Medicare payment policies for advanced practice registered nurses (APRNs) and physician assistants (PAs)

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Overview

- Background on advanced practice registered nurses (APRNs) and physician assistants (PAs)
- Billing trends
- Prevalence of “incident to” billing
- Potential policy options
- Discussion

Definition of APRNs and PAs

- APRNs
  - Four types of APRNs: nurse practitioners (NPs), certified registered nurse anesthetists (CRNAs), clinical nurse specialists (CNSs), and certified nurse midwives (CNMs)
  - Registered nurse and complete additional training (most commonly a master's degree)
  - Licensed to practice in a state
- PAs
  - Graduate of a PA educational program (including clinical rotations)
  - Licensed to practice in a state

Scope of practice

- States determine the activities that APRNs and PAs can perform
- Supervision/collaboration requirements vary by state and category of APRN
- Overall, states have substantially increased the authority and/or independence of APRNs and PAs over time

Evidence of NP and PA cost and quality outcomes

- Conclusions based on review of existing literature, which has some limitations
- NPs/PAs appear to provide care comparable to physicians in terms of clinical quality and patient experience (for services they provide in common)
- NPs/PAs' effects on costs and utilization:
  - Lower costs for the providers that employ them
  - Payer costs - literature is limited, mixed
    - Lower per-service payment rates (in some cases)
    - Referring/ordering patterns may be higher/lower
    - NP/PAs may alter downstream costs (e.g., hospitalizations)

APRN and PA specialties

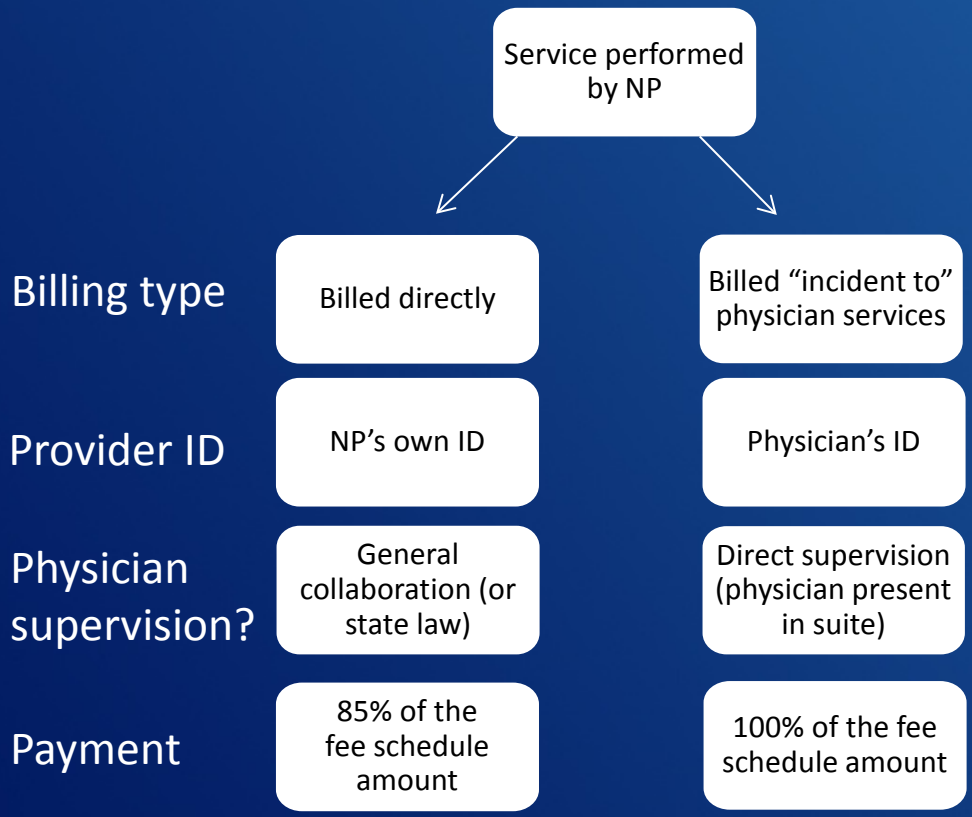
- The specialty information on APRNs and PAs is limited and not uniform
- Point-in-time estimates
  - NPs: Around half work in primary care
  - PAs: 27 percent work in primary care
- Medicare classifies all NPs as one specialty and all PAs as one specialty

