NATIONAL NURSE PRACTITIONER ENTREPRENEUR NETWORK

a New Paradigm

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DIRECT PROVIDER CONTRACTING MODEL COMMENTARY

TO CMS INNOVATION CENTERS (CMS) RE REQUEST FOR INFORMATION(RFI)

FROM THE NATIONAL NURSE PRACTITIONER ENTREPRENEUR NETWORK

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BACKGROUND of RESPONDENT

NNPEN is the NATIONAL NURSE PRACTITIONER ENTREPRENEUR NETWORK. My name is Sandra Berkowitz and I am the CEO and a co-founder of NNPEN, a network of Nurse Practitioners (NPs) who aspire to be owners of, and employees within, nurse-led clinical practices. Thank you for this RFI opportunity to share Nurse Practitioner perspective on a Direct Provider Contracting model as described by the CMS Innovation Center.

WHO IS AN ELIGIBLE MEDICARE DPC PROVIDER?

NPs are included within MACRA's QPP definition of "eligible clinician" and CPC+'s definition of "practitioner". Yet throughout this RFI CMS asks for physician practice input. CMS persists in using the term "physician", when MACRA's clear intent is to broaden the eligible provider pool to all whose scope of education and licensure permits rendering of the professional services needed—as here, in CMS' Direct Provider Contracting RFI:

"A DPC model would aim to enhance the beneficiary-physician relationship by providing a platform for physician group practices to provide flexible, accessible and high-quality care to beneficiaries that have actively chosen this type of care model.".

CMS has narrowed opportunity for feedback on its DPC model by overlooking nearly 200,000 Nurse Practitioners-- the 80% of the profession who can independently deliver primary care services in ways that boost access and convenience for their patients. If 10% of the 200,000 NPs in primary care—roughly 20,000 NPs-- choose to own their own practices, they too need innovative payment models that sustain their operations year after year. Closing off these NPs means closing off access to primary care services to the patient panels of those 20,000 NPs: roughly 30M or more consumers of care.

Why is CMS looking backward rather than welcoming the new "eligible clinicians" and "practitioners" envisioned by MACRA? We urge CMS to require that responses to this RFI --and ultimately proposals to any DPC RFP-- insert the more broadly inclusive term "practitioner" where "physician" now appears.

On behalf of 30M consumers and 20,000 NP entrepreneurs, NNPEN thanks the CMS Innovation Center for our opportunity to comment from the Nurse Practitioner's vantage point in a Full Practice Authority (FPA) state where NPs can practice independently…and yet not.

NURSE PRACTITIONERS HAVE THE NUMBERS (IN COST AND QUALITY OUTCOMES) AND THEY HAVE THE NUMBERS (IN WORKFORCE GROWTH)

Without exception, studies show us that Nurse Practitioner(NP) Primary Care Providers (PCP) produce quality outcomes equal to or better than physician PCPs at 10-30% lower overall healthcare cost. For example, see https://www.mathematica-mpr.com/news/medicare-costs.

Why? Because NPs are hard-wired into a nursing model that is grounded in patient engagement, health literacy and self-sufficiency and emphasizes patient function.

CMS BARRIERS CONFRONTING INDEPENDENT NPs

While NP PCP quality and cost outcomes suggest them as perfect primary care partners for Medicare beneficiaries, CMS has constructed significant barriers to its own Triple Aim success, including:

- An FFS payment schedule that pays an NP PCP at 85% of the Medicare Physician FFS schedule for performing the same or comparable primary care services. This tempts medical practices to bill for services under the Physician, not the NP.
- Incident-to billing allows billing under the Physician for the NP's services, but siphons attribution of outcomes away from the rendering (NP) provider at a time when value-based payment (VBP) expects alignment of outcome to the rendering provider. Incident-to billing is incompatible with VBP. It both inflates the provider payment and permits the physician to claim quality outcomes as her/his own, so that shared savings flow to the physician, not to the NP that produced the outcomes.
- Lack of attribution of beneficiaries to NPs in Medicare ACOs results in NP PCP exclusion from participation in Medicare ACO shared savings programs. This in turn influences the modeling of other payors' shared savings product offerings, effectively blocking NP participation in commercial shared savings products far beyond Medicare.

