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*Sent via email:* [DPC@cms.hhs.gov](mailto:DPC@cms.hhs.gov)

Department of Health and Human Services  
Centers for Medicare & Medicaid Services  
Center for Medicare and Medicaid Innovation

RE: Comment by PCNP: RFI-Direct Provider Contracting Models

To Whom It May Concern:

Thank you for the opportunity to provide comment to the Department of Health and Human Services, Centers for Medicare & Medicaid Services, Center for Medicare and Medicaid Innovation, regarding direct provider contracting (DPC) models.

The Pennsylvania Coalition of Nurse Practitioners (PCNP) is a state organization that promotes and protects the practice of over 11,000 certified registered nurse practitioners (CRNPs) in the Commonwealth of Pennsylvania. Currently, there are two bills pending in the Commonwealth, Senate Bill 25 (2017-2018 session) and House Bill 100 (2017-2018 session), which would provide full practice authority to CRNPs. In anticipation of the potential passing of one of those bills in the near future, the PCNP is pleased to provide comment related to DCP models as noted below.

**General Statement:** To date, twenty-two (22) states have provided nurse practitioners with full practice authority. In that role, nurse practitioners are primary care providers and must be able to bill as a provider or primary care provider (PCP) for services rendered under CMS guidelines and regulations. Any definition of provider or primary care provider for purposes of services and billing should not be limited to physicians and include other PCPs, such as nurse practitioners. By allowing nurse practitioners to be identified as a provider or PCP with the ability to treat and bill for services, consumers benefit with increased choices, reduced costs, reduced wait times for care and enhanced quality care. This is especially true in rural areas where there is a physician shortage.

## A. Provider/State Participation

**Q1: How can a DPC model be designed to attract a wide variety of practices, including small, independent practices, and/or physicians? Specifically, is it feasible or desirable for practices to be able to participate independently or, instead, through a convening organization such as an ACO, physician network, or other arrangement?**

A: In the Commonwealth of Pennsylvania, under The Professional Nursing Law,<sup>1</sup> nurse practitioners work within the scope of their practice for a particular clinical specialty area in which the nurse is certified and in collaboration with a physician through collaborative agreements. Should SB 25 or HB 100 become a law in the Commonwealth, nurse practitioners would be considered a PCP and bill as a PCP for services rendered after the initial requirements are satisfied of a nurse practitioner working in collaboration with a physician for a period of not less three years and not less than 3600 hours of practice time. As such, the nurse practitioner members of PCNP are very interested in offering comment on alternative payment models (DPC model) with a desire to transform their practice and engage with patients in a way in which current initiatives have not previously offered, through which CMS would directly contract with Medicare providers and suppliers.

To that end, PCNP, on behalf its members, believes that it is important that a DPC model be designed to provide for a nurse practitioner to be permitted to participate independently with CMS. Ideally, any DPC model would be designed to fit all types of PCP practices or provide for all QPP eligible clinical types, in accordance with their scope of practice to lead healthcare entities and serve as PCPs, either independently or as full, and equally participating, members with their own attributed patients in ACOs if they choose.

PCNP also recommends that primary care practices need to be able to benefit from incentives while remaining and working independently. This is especially true because very small practices work on a different budget structure and staff ratio as compared to larger practices. This disparity becomes more evident when a practice is grouped with other practices, which may be owned by larger corporations. The larger corporations can dictate or influence guidelines or parameters for others. In addition, the practice sites and population demographics vary between a smaller practice and a larger practice so that specific parameters may not be appropriate across the board.

It is also recommended that because nurse-led practices tend to be solo or small, that CMS DPC models should offer nurse practitioners with the ability to participate as virtual groups at a state-by-state basis and possibly nationally. The virtual group's infrastructure is the digital platform and takes the administrative burden away from the independent practice. PCNP would ask that CMS investigate as to whether it can recognize multiple practices as a virtual group under one TIN for

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<sup>1</sup>Act of May 22, 1951, P.L. 317, No. 69, *as amended*, 63 P.S. §§ 211-225.5.

administrative purposes, but would also provide for merit based incentive or quality care measures that is returned back to the practices for use as deemed appropriate for quality care.