Medicare coverage and payment policies for APRNs and PAs

- Coverage
  - Medicare generally covers all medically necessary APRN and PA services provided in accordance with state law
  - Medicare imposes some restrictions on ordering/certifying certain services (e.g., home health)
- Payment
  - Bill under own NPI = 85% of fee schedule
  - Bill under physician NPI = 100% of fee schedule
    - Practice referred to as “incident to” billing

NPI: National Provider Identifier

Direct and “incident to” billing in Medicare



In the following circumstances, NPs *must* bill directly

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

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Medicare FFS allowed charges for APRNs and PAs increased rapidly from 2010-2016

Practitioner type	Total allowed charges billed, 2010 (in millions)	Total allowed charges billed, 2016 (in millions)	Percent growth, 2010-2016
Nurse practitioner	$1,249	$3,217	158%
Physician assistant	916	2,001	118
Certified registered nurse anesthetist	869	1,162	34
Clinical nurse specialist	54	71	31
Certified nurse midwife	2	5	216
Total	3,090	6,456	109

Source: MedPAC analysis of the Physician/Supplier Procedure Summary file.

Notes: Numbers rounded. Percentages based on unrounded numbers. Numbers exclude “incident to” billing.

Data are preliminary and subject to change

Number of E&M office visits billed by APRNs and PAs grew rapidly from 2010 to 2016

Practitioner type	Number of visits, 2010 (in millions)	Number of visits, 2016 (in millions)	Percent change, 2010-2016
APRN or PA	11	28	149%
Primary care physician	97	84	-13
Specialist	133	143	8
Total	241	255	6

Source: MedPAC analysis of the Physician/Supplier Procedure Summary file; HCPCS codes 99201-99205 and 99211-99215.

