favor hospital-based care;
• Crushing regulatory burden that is overly costly for small practices (e.g., CEHRT; HIE); and
• Modernizing various outdated laws and regulations that restrict physicians’ abilities to compete on a level playing field with hospitals, health systems, and insurers (e.g., physician-owned hospitals; self-referral; antitrust laws).

The combined regulatory burden across the health care system along with the various requirements that must be met, compound the stress placed on physicians and practices who are trying to focus on providing patient-centered care but also trying to keep afloat and meet the regulatory expectations set for them. Ultimately, this results in burnout, especially for small and solo practices, and makes it difficult for them to sustain in the current environment. However, as we have outlined above and describe in further detail throughout these comments, we believe that there are opportunities to address these issues and barriers. PAI is committed to working with CMS and CMMI on leveraging existing policies and structures, and developing new ones as appropriate, to help smaller and solo practices not only sustain but thrive and continue to provide tailored, high-value, cost-effective care to their patients. This is important not only for primary care practices but is also just as important for specialists and subspecialists.

**Opportunities**

We believe this RFI is a positive step forward to supporting continued physician leadership in health care with CMMI as an understanding partner and voice for change. To begin, we specifically draw your attention to key imperatives aligned with PAI’s overarching advocacy work. Accordingly, PAI believes it is important for CMMI to:

• Recognize the valuable role physicians play in health care and the impact of the corporatization of health care/for-profit entities making clinical decisions;
• Support APM participation for physician-led and community-based private practices, creating beneficial options for patients and physicians alike; and
• Advance, fully invest in, and successfully implement policies that empower patients, improve outcomes, support physician leadership, and support innovative and market-driven approaches.

Specific to this RFI, PAI believes that CMMI should address key policies to invite and engage physician practices in DPC and other models, including:

• Model design (e.g., patient alignment/attribution; type and levels of risk; risk-adjustment);
• Participation requirements and organizational structure;
• Data collection requirements and regulatory burden; and
• Alignment with other payer arrangements.
In addition to the comments provided in response to the RFI, PAI believes another avenue for CMS and CMMI to understand the current practice of medicine in different settings by different providers to truly drive change and improve practice options for physicians is by engaging in more in-field engagement activities. These should be at the local and regional levels, which PAI’s member state societies could help coordinate and facilitate. In-field engagement meetings would allow the agency to see the innovations happening on the ground as well as the impact of different program requirements, changes, and activities on the provision of health care services to patients.

**Overview**

PAI believes that by creating opportunities for physicians to directly contract to care for Medicare and Medicaid patients, CMMI is signaling a welcome understanding of the importance of preserving an important option for patients, physician-directed health care. Over the past five years, a dramatic shift in physician practice arrangements underscores the need for new policies to allow physicians the option of competing independently. PAI and Avalere Health partnered to study the growth of hospitals acquiring physician practices and hospital employment of physicians and found that over a four-year period from 2012-16, hospital acquisitions of physician practices grew by 100%, with hospitals acquiring 42,000 physician practices. Over the same period, physician employment grew 63%. This trend has been fueled by federal payment policies that favor hospital-based care, a crushing regulatory burden that is overly costly for small practices and various outdated laws and regulations that restrict physicians’ ability to compete on a level playing field with hospitals, health systems, and insurers. Without addressing these barriers and creating new opportunities for physicians, the trend towards employment will likely continue.

Given our concerns about the lack of opportunities for physicians to compete in independent practice arrangements in today’s environment, PAI is pleased to see CMMI’s interest in developing DPC models, an approach that offers new avenues for physicians to engage with their patients. In doing so, CMS will be able to directly contract with physicians and other entities, and physicians will be afforded new opportunities to participate in alternative payment models (APMs). The DPC model approach aligns with PAI’s goals for advancing policies that empower patients, improve outcomes, support physician leadership, and advance innovative and market-driven approaches. PAI agrees that the four goals outlined by CMMI in this RFI are the essential elements that should be considered in the development of payment models and that they serve to increase patient-centered care and access to necessary services.

PAI has identified five guiding objectives to inform the future development of DPC models and modifications of existing CMMI alternative payment models (APMs). Innovative payment models should:

- Provide increased flexibilities, incentives, and resources for physicians and other clinicians;
- Include elements that focus on patient needs, as well as encourage and incentivize patient engagement;
- Include pilots and programs with clear guidance and enhanced clarity;
- Rely upon input from, and collaboration with, physician organizations, and state medical societies/associations; and
- Reduce physician administrative/regulatory burden.
In this letter, we provide comments based on the application of CMMI’s goals and PAI’s objectives in response to specific questions posed in the RFI.

