PEPC
PARTNERSHIP TO EMPOWER PHYSICIAN-LED CARE

May 24, 2018

Submitted via email at DPC@cms.hhs.gov

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:

Thank you for the opportunity to provide comment on the Direct Provider Contracting (DPC) Request for Information (RFI). We appreciate your commitment to value-based care, and welcome the opportunity to share our view on steps the Innovation Center could take to further advance physician-led care models.

The Partnership to Empower Physician-Led Care (PEPC) is a membership organization dedicated to supporting value-based care to reduce costs, improve quality, empower patients and physicians, and increase access to care for millions of Americans through a competitive health care provider market. We believe that it is impossible to achieve truly value-based care without a robust independent practice community. Our members include Aledade, American Academy of Family Physicians (AAFP), California Medical Association (CMA), Florida Medical Association, Medical Group Management Association (MGMA), and Texas Medical Association/PracticeEdge.

One of our core policy objectives is to encourage the Centers for Medicare & Medicaid Services (CMS) to prioritize physician-led alternative payment models, including physician-led accountable care organizations (ACOs) and other approaches to achieve improved outcomes for patients, greater value through lower cost of care, and the preservation of independent clinical practice.

With this objective in mind, following are several principles we encourage the Innovation Center to adopt when developing new models or refining existing approaches to value-based care:

1. **Physicians are best positioned to drive delivery system transformation.** Physicians – especially independent physician practices – are the lynch pin of our nation's health care system. They have repeatedly demonstrated their superior ability to generate positive results in value-based care arrangements, both in improved health outcomes and reduced costs. They are the most powerful tool we have to foster an affordable, accessible system that puts patients first.

2. **Models should be accessible to a wide range of physicians, including physicians choosing to remain independent.** As you know, the physician workforce is not homogenous. Instead, there are physicians in large practices and small practices, in rural and urban settings, in a variety of different employment arrangements. CMS should consider the unique circumstances of

physicians in independent practice when developing models, ensuring that there are options available for this cohort of the workforce and recognizing that models that are appropriate for large hospital-led groups and/or large physician practices may not be appropriate for all.

3. **New models should allow physician practices to assume appropriate financial risk for reducing costs proportional to their finances while offering greater reward over time for practices agreeing to take on more risk.** To attract independent practices, risk must be proportional to their finances and not so large as to favor consolidation of practices. An example of a recent model that is calibrated to reflect the financial realities faced by small physician practices is Track 1+, which incorporates risk that is meaningful but not so large as to be an existential threat to a physician's business. CMMI should also provide more predictable and accurate risk adjustment and benchmarks that work for a range of physician practices.

4. **Models should test a range of innovations aimed at encouraging consumers to engage in their care while not imposing substantial new administrative burdens or paperwork requirements on physician practices.** In implementing new models, CMS could consider a range of beneficiary-focused design elements including allowing Medicare beneficiaries to voluntarily enroll in the model(s) with the primary care physician of their choice; or rewarding beneficiaries for decision-making that results in cost reductions by, for example, sharing in any savings obtained by the practice if the practice is participating in a shared savings model, receiving added benefits from their physicians and/or having their cost-sharing reduced or eliminated. As CMS considers requiring practices to voluntarily enroll and/or recruit patients to participate in care models, we caution that this would be a significant barrier to participation for many independent practices. We urge CMS to consider maintaining and improving processes for attributing patients based on historical claims for practices and clinicians that do not have the resources or desire to implement robust patient outreach and enrollment strategies.

5. **Quality measures should be harmonized across new and existing models to the extent possible and CMS should use a parsimonious list of meaningful measures that reduce the burden of reporting.** Quality measurement and improvement is of the utmost importance for value-based care, and should be incorporated into all alternative payment models, including physician-led models. We urge CMS to harmonize measures across new and existing models, focusing on those measures that have the greatest impact on patient care.

You have also asked how new models should interact or align with existing ACO initiatives, including how ACO initiatives could be strengthened to attract more physician practices and/or enable a greater proportion of practices to accept two-sided financial risk. As indicated above, models that require two-sided risk must be attractive to a range of physicians. With the exception of Track 1+, CMS's other two-sided ACO models require physicians to take on levels of risk that are so high as to be a significant deterrent to program participation. We urge CMS to consider implementing additional shared savings models that cap downside risk at an appropriate level while requiring physicians who choose to participate to take risk proportional to their finances. We also urge CMMI to expand the alternative payment model options available to physicians and physician-led groups.

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Please do not hesitate to reach out to me if the Partnership to Empower Physician-Led Care can be a resource to you. I can be reached at kristen@physiciansforvalue.org or 202-640-5942.

Sincerely,

Kristen McGovern
Executive Director