January 9, 2025

Physician Focused Payment Model Technical Advisory Committee
C/o U.S. DHHS Assistant Secretary for Planning and Evaluation Office of Health Policy
200 Independence Avenue, S.W. Washington D.C, 20201

Letter of Intent – Geoff Teed, Paradigm Provider Partners, Inc. (Submitter)

Dear Committee Members,

We would like to express intent to submit a proposal to launch a physician-focused payment model via the formation of Accountable Care Organizations/Risk Bearing Entities, for PTAC review on January 9, 2025.

Introduction

Medicare beneficiaries currently have a choice between Original Medicare and Medicare Advantage, but neither model alone achieves the desired high-quality, low-cost outcomes of coordinated care. Original Medicare lacks coordination, efficiency, and financial sustainability, while Medicare Advantage raises cost concerns.

To address these challenges, we propose a new physician-led payment and delivery model. Drawing from successful ACOs, Direct Contracting entities, and advanced payment models, this innovative solution combines valuable lessons learned. We envision an interoperable healthcare omni-channel that leverages capitated, coordinated care expertise, and incorporates successful elements from other contexts like Primary Care Neighborhoods and provisions for housing, nutrition, and transportation. This physician-driven and population-focused model seeks to rectify existing flaws, including the lack of true physician representation, health equity, and conflicting values observed in Health System-, Health Plan-, and Venture Capital-backed models.

Establishment of Accountable Care Organizations (ACO) or similar Risk Bearing Entities (RBE)

We propose that the Center for Medicare & Medicaid Services (CMS) directly contract with physician controlled ACO/RBEs to deliver cost-effective and coordinated care to attributable populations, prioritizing underserved racial/ethnic communities. These physician-owned entities, formed by existing organizations or new collaborations, will ensure a patient-centric approach led by primary care physicians. Revised agreements with hospitals, nursing homes, home health organizations, and stakeholders will foster comprehensive and integrated care delivery under this innovative model. Key features of the proposed ACO/RBEs include:

1. Multispecialty Team-Based Care: The most effective population based total cost of care (PB- TCOC) models for patients with multiple chronic conditions prioritize proactive, patient-centered care by utilizing high-touch, multidisciplinary teams centered around primary care. Our ACO/RBE will implement a collaborative care model that emphasizes high-touch interactions and involves specialists, Advanced Practice Providers, and home and community-based care networks. By harnessing the strengths and expertise of each team member, we aim to enhance healthcare delivery and achieve improved outcomes for our ACO/RBE patients.
2. Enhanced Clinical Outcomes: ACO/RBEs prioritize care coordination, continuity, and evidence-based practices to improve clinical outcomes and patient experience. Collaborative care planning and shared decision-making ensure personalized and comprehensive treatment.
3. Increased Access and Reduced Disparities: ACO/RBEs target underserved communities, aiming to enhance healthcare access. By addressing social determinants of health and implementing culturally competent care, disparities are reduced, promoting health equity.

4. Cost-Effectiveness: The physician owned ACO/RBE model (see Model Overview below) lowers total care costs through optimized site of care, processes, reduced unnecessary procedures, and cost-effective practices, and improves financial sustainability for providers.
5. Social Determinants of Health: A specific feature/goal of the ACO/RBE is the systematic and organized use of Community Benefit Organizations (CBOs) to support medical care with social interventions, including but not limited to nutritional support, health coaches, and transportation. Leveraging existing CBO resources will reduce the PB-TCOC and improve health outcomes for the entire population.
6. Specific Condition goal: It shall be the explicit goal of the ACO/RBE to eliminate diabetic foot ulcers and consequent foot and leg amputations. This goal is chosen because it is achievable and because it is a bell-weather representative of a broad range of related disease conditions. The applicant invites the inclusion of bonuses and penalties to incent the achievement of this goal.

Expected Participants

The proposed program initially targets original Medicare and dually eligible beneficiaries, with plans to expand to include Medicaid, Commercial, and self-insured beneficiaries. The program aims to have 100 to 200 physicians initially, caring for approximately 15,000 beneficiaries determined through claims-based attribution and voluntary enrollment.

Goals of the payment model

Quintuple aim: 1) Improving population health; 2) Enhancing the care experience; 3) Care team well-being; 4) Advancing health equity; 5) Reducing costs.

Model overview

The envisioned model resembles a physician mutual insurance company. The applicant will initially focus on original Medicare and then proceed with the intention to convert all other payers to global capitation (category 4-C HCP-LAN) for all attributable populations. Participating Providers will receive approximately 2.5% of the PB-TCOC benchmark prospectively and retain all surplus savings, which will be distributed equitably among participating physician providers.

The ACO/RBE will be supported by a partnership with a Managed Services Organization (MSO) that will be paid fees to provide back-office infrastructure-as-a-service.

Implementation strategy

NewCo/DocCo (Kenji) (Applicant) is envisioned as a strategic collaboration comprising participating physicians and providers, Business of Interest partners, e.g., home care and hospice, transportation, housing, clinical laboratory providers, advanced tech platform partners, and others. P3 team and its esteemed Advisors are currently convening physicians to aggregate sufficient attributable beneficiary count to be actuarily viable.

Expected timelines:

Proposal submission: June 2025; Physician Network Convening: January 2025 – August 2025
Beneficiary Aggregation: January 2025 – ongoing; Implementation of the payment model: January 2026

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