How can a DPC model be designed to attract wide variety of practices, including small, independent practices, and/or physicians?

PAI supports the agency in its efforts to adopt policies and develop models that attract a wide variety of practices, particularly small and independent practices and solo practitioners. We appreciate the agency recognizing and addressing a growing concern in the physician community by considering how to provide greater options for small and independent physician practices to competitively participate in innovative payment models, like the DPC model, while sustaining their independence.

Over the last decade, integration in the health care sector has led to increased consolidation and decline of independent medical practices,¹ which PAI feels has had negative implications for continuity of patient care, quality, and innovation in the health care system. From the physician perspective, selling a medical practice to a hospital or entering into an employment arrangement often presents an attractive or unavoidable alternative to dealing with ever-increasing administrative and regulatory burdens and high costs associated with running a medical practice in today’s environment. Physicians should be able to choose an employment arrangement by will, not pure necessity.

Based on feedback PAI has heard from physicians, there are several design elements of current models that present obstacles to successful participation in APMs, including, for example:

- The patient alignment/attribution thresholds and minimum levels of risk, which are often set too high for many practices, especially those in individual and small practices
- Limitations on the ability of current APMs to accommodate and take into consideration different and innovative practice models and settings
- Challenges for APMs and their approaches to risk adjustment to account for different patient mixes and patient populations served by physician practices.

To attract a variety of practices, PAI recommends that a DPC model have lower patient attribution thresholds than current models, which can be met and exceeded by small and independent practices. To further entice small groups, PAI recommends including tracks with no or low nominal risk standards for solo practitioners and small practices that are interested in participating in and contributing to innovative care models. The agency may also include additional tracks with more

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graduated levels of risk and responsibility as additional options for practices. However, CMS should not require that practices take on down-side risk that is not sustainable for their practice. Furthermore, the DPC model should accommodate physicians practicing in care settings that are not traditionally considered under APMs, for example, in rural areas, socially-isolated urban communities, home-based settings, rehabilitation and nursing facilities, and other clinical settings. There are many examples of physicians providing care outside of traditional practice settings, and these physicians are often providing care to more complex, higher-cost, and chronically ill patients who are subject to disparate health outcomes based on multiple and complex social conditions negatively impacting their health and health care. The DPC model should be designed to encourage and support these and other physicians and practices that are extending care to patients who face significant barriers in managing their health appropriately at settings and in a manner that is most convenient and beneficial to them. By extending beyond traditional primary care to those specialties also caring for patient populations in non-traditional settings and patients with chronic conditions and ongoing health care needs (e.g., diabetes, asthma, depression, etc.), the DPC model can help improve local population health efforts. Thus, combining and/or enhancing reimbursement for services that address the social determinants of health is worthy of consideration and research.

The DPC and other physician-led models that are developed should appropriately account for varying patient populations, practice sizes and settings, and innovative care models that best meet patients’ needs. It is important that the agency develop physician-led models that improve access and care across a wide range of geographies, practice settings, and communities, including underserved communities, and also encompass a wide range of physicians and other providers involved in patient care. Furthermore, it is critical that the model incorporate a risk adjustment methodology that works for a variety of practices, particularly those practices that do not serve an average risk-mix of patients and instead provide care to higher-risk patients who are at the “right end of the tail” with respect to risk. A shortcoming of existing models that we believe can be addressed through the DPC model is a better risk adjustment methodology that incentivizes – not penalizes – physicians and practices for providing care to high-risk, high-touch, high-cost, complex patients. The risk adjustment model should factor in frailty, socioeconomic status, social determinants of health, as well as family and social supports that can help patients better manage their care on their own at home. While there has long been a focus on the need for both more accessible and applicable physician-led models and enhanced risk adjustment that better address socioeconomic barriers to care and social determinants of health, PAI believes the opportunity is ripe now to act on those needs as they align with and further support the goals of the agency to develop a model that aims to enhance the patient-physician relationship, empower patients, and increase choices and competition to drive quality while reducing costs and improving outcomes.

