Assessing payment adequacy and updating payments: Physician and other health professional services; and Medicare payment policies for advanced practice registered nurses and physician assistants

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Outline

- Payment adequacy assessment: Physician and other health professional services
- Medicare policies for advanced practice registered nurses (APRNs) and physician assistants (PAs)

Measures of payment adequacy

- Access to care
  - Measures of reported access
    - Telephone survey
    - Focus groups of beneficiaries and site visits
  - Supply of providers
  - Volume of services
- Access to capital: N/A for clinician sector
- Quality
- Medicare payments and provider costs

Background: Physician and other health professional services in Medicare

- $69.1 billion in 2017, 14 percent of FFS benefit spending
- 985,000 clinicians billed Medicare in 2017
  - 596,000 physicians
  - 389,000 APRNs, PAs, and other clinicians
- Clinicians paid using a fee schedule of over 7,000 discrete services
- No update in current law for 2020, 5% A-APM incentive payment for certain A-APM participants

A-APM (advanced alternative payment model)
Data preliminary and subject to change.

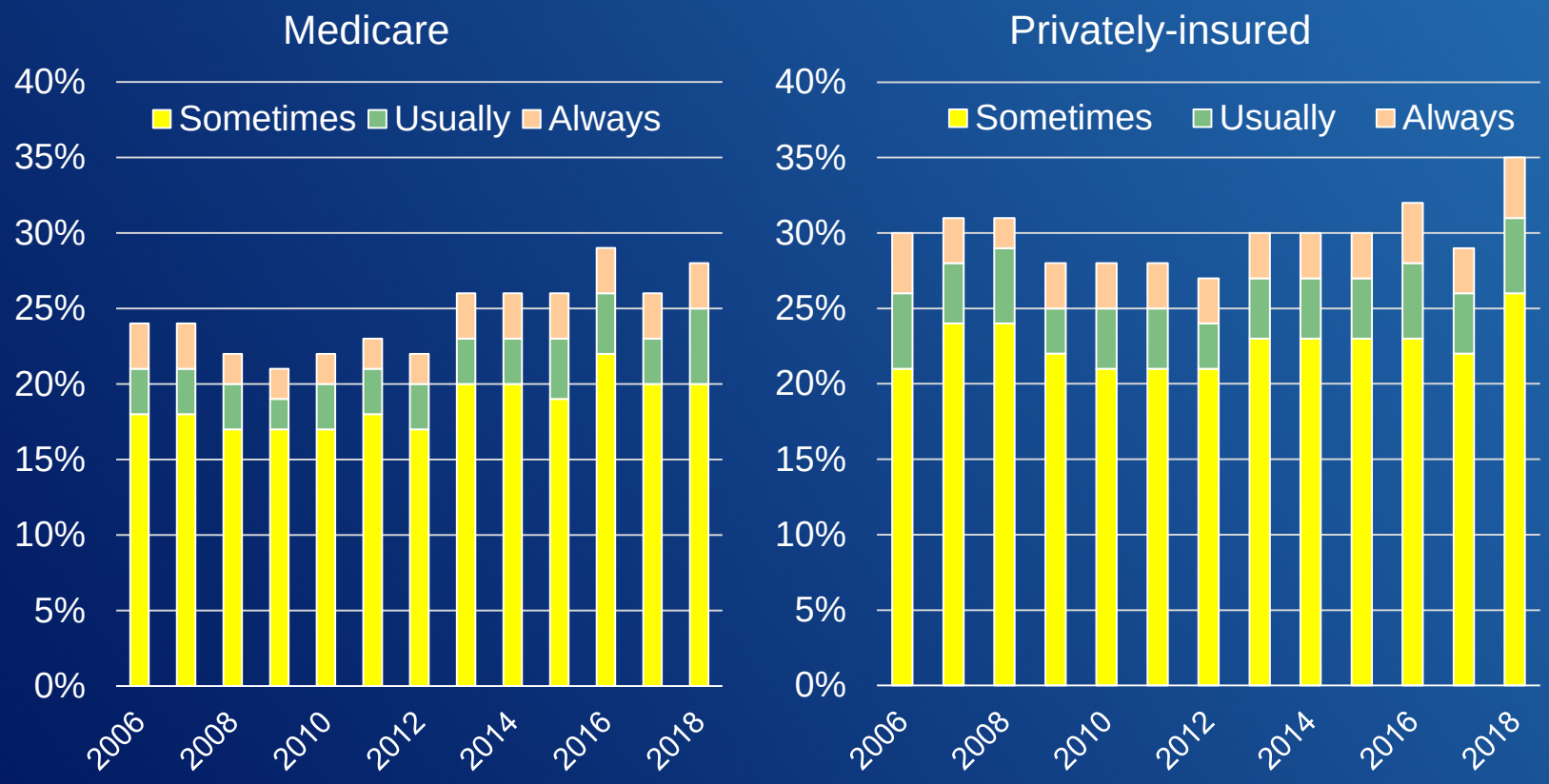
Beneficiaries' ability to obtain needed care as good as or slightly better than individuals with private insurance