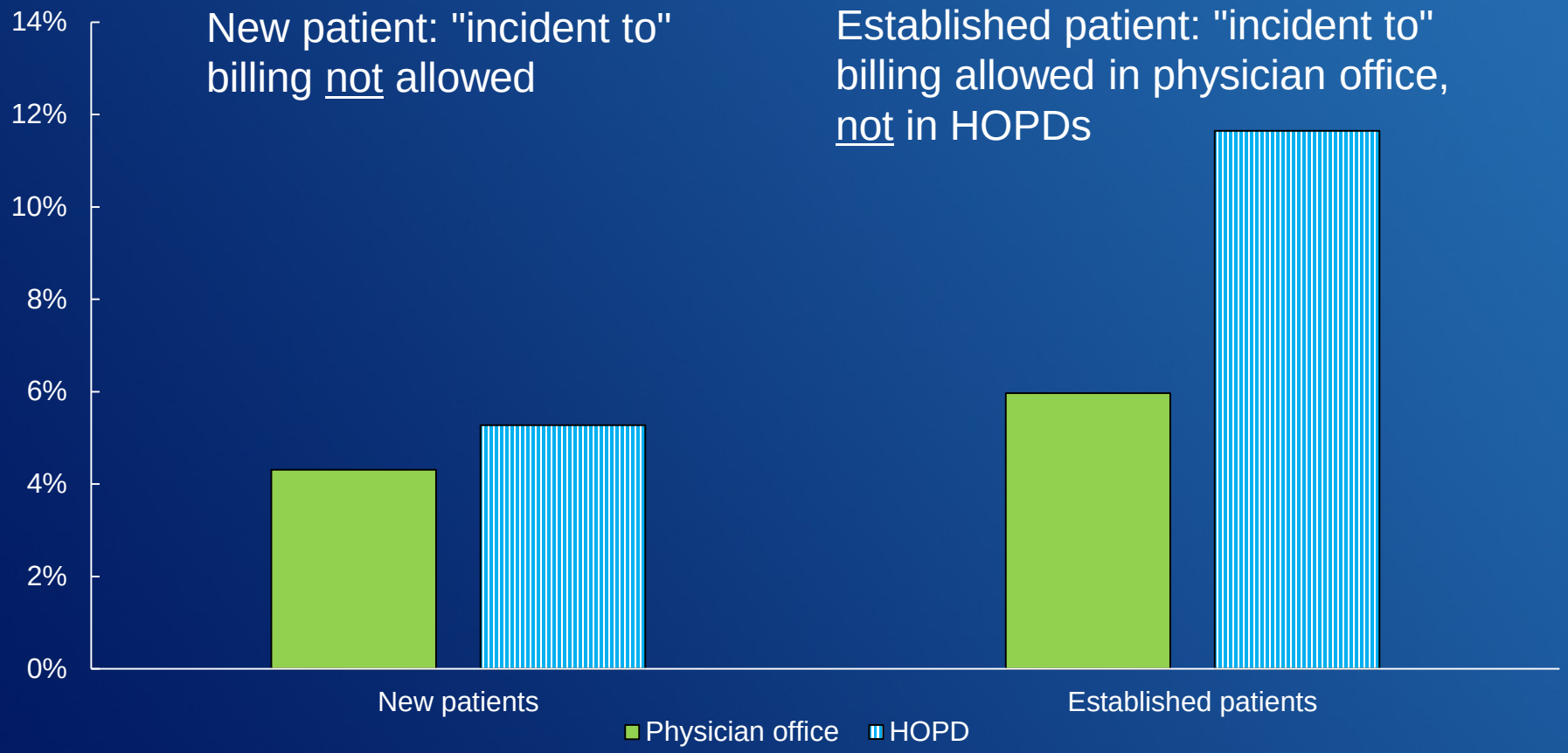
Note: The primary care physician category includes internal medicine, family medicine, pediatric medicine, and geriatric medicine. The specialist category is defined as not being a primary care physician, APRN, or PA. APRN/PA numbers exclude “incident to” billing.

Data are preliminary and subject to change

Prevalence of “incident to” billing by NPs and PAs

- “Incident to” billing obscures the number of services furnished by NPs and PAs
- Rapidly expanding supply of NPs and PAs suggests “incident to” rules could apply to increasing number of Medicare services
- Research on prevalence of “incident to” billing is limited
- We conducted analyses to estimate the share of E&M services billed “incident to”

Share of E&M office visits billed by NPs in physician offices and HOPDs, 2016



Source: MedPAC analysis of Carrier SAF.

Note: Percentages displayed are weighted averages of HCPCS codes 99201-99205 (new patients) and 99211-99215 (established patients). HOPD (hospital outpatient department).

Prevalence of “incident to” billing by NPs and PAs

- We conclude that:
  - ~40 percent of E&M office visits NPs’ performed for established patients in physician offices likely billed “incident to” in 2016; and
  - ~30 percent of such visits performed by PAs’ likely billed “incident to” in 2016
- This means that ~5 percent of all E&M office visits billed by physicians were likely performed by an NP or PA in 2016

Policy option 1: Eliminate “incident to” billing for APRNs and PAs

- APRNs and PAs would be required to bill Medicare FFS under their own NPI
- Potential implications:
  - Reduce Medicare and beneficiary expenditures
  - Improve fee schedule valuations
  - Enhance program integrity
  - Improve comparisons of care furnished by physicians and APRNs/PAs

Policy option 2: Improving Medicare's specialty designations for APRNs and PAs

- APRNs and PAs could be required to:
  - Indicate field of practice (e.g., primary care)
  - Update information regularly
- Policy would help Medicare identify primary care clinicians

Commission discussion

- Clarifying questions
- Requests for additional information or analyses
- Discussion of potential policy options
  - Eliminate “incident to” billing for APRNs and PAs
  - Improving Medicare’s specialty designations for APRNs and PAs