Finally, PCNP would like CMS to be aware that there are approximately 234,000 nurse practitioners in primary care practices. Should even a small percentage of those nurse practitioners engage in an independent practice and were not provided the opportunity to be a PCP under DPC models for services to consumers and payments, then millions of consumers would be denied the ability to receive care under the DPC models if their PCP was a nurse practitioner.

**Q2. What features should CMS require practices to demonstrate in order for practices to be able to participate in a DPC model (e.g., use of certified EHR technology, certain organizational structure requirements, certain safeguards to ensure beneficiaries receive high quality and necessary care, minimum percent of revenue in similar arrangements, experience with patient enrollment, staffing and staff competencies, level of risk assumption, repayment/reserve requirements)? Should these features or requirements vary for those practices that are already part of similar arrangements with other payers versus those that are new to such arrangements? If so, please provide specific examples of features or requirements CMS should include in a DPC model and, if applicable, for which practice types.**

A. There are many benefits of electronic health records (EHRs). However, EHRs were initially not designed to gather big data. As a result, many times a small practice reverts to hand counting or individual chart review to comply and complete requests or requirements, which is a manual process and very time consuming. Additionally, many of the EHR systems do not ‘speak’ to each other and if a provider is in many insurances, the Healthcare Effectiveness Data and Information Set (HEDIS) requirements may be the same or be very similar. Also, unlike a small or solo practice, large health systems may have the ability and resources to share health records through collaborative interface systems as well as have the ability to extract data for quality measurement purposes through sophisticated computer systems/design modules.

In the Commonwealth, some small nurse practitioner practices have been participating in the Transforming Clinical Practice initiatives. The requirements for quarterly submission of information is very similar to those parameters required or requested by most insurance companies. For a small practice, such similar gathering of information is much easier and most reflective of what you are seeing in a primary care practice. It is recommended that such parameters most commonly used by insurance companies be a basis for continuity throughout, including for CMS. By using consistent parameters with those required in the insurance industry, repetition of work for reporting purposes is streamlined and less time is needed by the provider or ancillary staff to comply with such reporting requirements. Conversely, when different parameters are required of a provider for reporting purposes to different insurance companies or CMS, there is more repetition of work and increased workload of providers or the ancillary staff.



**Q3. What support would physicians and/or practices need from CMS to participate in a DPC model (e.g., technical assistance around health IT implementation, administrative workflow support)? What types of data (e.g., claims data for items and services furnished by non-DPC practice providers and suppliers, financial feedback reports for DPC practices) would physicians and/or practices need and with what frequency, and to support which specific activities? What types of support would practices need to effectively understand and utilize this data? How should CMS consider and/or address the initial upfront investment that physicians and practices bear when joining a new initiative?**

A. It is recommended that for a practice to participate in a DPC model with CMS there needs to be an initial low risk to practices to recruit their involvement. PCNP also requests that CMS be mindful that with any new model offered, education be provided so confusion is minimized for providers and consumers. Training sessions and/or webinars should be offered to providers on the new model. In addition, proven practice delivery suggestions should be provided to providers to equip them for success with a dedicated line to call with questions. Moreover, it is recommended that practices are provided with current actionable data on a quarterly basis to improve their ability to impact the quality metrics they are trying to improve.

It is also recommended that a DPC model would need a complimentary network of specialists and facilities to wrap around the primary care delivered by the DPC provider. Furthermore, it is recommend that a DPC model provide for a stop loss provision on an individual and on an aggregate basis.

Questions that should be considered with any new model are: 1) How will the DPC model be different as it relates to CMS?; and 2) Will large insurance companies be provided grants to coordinate care, which may result in such insurance companies providing another insurance product in conjunction with CMS?

From the recent 'dual insurance' initiative in Pennsylvania, some small nurse practitioner practices have seen at least three (3) new insurances, which 'coordinate care,' yet they are all new Medicaid insurance products. The providers have not been benefitting from these products, nor are the patients. Rather, more prior authorizations have been needed and more everyday medications, which were previously covered by insurance, are not being covered.