- Most beneficiaries report no problem obtaining needed care
- Small share of beneficiaries report trouble finding a new provider, with more difficulty obtaining a new primary care doctor than a new specialist
- Certain groups report higher rates of difficulty: Minority beneficiaries report more trouble obtaining care when needed than non-Hispanic Whites
- Minimal differences in reported access between rural and urban beneficiaries

Source: MedPAC telephone survey, 2018
Data preliminary and subject to change.

Timely access to regular or routine care is slightly better for Medicare beneficiaries than privately-insured

Waiting longer than wanted for regular or routine care



Source: MedPAC telephone surveys, 2006-2018
Data preliminary and subject to change.

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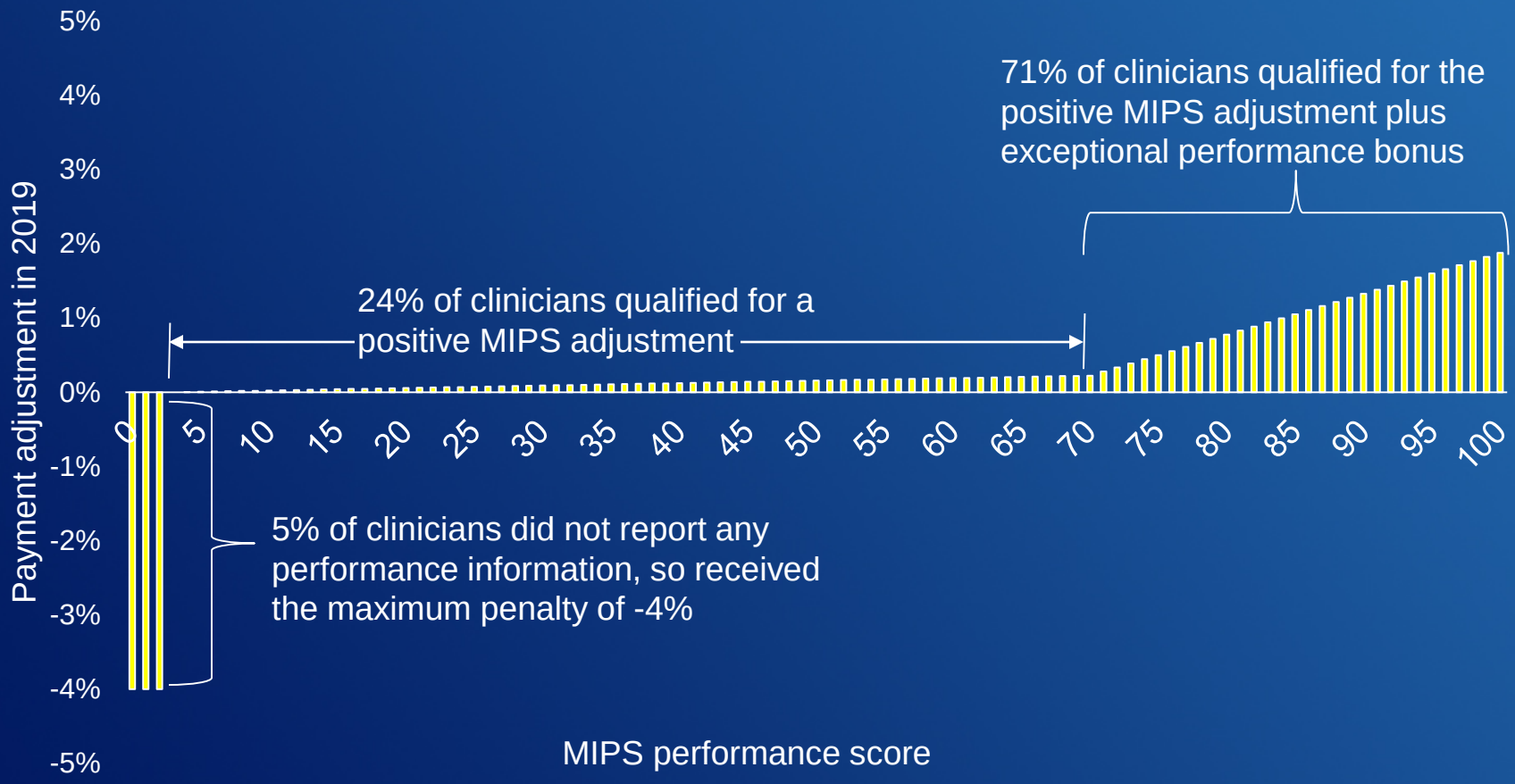
Quality