DIRECT PRIMARY CARE MODEL IS A PATH FORWARD FOR INDEPENDENT NPs IN FULL PRACTICE AUTHORITY STATES

Given the above CMS constraints, combined with commercial insurers following Medicare's lead, it is not surprising that NPs who want to preserve the benefits of nurse-led care –for themselves and for their patients—see Direct Primary Care models that are not insurer-reliant as an important path forward. However, this path does not accommodate traditional Medicare, Medicaid and dual eligible beneficiaries (the populations NPs are most aligned with), more likely focusing on self-insured employers and self-pay populations. NPs do not want to give up their historic relationship with government health plan beneficiaries but may otherwise see no sustainable business model for a nurse-led practice. Another concern with the Direct Primary Care model is that it does not afford individual NP practices, who are often 1-3 NP FTEs, a way to organically form joint practice entities such as IPAs to spread/minimize financial risk and create appropriate oversight mechanisms for evaluating quality of care and sustainability of business practices. CMS's Direct Provider Contracting model may offer NPs greater opportunity to continue serving safety net populations, to find administrative support through a convening organization, and to grow with the demands of a Value-Based Payment model.

MEDICARE DPC COULD FILL A SUBSTANTIAL GAP IN CMS VBP SHARED SAVINGS MODELS OFFERED TO NPs IF…

Does the DPC model proposed by CMS fills a "gap"? For Nurse Practitioners, the answer is yes—so long as its shared savings opportunities include NPs. It offers a shared savings opportunity to NPs that has not been available thus far—and that is quite significant if we are confident that that the nursing model will continue to produce quality, cost-effective outcomes. Given that the evidence relied upon in more than 100 published studies, without exception, demonstrates the clinical effectiveness of the nursing process, it is reasonable to expect that NP participation in shared savings models, even including downside risk models, is the key to long-term NP business practice sustainability.

Based on this recurring evidence of the nursing process' salutary impact in primary care and chronic disease partnerships with patients, NPs should be given the opportunity to test out this CMS DPC model and other VBP models in their own practices--where NPs and their patients are the direct beneficiaries of newly contracted patient-centered primary care capacity in this country.

But with opportunity there are also reservations. At this time, here are our questions:

- Can CMS confirm that an NP in an FPA state is a practitioner eligible to participate in Medicare DPC models?
- Since beneficiaries with costly chronic illnesses are attracted to patient-centered PCPs, (e.g., an NP), is CMS making a commitment to a sustainable, solvent business model that does not cause harm to the NP practice for risks beyond their control? E.g., can CMS affirm that it will offer practices aggregate Medicare-reinsured provider stop loss insurance at reasonable deductible and premium levels as well as acuity mix payment adjustments?
- Is there room in this model to partner with a convening organization that insulates the small practice from the administrative burden and complexity associated with government undertakings, especially with CMS (we see the RFI is explicit about reduction in provider burden being one goal of the DPC models)? Will CMS collaborate with a convening organization that represents the participating NP practices?
- Will the CMS DPC model preempt the "DPC is insurance" position still held by half the states—and will this preemption apply only for the CMS product, or also for commercial DPC models pursued simultaneously?

Again, on behalf of 30M consumers and 20,000 NP entrepreneurs, NNPEN thanks you for this opportunity to comment from the Nurse Practitioner's vantage point in a Full Practice Authority state where NPs can practice independently…and yet not. Nurse Practitioners are the key to unlocking quality, cost-effective primary care capacity in this country—in full alignment with CMS' Triple Aim goals. We are available for further dialogue with CMS and at your request would be pleased to share our NP outcomes bibliography with you.

Respectfully submitted,

/s/

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