The support needed for any new model implementation is the same support as from other insurances. Support tools need to be streamlined, user friendly and every link and website must work at any given time. Reimbursement for services must also be competitive and as indicated in the answer to question 5.



- Q5. CMS is also interested in understanding the experience of physicians and practices that are currently entirely dedicated to direct primary care and/or DPC-type arrangements. For purposes of this question, direct primary care arrangements may include those arrangements where physicians or practices contract directly with patients for primary care services, arrangements where practices contract with a payer for a fixed primary care payment, or other arrangements. Please share information about: how your practice defines direct primary care; whether your practice ever participated in Medicare; whether your practice ever participated in any fee-for-service payment arrangements with third-party payers; how you made the transition to solely direct contracting arrangements (if applicable); and key lessons learned in moving away from fee-for-service entirely (if applicable).**

It is recommended that any experiences shared by physicians and practices dedicated to direct primary care and/or DPC-type arrangements, including lessons learned, should then be stratified to apply to other types of direct primary care arrangements, such as with nurse practitioners.

For some small nurse practitioner practices in Pennsylvania, direct contracts with individual patients, i.e., set amount of money paid for open ended visits per month, are not provided. When patients don't have insurance, those nurse practitioner practices provide care on a fee-for-service basis, with a set amount paid for the visit. Discounts are also provided through the nurse practitioner office for laboratory services, and referrals to low-income sliding fee specialties are given. Such practices, however, do have contracts with multiple insurers.

Additionally, some small nurse practitioner practices in Pennsylvania have participated in Medicaid HMO's (capitation), with payment of \$7.00 per month for a 30-year-old and \$11.06 per month for a 60-year-old, whether the practice sees the person one or more times in a given month. The goal of seeing patients more than one time per month is to keep those consumers out of the hospital. So, if a patient is seen 3-4 times per month with the provider only receiving \$7.00-11.00 for the combined visit care, there needs to be better compensation model to the provider for keeping those types of patients out of the hospital.

Moreover, some small nurse practitioner practices participate in Medicare, due to sequestration and the 2% penalty for not participating in meaningful use. Further, because of a small practice dynamic, there is a decrease in reimbursement. Also, because such practice is too small to participate in the merit-based incentive payment system (MIPS), bonuses for keeping the patient out of the hospital are not received. It is recommended that any DCP model have tiers of MIPS so that small practices can also benefit from bonuses by keeping consumers healthy and out of the hospital.

It should also be noted that if a patient has both Medicare and secondary Medicaid, the provider is penalized. For example, if a provider visit for a consumer is \$115.00, Medicare will pay the practice \$40.00. Then, when the bill is sent to the secondary insurance, Medicaid, Medicaid will not pay

anything additional to the provider. This denial of reimbursement from Medicaid has been seen for at least the last two years. Furthermore, the provider is not permitted to bill the patient.

Finally, it should be noted that direct primary care is defined as providing services to ages across the life span, including preventative services, woman services, diagnosing, referring, and treatment of acute and chronic diseases. When a nurse practitioner refers a patient to a specialist, the nurse practitioner keeps track of that appointment, the results of the referral visit, and then follows up with the patient to support or explain that specialist's visit. In essence, nurse practitioners educate a great deal through their care to the consumer and include the family, as appropriate and authorized by law.

## B. Beneficiary Participation

**Q6: Medicare FFS beneficiaries have freedom of choice of any Medicare provider or supplier, including under all current Innovation Center models. Given this, should there be limits under a DPC model on when a beneficiary can enroll or disenroll with a practice for the purposes of the model (while still retaining freedom of choice of provider or supplier even while enrolled in the DPC practice), or how frequently beneficiaries can change practices for the purposes of adjusting PBPM payments under the DPC model? If the practice is accountable for all or a portion of the total cost of care for a beneficiary, should there be a minimum enrollment period for a beneficiary? Under what circumstances, if any, should a provider or supplier be able to refuse to enroll or choose to disenroll a beneficiary?**

A. There should be limits when a beneficiary can enroll or disenroll with a practice. It is recommended that a beneficiary should be required to stay with a DPC model practice for a minimum 12-month lock-in period, unless circumstances justify otherwise. From experience, nurse practitioners have seen that building effective provider partnerships with patients takes time. Additionally, it is recommended that the provider should be able to refuse a beneficiary.