- Commission's principles for quality measurement
  - Quality measurement should be patient-oriented, encourage coordination, and promote delivery system change
  - Medicare quality incentive programs should use a small set of clinical quality, patient experience, and resource use measures
- Medicare's current system for clinicians, the Merit-based Incentive Payment System (MIPS), does not meet these criteria—therefore, we recommended eliminating MIPS

95% of MIPS-eligible clinicians met or exceeded the performance threshold for the first year



Data preliminary and subject to change.

Other payment adequacy indicators

- 96% of clinicians are in Medicare's participating provider program
  - Almost all claims are paid on assignment (clinician accepts fee schedule amount as payment in full)
- Number of clinicians billing Medicare grew in 2017
- On a per beneficiary basis, number of clinicians was similar in 2016 and 2017
  - Number of primary care physicians and specialists per beneficiary fell slightly but number of APRNs and PAs increased
- Medicare's payment rates to clinicians were 75% of commercial PPO rates in 2017 (same as 2016)

Data preliminary and subject to change.

Annual volume growth was slightly higher in 2017 than 2012-2016

- Volume growth accounts for change in number of services and change in intensity (e.g., substitution of CT for X-rays)
- Average annual volume growth per FFS beneficiary, 2012-2016 = 1.0% (across all services)
- Volume growth in 2017 = 1.3%
- Growth by type of service in 2017 ranged from 1.0% to 2.2%

Data preliminary and subject to change.

Wide disparities in physician compensation between primary care and surgeons, nonsurgical proceduralists, and radiologists, 2017

Source: Urban Institute analysis of data from SullivanCotter's Physician Compensation and Productivity Survey, 2018.

Data preliminary and subject to change.

Payments for physician and other health professional services appear adequate

- Access indicators are stable
  - Telephone survey and focus groups
  - Provider participation rate
  - Number of clinicians billing Medicare per beneficiary
- Quality indeterminate
- Ratio of Medicare payment rates to private PPO rates did not change
- Increase in volume of services

Overview: Medicare payment policies for APRNs and PAs

- Commission examined Medicare payment policies for advanced practice registered nurses (APRNs) and physician assistants (PAs) in October 2018
- Background on APRNs/PAs
- Billing trends
- Estimates of “incident to” billing
- Chairman’s draft recommendations

