"Value" as a Value: Highest and Best Use of NPPs

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Introduction

As the move to new payment models to deliver better value intensifies, renewed attention is being given to the role of Non-Physician Practitioners (NPPs) in generating improved results, particularly in primary care and in the treatment of chronic disease. Typically included in this cadre of clinicians are Nurse Practitioners (NPs), Physician Assistants (PAs), and Clinical Nurse Specialists (CNSs), whose roles are the focus of this article. If "value" is defined as improved results at lower cost, the deployment of all clinicians at their highest and best use will be fundamental, using the least expensive resource to achieve optimal results. Medicare and organizations redesigning their care processes to reflect team delivery of care and clinical integration increasingly are recognizing NPPs[1] as physician substitutes, physician extenders, and physician adjuncts.[2]

While the basic idea of reordering care delivery to produce value naturally would direct attention to how to use NPPs, the expectation of physician shortages to meet the demands of a new world order, as well as vastly more-insured patients, also are drivers of this focus. A recent study commissioned by the Association of American Medical Colleges estimates that, under the status quo, the physician population will grow by a total of 9%, while the demand for physicians will grow by 17%, with an overall shortfall of between 46,000 and 90,000 physicians. At least 2% of the demand is estimated to derive from full implementation of the Patient Protection and Affordable Care Act of 2010 (ACA).[3] Because NPPs can perform many of the functions physicians perform in relation to primary and chronic care—freeing physicians to spend more time on coordination of care and more-complex patients—the decision as to how to use these clinicians will be a real determinant of whether care teams can deliver more-effective care. Data demonstrate that the use of NPPs can increase timely access to care, patient satisfaction, and patient engagement.[4]

Models of Care Delivery and the Role of NPPs[5]

Patient-Centered Medical Home

In a hierarchy of complexity, the Patient-Centered Medical Home (PCMH) is the starting point for considering new models of care. The American College of Physicians, the American Academy of Family Physicians, the American Academy of Pediatrics, and the American Osteopathic Association initially postulated the current version of PCMH in 2007[6] to find a way to pay physicians for the coordination of care in which they engaged. The basic PCMH idea is one of changed care delivery, not payment. Commercial payers frequently pay an enhanced per-member per-month payment to the PCMH practice that includes all the clinicians delivering care. Other payers offer a stipend for their care coordination. The success stories of PCMH, despite some controversy, turn on patients' engagement in their care and keeping chronic patients out of the hospital.[7] PCMH certification is available, and one of the hallmarks of the standards, which also now are being extended to specialists, is a strong emphasis on team-based care.[8] NPPs frequently are cited as significant players in successful PCMH implementations.[9]

Bundled Payment[10]

Bundled payment is expected to improve value by eliminating the incentives in Fee-for-Service (FFS) payment through putting disparate providers at risk in the same budget. Most bundled payment models pay the practice on an ongoing basis (e.g., capitation or FFS), and then the multiple providers who are participating share in the savings from the budget. The Bundled Payments for Care Improvement Initiative[11] is Medicare's current version of this concept, and it offers one prospective payment model. In bundled payment, engagement of the patients in their care and, again, the highest and best use of the most efficient practitioners (e.g., NPPs) lower the expenses and therefore provide the potential for greater financial reward. Some commercial payers offer bundled payment based on savings against prior years. The PROMETHEUS Payment model[12] defines its now 80 Evidence-Informed Case Rate bundles based on the resources necessary to deliver what good clinical practice guidelines say a patient needs to treat that condition. The incentive of highest and best use is very much at issue.

Accountable Care Organizations

Whether the Medicare Shared Savings Program (MSSP) version or a commercial Accountable Care Organization (ACO), these entities are a type of bundled payment program, but typically they include all care paid for by the sponsoring payer, and not a condition-specific set of bundles. ACOs are expected to produce value, again, by changing the financial incentives so that the multiple participating providers have the opportunity for better financial rewards for more efficient, quality-measured ("accountable") care. NPPs figure in the mix, to enhance efficiency and patient satisfaction.

Federal Programs Targeting Enhanced Value

In the push toward enhanced value, a range of other programs and incentives have been created—all of which have relevance to the use of NPPs.