**Q7. What support do practices need to conduct outreach to their patients and enroll them under a DPC model? How much time would practices need to “ramp up” and how can CMS best facilitate the process? How should beneficiaries be incentivized to enroll? Is active enrollment sufficient to ensure beneficiary engagement? Should beneficiaries who have chosen to enroll in a practice under a DPC model be required to enter into an agreement with their DPC-participating health care provider, and, if so, would this provide a useful or sufficient mechanism for active beneficiary engagement, or should DPC providers be permitted to use additional beneficiary engagement incentives (e.g., nominal cash incentives, gift cards)? What other tools would be helpful for beneficiaries to become more engaged and active consumers of health care services together with their family members and caregivers (e.g., tools to access to their health information, mechanisms to provide feedback on patient experience)?**



- A. It is recommended that providers who are already enrolled should not be required to be reenroll in a DPC model. Further, if a provider is already enrolled, no additional forms or information should be required from the provider. Hence, those practices which are already enrolled as providers in Medicare and/or Medicaid should be accepted into any DPC model.

If there is no additional information required by providers to be a part of a DPC model, it is recommended that forms and visual information be provided to beneficiaries prior to the inception of a DPC model. Visual literature should be available to explain the benefits of the DPC model. Also, active enrollment is not necessarily sufficient to ensure beneficiary engagement. It is recommended that a monetary incentive be provided within the application process requiring the patient to contact the provider for a visit to activate the incentive. By requiring a consumer to see a provider to active the DPC model and receive the incentive, the consumer benefits from a health care visit, an explanation of the new model by the provider, the enrollment into the new program, and the consumer becomes actively engaged in the entire process from the onset.

- Q8. The Medicare program, specifically Medicare Part B, has certain beneficiary cost-sharing requirements, including Part B premiums, a Part B deductible, and 20 percent coinsurance for most Part B services once the deductible is met. CMS understands that existing DPC arrangements outside the Medicare FFS program may include parameters such as no coinsurance or deductible for getting services from the DPC-participating practice or a fixed fee paid to the practice for primary care services. Given the existing structure of Medicare FFS, are these types of incentives necessary to test a DPC initiative? If so, how would they interact with Medicare supplemental (Medigap) or other supplemental coverage? Are there any other payment considerations or arrangements CMS should take into account?**

- A. It is recommended that CMS consider the interaction between Medicare co-pays and deductibles. It is also recommended that Medicare Part C be used as an example to follow as Medicare Advantage and Part C are essentially “capitated” payments/PBPMs that accommodate traditional Medicare co-pays. One question posed to CMS is whether direct primary care, between a provider and patient, is able to substitute a third party payor for the patient. One workaround is to indemnify the beneficiary for his/her monthly DPC payments.

### C. Payment

- Q9. To ensure a consistent and predictable cash flow mechanism to practices, CMS is considering paying a PBPM payment to practices participating in a potential DPC model test. Which currently covered Medicare services, supplies, tests or procedures should be included in the monthly PBPM payment? (CMS would appreciate specific Current Procedural Terminology (CPT®1)/Healthcare Common Procedure Coding System (HCPCS) codes as examples, as well as ICD-10-CM diagnosis codes and/or ICD-10-PCS procedure codes, if applicable.) Should items and services furnished by providers and suppliers other than the DPC-participating**

**practice be included? Should monthly payments to DPC-participating practices be risk adjusted and/or geographically adjusted, and, if so, how? What adjustments, such as risk adjustment approaches for patient characteristics, should be considered for calculating the PBPM payment?**

- A. PCNP recommends that any per beneficiary per month (PBPM) payment to practices participating in a potential DPC model test also include other providers, such as nurse practitioner practices. Additionally, nurse practitioners, as PCPs, should be provided the same PBPM rate as physician practices as the costs will be the same to the practice.