Beyond just including this information in the risk adjustment methodology, PAI also believes that information on socioeconomic status and social determinants of health be shared with physicians and practices so they have a more accurate picture of the patients and can better tailor services to the specific needs of their patients in an impactful and meaningful way. For example, sharing information in a manner that can help physicians and practices collaborate with other providers in the community, including those providing social services, to increase access to, e.g., meals and
housing to positively improve outcomes for patients. Physicians and practices need to be equipped with the appropriate tools that can allow them to build partnerships with key housing and health stakeholders and use a data-driven approach to identify target populations and systems gaps to inform resource allocation and program evaluation at local, state and federal levels.

Whether it is feasible or desirable for practices to be able to participate independently or, instead, through a convening organization such as an ACO, physician network, or other arrangement?

PAI believes that the agency should provide physicians and practices the option to participate in a DPC model either independently or through a convening organization or other arrangement to support physician collaboration, and physicians and practices should have the ability to change their participation option each year. We do not believe that physicians or practices should be required or restricted from testing and exploring what is best given their circumstances and the needs of their patients.

In addition to convening organizations and physician networks, other collaborative models the agency should consider and encourage would be an arrangement similar to the management services organization (MSO) or the virtual groups option currently available in the Quality Payment Program (QPP). Under these models, physicians and practices can maintain their independence while collaborating and pooling resources to collectively meet program requirements, such as care coordination, while dispersing the administrative burden and costs of participation. However, PAI stresses the importance of the potential these types of collaborative models hold, but only if greater investment is made to ensure their design, implementation, and participation are all appropriately supported. In doing so, CMMI should work to ensure data integrity across models is maintained to capture learnings.

What features should CMS require practices to demonstrate for participation in a DPC model? Should these features or requirements vary for those practices that are already part of similar arrangements with other payers versus those that are new to such arrangements?

PAI believes that the DPC model is an opportunity for the agency to evolve from the “check-the-box” model designs that do not necessarily increase quality or value of care, towards creating the appropriate incentives and structure for physicians and practices to provide patient-centered care. For those practices already in a similar arrangement with other payers versus those that are new to a DPC model arrangement, PAI believes that the agency should streamline requirements to best align with existing payer arrangements and not create different standards that increase the participation burden.

PAI further suggests that the agency not establish strict and inflexible participation requirements that are unfeasible for many physicians and practices and that would limit participation in the DPC model. As discussed above, much of the criticism centered around existing APMs is the inability
for models to accommodate different practice sizes, care models, and settings. In addition to the
requirements discussed above, PAI recommends against the agency specifying the technology that
must be used. This has been an impediment to successful participation in existing models that
require the use of certified electronic health record technology (CEHRT).

Many physicians and small practices do not have the financial resources to acquire a specific
technology or related component, for example, an upgrade for a technical capability for their
existing technology. In cases where a practice or physician may have access to CEHRT, they are
unable to utilize the CEHRT to its full capacity and value due to information blocking, data
exchange issues, and lack of interoperability tied to health information technology vendors. As a
result, physicians and practices are often penalized under model requirements for actions that are
out of their control and are instead the responsibility of the vendors providing or developing the
technology. Physicians are also often unjustly penalized for reliance on vendors and trusting that
their vendors will become certified, maintain their certification, and appropriately submit their
data to CMS on their behalf. Many vendors have delayed their updates and continue charging
practices exorbitant fees for these updates (e.g., for interoperability functionality) even when they
are delayed or not completed. Unless the agency strictly holds vendors, not physicians and
practices, accountable for compliance with program requirements, data exchange, ownership
standards, and information blocking, the use of a specific technology should not be an element of
the DPC model.

PAI also believes that specifying the organizations structure, requiring participants to exceed high
minimum patient/payment thresholds or take on high levels of risk, and similar requirements in
the DPC model would continue to further restrict and create obstacles to participation.

What support would physicians and practices need from CMS to participate in a DPC
model? What types of data would physicians and/or practices need and with what
frequency, and to support which specific activities? What types of support would
practices need to effectively understand and utilize this data? How should CMS
consider and/or address the initial upfront investment that physicians and practices
bear when joining a new initiative?

As DPC models are evolving in the marketplace, there are several areas where CMS could provide
support to physicians and practices participating in the DPC model. While some physicians are
participating in DCP-type arrangements and elements, including CPC+, ACOs, and MA, others are
unfamiliar with the aspects and benefits of these payment arrangements, as well as the future
options available as those evolve. The supports CMS can offer include: model education,
infrastructure and health IT support, and data sharing and feedback reports. We expand on each
of these below.