Physician Quality Reporting System and Electronic Prescribing Incentive Program

Medicare's Physician Quality Reporting System (PQRS) and its Electronic Prescribing (eRx) Incentive Program both "incentivize" the reporting of certain quality metrics. As of 2015, these programs impose reductions of up to 2.0% to *all* Medicare payments for failure to properly report. The programs apply to a variety of NPPs, too, meaning they must report or face payment reductions.[13] These programs are not focused on outcomes of care, but rather on the mere reporting of data.

Health Reform and NPPs

The ACA mandated the creation of a Medicare Physician Value-Based Purchasing (VBP) program, which focuses on enhanced quality and efficiency by measuring providers against a baseline of quality metrics, penalizing those who fall below the baseline, and rewarding those who rise above it.[14] The baseline itself is derived from reported PQRS metrics. In such a system, NPPs can help to deliver both high quality and efficient care.

Several other sections of the ACA also address NPPs, especially with an eye toward value and efficiency. For example, nurse-managed health clinics, run by advanced practice nurses, are designed to provide primary care services to underserved populations.[15] The ACA also permits PAs to order post-hospital extended care services under Medicare.[16] The "Independence at Home Medical Practice Demonstration Program," an ongoing pilot program designed to test the effectiveness of primary care services delivered in a patient's home, further demonstrates the government's desire to use lower-cost practitioners to deliver primary care.[17] The care may be NP-directed, in conjunction with a range of other provider types, and the statute explicitly states that it does not prohibit either NPs or PAs from being involved in, or even leading, home-based primary care teams, if permitted under state laws and if they are appropriately trained and otherwise meet the statutory requirements.[18] In their utilization of NPPs, each program recognizes the effectiveness of the care that NPPs provide, as well as the value they offer the health care system.

Legal Issues

State Licensure and Collaboration/Supervision Requirements

State law requirements for NPPs vary among different NPP types with respect to educational requirements, scope of practice, and degree of autonomy. Typically, state licensure laws require PAs to hold a college degree. The PA may perform services similar to physicians, including minor surgeries, usually under physician supervision. A PA's authority to prescribe drugs also usually is limited.

By contrast, NPs hold master's or doctoral degrees and have a broader scope of practice than PAs, including a greater prescriptive authority. Although NPs usually work in collaboration with a physician, they have greater autonomy than a physician-supervised PA.

Medicare Enrollment

Medicare permits PAs, NPs, and CNSs to enroll, but there are quirks to the enrollment process.[19] All three types of practitioners must complete an individual enrollment application, either using the Centers for Medicare & Medicaid Services 855I enrollment form or the Provider Enrollment, Chain, and Ownership System online enrollment system. However, there are significant differences in Medicare's enrollment rules between PAs on one hand and NPs and CNSs on the other.

Medicare's billing rules permit NPs and CNSs to enroll and be paid directly for their services. They may practice as independent contractors to physician practices, allowing the

practice the flexibility to use their services on a much more part-time basis.

Medicare does not see PAs as independent, however, viewing them as extensions of their W-2 physician employers. Medicare will issue payment only to the employer, regardless of what state law may otherwise permit.

Commercial insurers establish their own credentialing rules, which often differ from Medicare's rules. Some allow credentialing of NPPs as practitioners capable of billing independently, including those which Medicare does not recognize, but many do not.

Freedom from Stark

One benefit of using NPPs is that they are not subject to the restrictions of the Physician Self-Referral Law (Stark Law) and its regulations. The Stark Law prohibits physicians from referring Medicare patients for Designated Health Services (DHS) to an entity with which the physician or an immediate family member of the physician has a financial relationship, unless the arrangement qualifies for one of the limited exceptions to the Stark statute, including the "in-office ancillary services" exception.[20] Assuming that a physician practice utilizing NPPs meets the definition of a "group practice" under the Stark Law,[21] and qualifies for the in-office ancillary services exception, the physicians can delegate DHS tasks to NPPs who may be supervised by other physicians in the group.