It is also recommended that CMS implement risk adjustments as nurse practitioners attract patients with co-morbidities who can potentially cost or save CMS substantial premium. Risk adjustments would permit nurse practitioners to sustain and maintain a practice for chronically ill panels of patients.

**Q10. How could CMS structure the PBPM payment such that practices of varying sizes would be able to participate? What, if any, financial safeguards or protections should be offered to practices in cases where DPC-enrolled beneficiaries use a greater than anticipated intensity or volume of services either furnished by the practice itself or furnished by other health care providers?**

- A. PCNP understands that under a DPC model, CMS would pay participating practices a fixed PBPM payment to cover the primary care services the practice would be expected to furnish under the model. In the event that a DPC patient is of such health intense requirements, i.e. cancer, it is recommended that a separate category be provided in CMS guidelines/regulations to define those types of patients, based on disease codes and other data. Then, the DPC provider would have the opportunity to negotiate with CMS for a percentage of the practice that would take on those identified intense patients for a fee. Moreover, since beneficiaries with costly chronic illnesses are attracted to patient-centered primary care providers, such as nurse practitioners, CMS should 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.

It is also recommended that DPC models should allow small providers, including independent nurse practitioners, to partner with a convening organization that insulates the small practice from the administrative burden and complexity associated with highly regulated large scale models such as Medicare.

PCNP also recommends that practices should receive an adjustment for visits to patients' homes to evaluate their setting for risk of falls, which evolve into high cost illnesses. It is also recommended that CMS take into consideration costs of United States Preventative Service Task Force (USPSTF)



recommended evaluation and testing such as a colonoscopy, dexta scanning, bisphosphonate therapy for osteoporosis prevention and other similar costs when calculating the PBPM fee.

Additionally, it is recommended that the PBPM payments are clearly defined. Such PBPM payment to cover services should identify whether the PBPM payments would only apply to primary care services or whether such payment would also include outpatient and inpatient services by a provider. Finally, financial safeguards should be in place to protect a practice from undue intensity or volume by the practice or by other providers.

It should also be noted that nurse practitioner primary care provider business owners are reimbursed under a FFS payment schedule that pay a nurse practitioner primary care provider at 85% of the Medicare Physician FFRS schedule for performing the same or comparable primary care services. As a result, consumers benefit from nurse practitioner high quality care while CMS sees a 15% savings on identical or equal services over that provided by a physician. That said, PCNP is open to consideration for 100% reimbursement to nurse practitioners since they provide the same or equal services as a physician to the consumer.

**Q11. Should practices be at risk financially (“upside and downside risk”) for all or a portion of the total cost of care for Medicare beneficiaries enrolled in their practice, including for services beyond those covered under the monthly PBPM payment? If so, what services should be included and how should the level of risk be determined? What are the potential mechanisms for and amount of savings in total cost of care that practices anticipate in a DPC model? In addition, should a DPC model offer graduated levels of risk for smaller or newer practices?**

- A. PCNP recommends that practices should have a low risk at the initiation of their participation in a DPC model test program with the understanding that there is a learning curve and practice delivery changes will occur gradually. Additionally, because many patients will only be seen a few times per year, data collection will take time to develop. Once a practice has been a part of a DPC model test program for a designated period of time, the practice can assume more risk of cost. PCNP is mindful that CMS will need to be vigilant in ensuring that safeguards are put in place to ensure that practices are not discharging patients who are high cost users of the DPC model program. Financial safeguards should also be in place to protect a practice for undue hardship due to an increase in volume or intensity by the practice or by other providers. Finally, criteria for the success of a DPC model test program must be established so that the program is long enough to identify its benefits, recommend modifications, and identify areas where the program would need to be eliminated.

