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May 18, 2018

Adam Boehler, Director
Center for Medicare & Medicaid Innovation
Center for Medicare & Medicaid Services
DPC@cms.hhs.gov

Dear Director Boehler:

Thank you for the opportunity to respond to your Request for Information (RFI) regarding Direct Provider Contracting (DPC). DPC has both potential benefits and harms. Including DPCs in Medicare and/or Medicaid therefore requires important protections so that DPC arrangements direct beneficiaries only to high quality clinicians, and do not increase beneficiary costs or exacerbate socioeconomic disparities.

High-Value Clinicians: DPC has potential to improve access, quality and patient experience if such contracts direct beneficiaries to high-value clinicians with a documented commitment to high-qualify, efficient, patient-centered care. DPC also has potential to lower quality if there are no standards for assuring that DPC arrangements provide access to only high-value clinicians. To prevent this, you should require independent Patient-Centered Medical Home (PCMH) or Patient-Centered Specialty Practice (PCSP) recognition from well-established, trusted entities for any practice participating in a DPC demonstration.

Requiring independent PCMH or PCSP recognition can be a critically important beneficiary protection. PCMH and PCSP practices have key features you suggested are important in the RFI. These include use of certified EHRs, organizational structure requirements and safeguards to ensure beneficiaries receive high-quality, necessary care. There is an abundant and growing body evidence on the benefits of well-established PCMH practices on cost, quality, access, evidenced-based care and disparities.

The National Committee for Quality Assurance (NCQA) has America's largest PCMH program, **with approximately 20% of all primary care physicians at 15,000 sites. We also have the only PCSP program. Congress recognized PCMH and PCSP**'s many benefits by giving clinicians **in these practices auto-**credit in Medicare's Merit**-Based Incentive Payment System (MIPS). You can readily apply Medicar**e's PCMH and PCSP MIPS auto**-credit criteria to DPC.**

In addition, 27 public-sector initiatives across 23 states require or use NCQA PCMH Recognition. Many commercial insurers also provide incentives for PCMH and/or PCSP recognition. We maintain a directory of public and private PCMH and PCSP incentives by state on our website.

Costs & Disparities: DPC further has potential to harm patients and increase socioeconomic disparities if it allows clinicians to discriminate on which patients they will serve or charge patients more than Medicare payment limits.

Ideally, you can prevent balance billing concerns by not letting clinicians in DPCs charge coinsurance or deductibles, as is common in many private sector DPCs. At the very least, you need clear and strong provisions to prevent discrimination and excessive balanced billing. These are thus essential for any demonstration testing DPC in Medicare and/or Medicaid.

You can help to prevent discrimination by closely monitoring use of DPCs and aggressively enforcing any violations of existing anti-discrimination provisions in law. You further will need to conduct regular analyses of DPC's impact over time **on access, cost, quality and disparities and publicly report results.**

The American College of Physicians (ACP) stressed these concerns in their analysis of DPCs and similar arrangements.[1] ACP's conclusions include **that:**

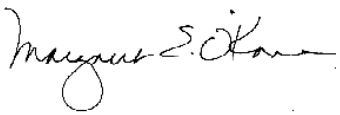
- Physicians in all types of practices must honor their professional obligation to provide nondiscriminatory care, serve all classes of patients who are in need of medical care, and seek specific opportunities to observe their professional obligation to care for the poor.

- Physicians in all types of practice arrangements must be transparent with patients and offer details of financial obligations, services available at the practice, and the typical fees charged for services.

- Physicians should consider the Patient-Centered Medical Home as a practice model that has been shown to improve physician and patient satisfaction with care, outcomes, and accessibility; lower costs; and reduce health care disparities when supported by appropriate and adequate payment by payers.

Thank you again for the opportunity to comment on your request for information. If you have questions, please contact Paul Cotton, Director of Federal Affairs, at (202) 955-5162 or cotton@ncqa.org.

Sincerely,



Margaret O'Kane,
President

[1] **Doherty et al,** Assessing the Patient Care Implications of "Concierge" and Other Direct Patient Contracting Practices**, Annals of Internal Medicine, December 2015.**