In addition, referrals made by an NPP fall outside of the scope of the Stark Law. The Stark regulations define a "referral" as a request or order for DHS that comes from a physician, which means that the Stark Law does not cover services ordered by NPPs.[22]

Reimbursement Principles

From the beginning of Medicare, ancillary personnel working in physician offices were included in the physician's service payments when their services were rendered "incident to" the physician and in accordance with the incident-to rules, which mandate direct supervision of the ancillary personnel, inclusion of the fee for the ancillary personnel's services in the physician's bill, and several other requirements. NPPs are among the ancillary personnel whose services can be billed "incident to" a physician's services (at 100% of the Medicare Physician Fee Schedule (MPFS)), but Medicare also has recognized NPPs since 1998 as able to obtain their own numbers and be reimbursed for services they render at 85% of the MPFS.

NPPs can be paid for almost anything a physician can, as long as it is within the scope of their state licensure. For certain services that require only physicians, such as the initial comprehensive visit in a skilled nursing facility, NPPs cannot qualify for coverage under Medicare. Commercial payers are widely variable in the extent to which they recognize these practitioners for credentialing or for direct payment, even if they are working for a physician group.

In considering how NPPs fit in the new value proposition, it is significant that most of the new payment models—most particularly, the MSSP and bundled payment—pay in the ordinary course and then gainshare with the participating providers some portion of the savings generated. It also is significant that while the shift to entirely new payment models is occurring, the MPFS, which currently pays for care coordination and work between visits on an FFS basis, is being expanded to pay for more such services on an FFS basis.

In 2005, through a correction to the Medicare Claims Processing Manual, NPPs became eligible to bill for care plan oversight services for patients under home health or hospice care.[23] This was the beginning of practitioners being paid to coordinate care rather than merely to render visits or procedures. Congress also added an initial preventive physical examination in the first six months of enrollment in Medicare, which an NPP also may bill.[24] This was another shift away from the emphasis on immediately medically necessary services and was paired with the Annual Wellness Visit for subsequent years.

Transitional care management services payment for patients discharged from an institutional setting to community care, who need more than basic monitoring, are available for NPPs to bill as is the most recent, complex chronic care payment.[25] All of these are FFS codes intended to provide payment for more of the continuum of care that will improve results and prevent complications. They all are available for NPPs to deploy under those payment models that turn on Medicare payment in the ordinary course followed by gainsharing.

Conclusion

This brief review has only touched on some of the existing issues in using NPPs in a more value-driven setting. NPPs' role in producing value will only increase over time. The existing systems already are changing to accommodate their broader deployment. We can expect the new emphases on measured care delivered under new payment incentives will result in even more-innovative developments.

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1 Many other non-physicians will contribute to improving value including, physical and occupational therapists, audiologists, psychologists, and social workers, who are variably recognized as independent practitioners under state law and Medicare. *See* Shay, *Highest and Best Use Revisited*, Health L. Handbook (2013 Edition) WestGroup, p. 309-344, *available at* www.gosfield.com/images/PDF/DFS.Highest%20and%20Best%20Use.pdf.

2 *See* Gosfield and Reinertsen, *Achieving Clinical Integration With Highly Engaged Physicians*, (Nov 2010), 31 pp., *available at* www.gosfield.com/images/PDF/ACI-fnl-11-29.pdf and Gosfield and Reinertsen, *Clinical Integration Self- Assessment Tool v.2.0* (May 2011), *available at* www.gosfield.com/images/PDF/CISAT.pdf.

3 *Physician Supply and Demand Through 2025: Key Findings, available at* www.aamc.org/download/426260/data/physiciansupplyandemandthrough2025keyfindings.pdf. For more in-depth analysis, *see The Complexities of Physician Supply and Demand: Projections from 2013 to 2025* (Mar. 2015), *available at* www.aamc.org/download/426242/data/ihsreportdownload.pdf.

4 *See Nurse Practitioners Outscore Physicians in Patient Satisfaction Survey,* Clinical Advisor, June 24, 2011, *available at* www.clinicaladvisor.com/nurse-practitioners-outscore-physicians-in-patient-satisfaction-survey/article/206090/; *More Patients Open to Primary Care Offered by Physician Assistants*, Fiercehealthcare.com, Oct. 20, 2014, *available at* www.fiercehealthcare.com/story/more-patients-open-primary-care-offered-physician-assistants/2014-10-20; Bauer, Jeffrey C., Ph.D., *Nurse practitioners as an underutilized resource for health reform: Evidence-based demonstrations of cost-effectiveness,* J. Am. Acad. Nurse Prac., 2010, *available at* http://onlinelibrary.wiley.com/doi/10.1111/j.1745-7599.2010.00498.x/epdf.