Model Education and Communication
One frustration physicians and practices have expressed is the lack of clear guidance and
understanding of the various models and program requirements and what all that information

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means at a practical level for their practice. With the DPC and other models, PAI encourages CMS to provide clearer guidance and step-by-step instructions and information on the model, what is specifically required of participants individually and/or collectively as a group or entity, and how physicians and practices join or participate in the model. The key to encouraging participation by physicians and practices is translating how the model provides flexibilities and the ability to improve and directly impact patient care and their everyday practice. It is also important to translate educational materials for the patients and their families and caregivers, so they too can better understand and make the connection between how a model, and the innovative way that the care is provided under that model, impacts their health, outcomes, and wellbeing. Education and communication speaking to the health care needs of the patients and how care is delivered is important for both physicians and patients to encourage their engagement and active participation.

**Infrastructure and Health IT Support**
DPC models will have different infrastructure and IT needs and will succeed with greater support and incentives for interoperability. The Administration, Secretary Azar, and Administrator Verma have been emphasizing the importance of interoperability for all stakeholder groups. They have announced several initiatives to improve interoperability, promote the exchange of medical data, and give patients greater access to control over their health data. PAI applauds these efforts and the continued commitment to implementing policies and initiatives focused on health information exchange that we believe are an important component of patient care.

As discussed above, PAI does not believe that the DPC model should specify the use of a specific technology like CEHRT. However, the agency, through the DPC model, should provide infrastructure and other support for physicians and practices to acquire the requisite technology and platforms that allow for health information exchange between providers and between providers and patients. For example, the agency could create a “vendor compare” similar to “Physician Compare” that would publicly report vendor data and error rates and their capabilities. This would allow physicians and practices participating in the model to evaluate the vendor that would be most appropriate for them and that aligns with their practice goals.

Another option is for the agency to create a funding source for physicians and practices that helps them acquire the technology required for interoperability and connectivity. For example, under Medicaid, states can request 90/10 Health Information Technology (HITECH) funding for health information exchange activities that support adoption and use of EHRs. A similar funding opportunity specifically for health information exchange or interoperability activities and technologies could be provided under Medicare and the DPC model to help smaller practices overcome funding and technology barriers.

**Data Sharing and Feedback Reports**
As discussed above, sharing information on patients’ socioeconomic status and social determinants of health provides physicians and practices with a more holistic view of their patients. PAI believes that the more information CMS can share, linking claims data to clinical data,
as well as other available social service information, the better equipped practices and physicians will be at making more informed care decisions for the patients. PAI would also like to emphasize the importance of sharing feedback reports on a timely and continuous basis so that physicians and practices can make closer to “real-time” modifications that can increase the quality of care being provided. Additionally, a critical next step will be providing the resources and assistance to practices to help them identify evidence-based workflows for care teams to use the data purposefully in clinical care.

We would also like to emphasize the importance of CMS sharing feedback reports on a timely and continuous basis so that physicians and practices can be responsive in modifying services to increase the quality of care being provided to patients at risk for disparate health outcomes. True community health requires an understanding of community dynamics. Therefore, metrics must be developed to capture community dynamics to replicate policy decisions and interventions that improve health outcomes for our most vulnerable patient populations.

**What support or technical assistance would States need from CMS to establish DPC arrangements in Medicaid?**

PAI encourages CMS to develop Medicaid DPC models with input from, and in collaboration with, state medical associations/societies who work closely with physicians across different regions and areas within a state. State medical associations understand the needs of physicians and the patient populations, as well as the current gaps in care. As such, state medical associations provide a valuable perspective and insight into the development of these local models. Importantly, new models should not overlook or disadvantage community-based private practices, which are committed to serving patients in familiar and comforting settings closer to their homes who would otherwise be required to travel further for their health care were it not for these community-based private practices.

Additionally, as the agency further pursues Medicaid DPC models, as discussed above, it is important to design the models to account for, through risk adjustment and other design elements, Medicaid programs providing support to some of the most vulnerable patients. Furthermore, it will be important to bridge the gap for dual eligible beneficiaries who require support from both Medicare and Medicaid DPC models. In these situations, the agency should develop policies that ensure and support coordination for the patient’s totality of care to ensure payment across Medicare and Medicaid programs is appropriate.