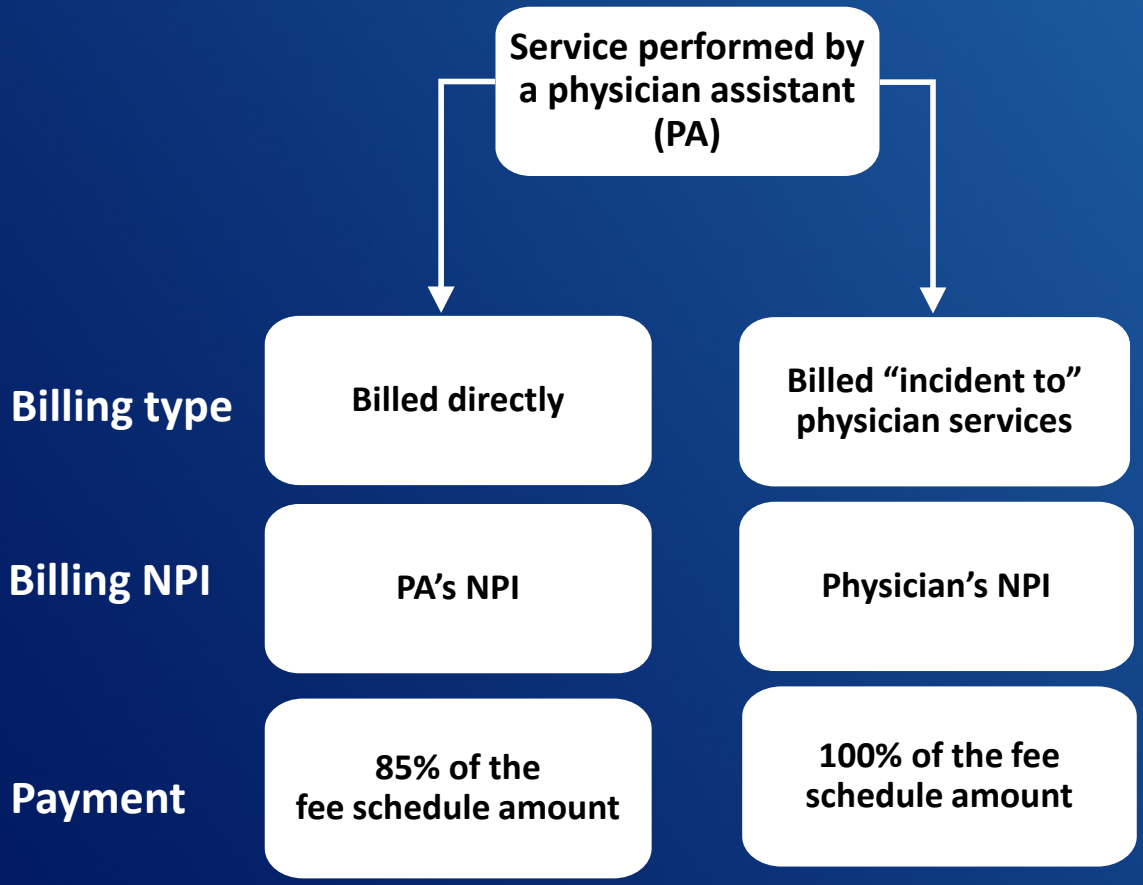
Definition and scope of practice

- APRNs
  - Nurse practitioners (NPs), certified registered nurse anesthetists, clinical nurse specialists, and certified nurse midwives
  - Registered nurses who have completed additional training (most commonly a master's degree)
- PAs
  - Graduate of a PA educational program (including clinical rotations)
- States determine the activities that APRNs/PAs can perform and have substantially increased the authority and independence of APRNs/PAs over time

NP and PA specialties

- NPs and PAs increasingly practice outside of primary care (e.g., dermatology, orthopedics, etc.)
- Recent point-in-time estimates
  - NPs: ~half practice in primary care
  - PAs: ~27 percent practice in primary care
- Medicare has limited specialty information

Illustration of direct and "incident to" billing in Medicare



"Incident to" billing is not allowed in certain circumstances, such as:

- Hospital settings
- New patients
- New problem for an existing patient

NPI = National Provider Identifier

Rapid growth in NP and PA billings

- Allowed charges billed, 2010-2017
  - NPs: $1.2B – $3.8B (17% annual growth)
  - PAs: $0.9B – $2.2B (14% annual growth)
- Clinicians billing Medicare, 2010-2017
  - NPs: 52,000 – 130,000 (14% annual growth)
  - PAs: 43,000 – 82,000 (10% annual growth)
- Allowed charges and number of NPs/PAs are understated because of “incident to” billing

Data are preliminary and subject to change

Prevalence of “incident to” billing in Medicare

- Medicare claims do not indicate when a service is billed “incident to”
- MedPAC analyses suggest that a substantial share of services performed by NPs and PAs are billed “incident to”
- For example, we estimate that ~40 percent of Medicare E&M office visits that NPs performed for established patients in physician offices were billed under a physician’s NPI in 2016

Data are preliminary and subject to change

Motivation for addressing “incident to” billing and Medicare’s specialty information for APRNs and PAs

- “Incident to” billing for APRNs and PAs
  - Obscures policymakers’ knowledge of who is providing care for beneficiaries
  - Inhibits accurate valuation of fee schedule services
  - Increases Medicare and beneficiary spending
- Medicare’s limited specialty information for APRNs and PAs
  - Limits ability to target resources towards areas of concern (e.g., primary care)
  - Inhibits operation of programs that rely on identifying primary care providers