See www.fiercehealthcare.com/story/more-patients-open-primary-care-offered-physician-assistants/2014-10-20.

5 *See Gosfield, Understanding the new payment models*, Med. Econ. (Aug. 10, 2013), pp. 44-46, 49, *available at* www.gosfield.com/images/PDF/MedEc.New%20Payment%20Models_081013.pdf.

6 *See* www.aafp.org/dam/AAFP/documents/practice_management/pcmh/initiatives/PCMHJoint.pdf.

7 Nielsen, Marci, PhD, MPH, et al., *Benefits of Implementing the Primary Care Patient-Centered Medical Home: A Review of Cost & Quality Results*, 2012, Patient-Centered Primary Care Collaborative, 2012, *available at* www.pcpcc.org/sites/default/files/media/benefits_of_implementing_the_primary_care_pcmh.pdf.

8 *See* www.ncqa.org/Programs/Recognition/Practices/PatientCenteredMedicalHomePCMH/PCMH2011PCMH2014Crosswalk.aspx.

9 Nielsen et al, *Benefits of Implementing the Primary Care Patient-Centered Medical Home*, Patient Centered Primary Care Collaborative (2012), *available at* www.healthtransformation.ohio.gov/LinkClick.aspx?fileticket=CPQoPjxO47Q%3D&tabid=114.

10 *See* Gosfield, *Bundled Payment: Avoiding Surprise Packages*, Health L. Handbook (2013 edition) WestGroup, p. 279-307, *available at* www.gosfield.com/images/PDF/AGosfield.Bundled%20Payment.pdf.

11 *See* http://innovation.cms.gov/initiatives/bundled-payments/.

12 *See* www.hci3.org/what_is_prometheus. Alice G. Gosfield is a member of the original design team for PROMETHEUS Payment Inc., was PROMETHEUS Payment Inc.'s first chairman of the board, was the first chairman of the board of its successor, the Health Care Incentives Improvement Institute Inc., and remains on the board as of this writing.

13 The PQRS and eRx Incentive programs each define an "eligible practitioner" to include PAs, NPs, and CNSs, as well as other NPP types, such as certified registered nurse anesthetists, registered dieticians, and clinical social workers. 42 C.F.R. §§ 414.90(b), 414.92(b), respectively. Interestingly, this inclusive streak does not extend to the "Meaningful Use" program. 42 C.F.R. § 495.4.

14 For more on the VBP program, *see* Shay, Daniel, *PQRS and its Penumbra*, Health L. Handbook k 2012 ed., pp. 87-119. *See also* 77 Fed. Reg. 69036-69328, (Nov. 12, 2012).

15 ACA § 5208.

16 ACA § 3108.

17 ACA § 3024. *See also* http://innovation.cms.gov/initiatives/independence-at-home/.

18 ACA § 3024(b)(2).

19 For a more in-depth examination of the enrollment process, *see* Shay, *'Halt! Who Goes There?': Coping with the Continuing Crackdown on Medicare Enrollment*, Health L. Handbook (2011 ed.) West Group; *Enrollment in Medicare: Fraternity Hazing or Keeping Out Bad Actor?*, Health L. Handbook (2009 ed.).

20 For more on the in-office ancillary services exception, *see* Gosfield, *The Stark Truth About Stark, Part I*, Fam. Prac. Mgmt., Nov.-Dec., 2003, *available at* www.aafp.org/fpm/2003/1100/p27.html.

21 For more on the definition of a "group practice," *see* Gosfield, Is *Your Group A Group? How The Stark Law Applies to You*, Physicians Prac., 2004, *available at* www.physicianspractice.com/articles/your-group-group.

22 Although it does include doctors of podiatry or optometry, and chiropractors. 42 C.F.R. § 411.351.

23 Transmittal 999.

24 Medicare Claims Processing Manual, Ch. 12 § 30.6.1.1.

25 *See* 79 Fed. Reg. 67725 (Nov 13, 2014).

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