Furthermore, one area of interest is in assisting states develop measures that are applicable to the patients treated and the way care is delivered under a model, and that can align across public and private programs to help reduce the administrative and participation burden for physicians.
What incentives and tools would be helpful for patients to become more engaged and active consumers of their health care services, along with their family members and caregivers?

PAI believes that transparency and allowing patients access to their health information are vital to helping patients and their families and caregivers become more engaged and active in health care decisions. We believe it is important for patients to understand the unique value and quality of care and services they can access under the DPC model and communicate information in plain language that resonates with patients and their families and caregivers and social service providers. The information should promote health and health care literacy and outline risk modeling in a meaningful way.

However, PAI also believes it is critical to ensure that the data and information being shared does not unintentionally misguide or misinform patients. Cost information is especially sensitive to these issues because there are several factors that must be taken into consideration when viewing the “dollar sign” associated with a specific clinician or service. For example, costs vary depending on specialty care, geographic issues, diagnoses/conditions, etc. If cost data is made available to patients, PAI would urge the agency to also focus its efforts on providing resources and assistance to patients to help them understand the different factors that are included in “costs,” especially as this may vary from practice to practice depending on the variation in their care models (as discussed in detail above). Cost data alone does not provide a complete or accurate picture to inform patients in their own decision making as we know from previously experienced challenges with Hospital and Physician Compare.

Additionally, PAI supports patient incentives, similar to those provided in the Coordinated Care Award available under the Next Generation accountable care organization (ACO) model, for selecting and aligning with “high-quality” physicians and other clinicians who are participating in the DPC model. We believe that these should be built into not only the DPC model but also other current models that lack such patient incentives, rewarding patients for being “active consumers” and making high-quality, cost-effective decisions about their health care services. PAI recommends that CMMI seek opportunities such as this to apply best practices from effective elements of existing models into DPC models as they are both proven and provide familiarity to physicians and patients.

How could CMS structure the PBPM payment such that practices of varying sizes would be able to participate? What, if any, financial safeguards or protections should be offered to practices in cases where DPC-enrolled beneficiaries use a greater than anticipated intensity or volume of services either furnished by the practice itself or furnished by other health care providers? Should a DPC model offer graduated levels of risk for smaller or newer practices? What additional payment structures could be used that would benefit both physicians and beneficiaries?
PAI believes that upfront PBPM payments that are contemplated in the RFI would allow physicians and practices to make the initial infrastructure and other investments often necessary to innovate and to begin taking on the level of risk and responsibility, even if nominal, required under the DPC model, for example, hiring care coordinators and purchasing health information technology. In addition to the PBPM payments, the DPC model should also include a shared savings or quality incentive component rewarding physicians and practices for increasing the quality of care provided to patients while decreasing overall costs. However, PAI would recommend that the agency establish and adopt more meaningful and applicable measures with further input from the physician community that are based on patients’ needs and the care they are receiving.

PAI believes that physicians and practices should be afforded safeguards from bad debt, which can severely disadvantage or send them out of business. Protections can be provided for excessive intensity or volume, especially that which is out of the control of the physician.

PAI strongly believes that the agency should offer both graduated levels of PBPM payments and levels of risk and responsibility to allow practices of varying sizes, including smaller and individual practices, to participate in the DPC model. To entice small and individual practices, PAI recommends starting with no or fairly low levels of downside risk and gradually increasing the level over time as the practices become accustomed to taking on more risk. We believe options should exist for practices across the spectrum providing them the choice and opportunity to participate in an innovative model, like the DPC model, at a level of responsibility at which they are prepared and is sustainable.

Beyond these elements, PAI also strongly believes that the agency should develop a payment structure that encourages and rewards care coordination, particularly for physicians and practices that focus resources on providing care to patients with one or more chronic conditions. Given the complexity and often high-costs associated with this patient population, there is an opportunity to improve coordination between providers and the multidisciplinary team that is responsible for these patients, as well as to improve the coordination of services, including, for example, nutritional, lab, and other diagnostic services. Complementary to the payment structure would be the need to provide physicians and practices with the authority and ability to negotiate the coordination and provision of these services with third parties and other service providers. With the appropriate incentives and flexibilities, this alignment of providers and services would increase coordination, communication, and efficiency, the lack of which currently can contribute to redundancies and increased costs.