**Q12. What additional payment structures could be used that would benefit both physicians and beneficiaries?**

- A. Any payment or additional payment structures designed to benefit both physicians and beneficiaries should also be available to other providers or PCPs, such as nurse practitioners. In essence, PCNP



is recommending that any DPC model should have provider neutral language and adopt provider neutral policies for the best outcomes for beneficiaries and their providers. Other areas for consideration in additional payment structures are as follows:

- Recommend eliminating the need for physician signatures for home health, diabetic footwear, etc. to improve greater patient access and increased participation.
- Recommend CMS to encourage states to update their regulations to allow nurse practitioners to practice independently.
- Recommend that payments should be updated to eliminate “incident-to” language and provide for full reimbursement for nurse practitioners services instead of at 85%.
- Recommend small practices would benefit from financial assistance from health insurance tax (HIT). These costs are exorbitant yet necessary for transitions and coordination of care.

PCNP also seeks guidance as to whether there is some HIT data warehousing solution through which CMS patients’ information can be housed as a repository of information. Such a repository would be helpful, for example, when a patient has a fall, is hospitalized out of the network, and their health information is readily available to assist in the coordination and transition of care.

#### D. General Model Design

**Q13. As part of the Agency’s guiding principles in considering new models, CMS is committed to reducing burdensome requirements. However, there are certain aspects of any model for which CMS may need practice and/or beneficiary data, including for purposes of calculating coinsurance/deductible amounts, obtaining encounter data and other information for risk adjustment, assessing quality performance, monitoring practices for compliance and program integrity, and conducting an independent evaluation. How can CMS best gather this necessary data while limiting burden to model participants? Are there specific data collection mechanisms, or existing tools that could be leveraged that would make this less burdensome to physicians, practices, and beneficiaries? How can CMS foster alignment between requirements for a DPC model and commercial payer arrangements to reduce burden for practices?**

A. It is recommended that when CMS is looking for ways to reduce burdensome requirements on primary care providers that it evaluate how it can reduce the administrative burden Medicare data collection imposes on practices.

**Q14. Should quality performance of DPC-participating practices be determined and benchmarked in a different way under a potential DPC model than it has been in ACO initiatives, the CPC+ Model, or other current CMS initiatives? How should performance on quality be factored into payment and/or determinations of performance-based incentives for total cost of care? What specific quality measures should be used or included?**



- A. Without specifically addressing the above question, will a DPC model that contracts with a provider, such as a nurse practitioner, address the historic data distortions created by incident-to billing's attribution of the nurse practitioner's outcomes to the billing of a physician?

**E. Program Integrity and Beneficiary Protections**

**Q16. CMS wants to ensure that beneficiaries receive necessary care of high quality in a DPC model and that stinting on needed care does not occur. What safeguards can be put in place to help ensure this? What monitoring methods can CMS employ to determine if beneficiaries are receiving the care that they need at the right time? What data or methods would be needed to support these efforts?**

- A. Evaluation of quality reporting is one recommended way to assess the care provided to patients. Current billing regulations allow for nurse practitioners to care for patients yet such service is billed under a physician's national provider identification (NPI)/TIN. The current billing process eliminates any opportunity to accurately identify an individual provider's performance, and in many cases, will allow for a physician's performance score to be higher for the services provided by the nurse practitioner. Therefore, value-based payment (VBP) of outcome aligned to the rendering provider is rendered inaccurate because the physician claims outcomes that were produced by the nurse practitioner and the provider payment is falsely inflated. Therefore, in states that have provided nurse practitioners with full practice authority, it is recommended that nurse practitioners be permitted to bill for their services without the need to bill under a physician NPI/TIN. That way, there is a direct correlation for services rendered, outcomes, and billing, which would all be attributed to the direct primary care provider.

The Pennsylvania Coalition of Nurse Practitioners appreciates the opportunity to comment on the RFI-DPC models. Should you have any questions, please do not hesitate to contact me at 215-896-3846, ext. 702 or by email at [maria@rckelly.com](mailto:maria@rckelly.com)

Very respectfully,

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