CITIZENS' COUNCIL FOR Health Freedom
SECURING HEALTH FREEDOM FOR ALL

May 25, 2018

Administrator Seema Verma
Centers for Medicare and Medicaid Services
Department of Health and Human Services

Director Adam Boehler
Center for Medicare and Medicaid Innovation
Department of Health and Human Services

Re: Request for Information on Direct Provider Contracting Models

Dear Administrator Verma and Director Boehler,

Thank you for issuing this RFI for comments on Direct Provider Contracting. Citizens' Council for Health Freedom (CCHF) is a national health policy organization whose mission it is to protect health care choices, individualized patient care and medical and genetic privacy. CCHF is providing general comments and responding to questions contained in the RFI.

CCHF has concerns with the proposed model of Direct Provider Contracting—and its acronym. Many physicians and providers have wisely chosen to move away from insurance contracts. They have also opted out of Medicare/Medicaid to remove federal and other third-party intrusion from their practice. They are third-party-payer free (TPF). The questions and commentary of the RFI propose to intrude into the patient-doctor relationship under the name of "DPC." The proposal asks "how can a DPC model be designed to attract a wide variety of practices, including small, independent practices, and/or physicians."

To be clear, once the government gets involved with a practice, it will no longer be "independent" in the true or practical meaning of the word.

Given that the proposed federal DPC model is the antithesis of the current private model embodied by the term DPC (direct primary care), the use of the acronym "DPC" would confuse the American public—and make it harder for them to find a truly independent, third-party-free DPC practice. We believe it would also make it harder for the true DPC (direct primary care) clinics to differentiate themselves from the government DPC (direct provider contracting) clinics. It could also make it more difficult for the true DPC clinics to survive, given the operating finances of the federal government and the likely financial capacity of government DPC clinic operators to advertise using the DPC acronym.

The RFI descriptions of possible "features" (Question #2) of the government DPC clinic sound similar to the costly third-party-payer overhead requirements that ACOs

and other Medicare/Medicaid approved clinics must meet, keeping medical care unaffordable.

True DPC clinics, which are not required to meet these costly federal requirements, offer truly affordable care to their patients, regardless of whether the patient is insured, uninsured, or publicly subsidized. Our organization offers a meeting place for patients and physicians who want to operate outside of the government costs and constraints. It's called The Wedge of Health Freedom. (JointheWedge.com)

If the federal government is truly interested in improving access, quality and prices, the CMS Innovation Center needs to do a **180-degree turn away** from the managed-care premises that we see in this proposal.

It needs to restore direct payment *between the patient and the doctor*. If patients want to seek reimbursement for services that are Medicare-reimbursable, that should be allowed. But the government should have no part in the transaction between the patient and the doctor, and the doctor and government should have no interaction with each other. The best, highest quality, and most affordable care emerges from direct payment, not government reimbursement or interventions.

Direct pay by the patient, either through true DPC or fee-for-service (FFS) allow for direct contracting (direct pay) *between patients and doctors*—either by a menu list of prices or set of services in exchange for an agreed-upon monthly price.

This CMS proposal would undermine these relationships by placing government between the patient and doctor. Besides direct reimbursement to patients from CMS for Direct Primary Care (true DPC) or FFS, another option would be patient-controlled Health Savings Accounts that could be used by Medicare or Medicaid beneficiaries. These options keep patients at the center of their medical decisions.

RE: question 1 of the RFI, CCHF believes it is not desirable for CMS to group practices together in an ACO, physician network, or other arrangement. An over-arching governing body—either private or government—is again the antithesis of true direct contracting (patient and doctor) or true DPC. As stated previously, a better model would be to empower patients to make their own informed decisions about where to spend their own health care dollars.

RE: questions 2 and 3, CCHF also believes these types of requirements are the antithesis of true DPC and true direct contracting (direct payment). CMS should not encourage the growth of federal oversight of practices, and certainly not independent practices. This burdens physicians with digital and other "paperwork" requirements resulting in less time with patients—one of the primary reasons many doctors and other providers have left their old practices to participate in true DPC or a third-party free FFS practice. Requiring CEHRT, data reporting, financial reporting, claims data reporting, etc. will increase the burdens of a practice and may cause doctors to leave their practice. Already **The Physicians Foundation found 48% of more than**

17,000 physicians are considering ways to decrease or leave patient care behind. If the federal government used this government DPC proposal to make it more difficult for them to thrive in true DPC, they may leave the practice of medicine altogether (as 10,000 baby boomers daily enter Medicare).

Regarding questions 4 and 5: Medicaid beneficiaries who wish to participate in direct contracting could be allowed to do so either through an HSA or CMS reimbursements for cash payments to TPF clinics/surgery centers. Some DPC and FFS clinics already have cash-paying Medicaid patients. When the patient is at the center of their own health care, they make more informed choices about what is best for them for the best price. If CMS wishes to provide direct contracting as an option for Medicaid patients, it should do so in a way that does not try to intrude on or potentially snuff out TPF and independent practices.

RE: question 6: minimum enrollment periods and rules around providers being able to refuse to enroll or disenroll a beneficiary portend federal controls, not independent practice. These types of rules are contradictory to the definition of a true direct contracting/direct pay relationship. CMS should encourage today's non-independent practices to become independent, not the other way around.

RE: questions 9 through 12 on payment: practices should not be paid by CMS or any other corporation or benefit manager. A true direct contracting relationship necessitates the *patient paying*. There can be no federal strings attached to the physicians or the practice. Direct pay is pure and clean, immediate and accountable—and affordable. Cost consciousness comes through market price competition. "He who pays the piper picks the tune." There's power in the American dollar.

In conclusion, Direct Provider Contracting is, by definition, a contract between the patient and the provider. There should be no government involvement in such a relationship, no government ICD-10 codes, no access to "practice and/or beneficiary data," no quality measures, no "monitoring methods" and no shift of financial risk (insurance function) by PBPM rates or risk-assumption. Instead, CMS should look at ways to empower the patient to make informed medical choices with their own dollars (reimbursable by CMS at whatever rate CMS sets).

CCHF believes CMS should empower the patient and physician to bring the entire health care system back toward the affordability, simplicity, and accountability of direct payment (true DPC and TPF-FFS). CMS could also work to free senior citizens from Medicare, so private coverage can be retained for a lifetime. Feel free to contact us at any time: info@cchfreedom.org or 651-646-8935.

Thank you,

Twila Brase, RN, PHN
President and Cofounder