**Whether there are specific data collection processes that could be leveraged to reduce participation burden for practices, physicians, and patients?**

There are several existing valuable data collection processes and tools that the agency could leverage for the DPC model and reduce the participation burden. For example, for physicians and practices already participating in DPC arrangements with other payers, PAI encourages the agency to allow for those data collection processes already being utilized to satisfy the DPC model requirements. Additionally, PAI encourages the agency to collaborate with existing health
information exchanges (HIEs) that could be leveraged for data collection and information exchange for the physicians and practices that are already connected. The agency should also consider leveraging opportunities to aggregate data from existing registries, including clinical data registries and qualified clinical data registries (QCDRs), that many physicians and practices already report to for other quality improvement purposes and utilize the data capabilities of these registries for the DPC model as well.

**How can CMS foster alignment between requirements for a DPC model and commercial payer arrangements to reduce burden for practices?**

PAI encourages the agency to create as much alignment between the different models and arrangements as is feasible, specifically reporting and participation requirements (e.g., measures, data reported, payment structures, etc.). This effort reduces the complexity and burden of participation often related to physicians and practices having to constantly monitor and adhere to different participation requirements for different models. The agency may consider a multi-payer DPC model approach, like other programs (e.g., Comprehensive Primary Care Plus), especially as the DPC model will likely be modeled after DPC arrangements or aspects of that already exist with other payers. There are also opportunities to incorporate specific alignment with the Medicare Advantage (MA) program by following the lead of the Next Generation ACO program to allow DPC model participants greater latitude to implement beneficiary enhancements similar to those available under MA.

**Different types of ACOs may face different challenges and have shown different levels of success in ACO initiatives to date. Would a DPC model help address certain physician practice-specific needs or would physician practices prefer refinements to existing ACO initiatives to better accommodate physician led ACOs? Are there refinements and/or additional provisions that CMS should consider adding to existing initiatives to address some of the goals of the DPC?**

PAI does not believe a DPC model, which addresses physician practice-specific needs or refinements to existing ACO programs, should be mutually exclusive. In addition to the recommendations and proposals discussed in detail above, (and which PAI believes should extend beyond just the DPC model and could be incorporated as modifications to existing models) PAI recommends two additional design elements that the agency should consider for both the DPC and other models. First, models should incorporate elements that focus on the needs of different patient populations for which lack of Medicare compensation for necessary services creates a disincentive for some clinicians to be able to offer appropriate care for these patients (e.g., groups who may require translation services, including those who require language assistance or sign interpretation). PAI believes that model elements could and should be incorporated which provide physicians and other clinicians with the right tools and resources to provide care and services to these patients.
Second, PAI encourages the agency to work with the Federal Trade Commission (FTC) and Department of Justice (DOJ) for more strategic application of antitrust laws that allow for and encourage collaboration between independent physicians and other providers that improves patient care. For example, the FTC and DOJ issued a joint Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations (ACOs) Participating in the Medicare Shared Savings Program (MSSP) that intend to ensure that the necessary clarity and guidance was provided for ensuring the providers could form procompetitive ACOs. The policy statement also applies a rule of reason analysis to determine if an ACO is likely to have anticompetitive effects, and if so, whether its efficiencies are likely to outweigh the effects.

However, this policy statement, which encourages collaboration but also promotes competition, has been limited in its application. PAI encourages the agency to extend, as appropriate, the application of the policy statement and consider updating other guidance that would provide greater clarity and support of physicians seeking to collaborate to participate in the DPC and other models. The lack of similar guidance applicable to models beyond the MSSP and broader collaborative opportunities, for example, the virtual groups options offered under MIPS, where related and similar antitrust issues might arise, is currently an obstacle to participation. It is important to take these actions so that physicians and practices can retain their independence while more readily operating under APMs and value-based payments on a joint-contracting basis, recognizing the pro-competitive and quality improvement benefits of these arrangements, and the encouragement of their creation across the public and private sectors.

Conclusion
PAI supports the agency’s efforts to develop new models, which provide greater options, opportunities, and incentives for physicians, practices, and patients, centered around the core guiding goals and the objectives outlined by PAI. We believe the barriers which currently exist to APM participation, to maintaining independent practice because of undue administrative/regulatory burdens, and to supporting physician-led patient-centered health care must also be addressed – CMMI through its model design work has the opportunity and ability to drive change as well as to be an important voice recognizing the importance of continued physician leadership.

PAI and the medical associations represented on the PAI Board of Directors welcome the opportunity to work with the agency to further develop and implement potential DPC models in a meaningful and impactful way. 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
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