



January 25, 2018

James E. Mathews, Ph.D.
Executive Director
Medicare Payment Advisory Commission
425 I St, NW
Suite 701
Washington, DC 20001

Dear Dr. Matthews:

On behalf of the American College of Physicians (ACP), I am pleased to share our comments on the Commission's unanimous vote in favor of draft recommendations to: 1) end incident to billing for Advanced Practice Registered Nurses (APRNs) and Physician Assistants (PAs) and require them to bill the Medicare program directly; and 2) refine Medicare specialty designations for APRNs and PAs.

The College is the largest medical specialty organization and the second-largest physician group in the United States. ACP members include 154,000 internal medicine physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness.

Incident to billing helps to facilitate and encourage care coordination across a team of clinical professionals and will become more important as we transition increasingly toward alternative payment models and team-based care. ACP has [long supported](#) incident to billing because it supports the College's goals to enhance patient care, increase patient access and improve physician productivity. As trained health care professionals, APRNs and PAs have a set of knowledge, skills, and abilities that, while not equivalent, are complementary to physicians and serve a valuable role in furnishing high-quality care to patients as part of a clinical team.

Incident to billing is critical to modern day medical practices functioning at their greatest capacity and delivering the highest quality, most appropriate care to patients. Medical practices function most effectively and efficiently when clinical professionals practice at the top of their licenses. Whenever possible, the needs and preferences of every patient should be met by the health care professional with the most appropriate skills and training to provide the necessary care. APNPs and PAs have the capacity to reduce both direct healthcare costs and

physicians' workloads and a team-based approach to care has been proven¹ to help reduce clinician burnout, which is currently at unprecedented levels.² Patients with complex medical problems, multiple diagnoses, or ongoing management challenges are often best served by physicians working with a team of healthcare professionals that include non-physician clinicians to meet their complex care needs.

Under direct supervision arrangements, supervising physicians should be reimbursed at 100% of the Medicare allowable for the services rendered because incident to billing requires more work and oversight on behalf of physicians and they are ultimately responsible for the care being rendered. As was pointed out in the presentation, APRNs and PAs have the option to directly bill Medicare at 85% of fee schedule rates. Medicare pays 100% of fee schedule rates only when a set of rigorous additional conditions are met that require more time and work on behalf of the physician, including a physician from the same practice conducting the initial visit, devising a care plan related to an episode of care, and providing direct supervision thereafter, which requires that the physician be physically present at the location where the service is furnished by the PA or APRN. APRNs and PAs bill at a higher rate for these services to reflect the additional work that goes into supervising and ultimately taking accountability for patient outcomes on behalf of the physicians.

While the College supports opportunities for responsible reductions in Medicare spending, ending incident to billing could threaten the financial viability of practices that rely on non-physician clinicians and would disproportionately affect primary care practices. According to the report, ending incident to billing is expected to reduce Medicare spending between \$50 million and \$250 million over one year and between \$1 billion and \$5 billion over five years, which means major hits to individual practices' bottom lines that may be difficult to overcome. Approximately one in four specialty practices and one in three primary care practices employing advanced practice clinicians³ and non-physicians now account for 40% of clinicians billing Medicare. Primary care practices would be disproportionately affected and already face lower reimbursement rates and razor thin margins compared to specialty practices.⁴

To remain financially viable, practices that rely on non-physician clinicians would likely be forced to shift certain services from APRNs and PAs back to physicians so that they can continue to bill at 100% fee schedule rates. This anticipated shift in services back to physicians would undercut projected savings, disrupt the hiring of APRNs and PAs, and exacerbate the existing primary care physician shortage,⁵ further limiting beneficiary access to services, especially primary care services. Access to primary care services has been linked to improved patient outcomes and lower costs⁶ and is already a concern due to an anticipated

¹ Implementing Team-Based Care to Reduce Clinician Burnout. National Academy of Medicine. Sept. 2018. [Link](#).

² Burnout and satisfaction with work-life balance among US physicians relative to the general US population. National Center for Biotechnology Information (NCBI). U.S. National Library of Medicine. Oct. 2012. [Link](#).

³ Employment of Advanced Practice Clinicians in Physician Practices. *JAMA Intern Med*. April 30, 2018. [Link](#).

⁴ Building Quality Improvement Capacity in Primary Care: Supports and Resources. Agency for Healthcare Research and Quality. April 2013. [Link](#).

⁵ The Complexities of Physician Supply and Demand: Projections from 2016 to 2030. Association of American Medical Colleges. March 2018. [Link](#).

⁶ Primary Care Visit Regularity and Patient Outcomes: an Observational Study. NCBI. Oct. 2018. [Link](#).

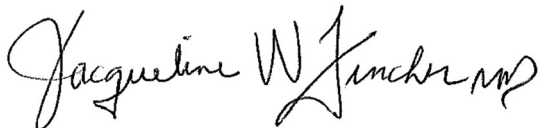
shortage of primary care clinicians, particularly for at-risk patient populations and patients suffering from multiple chronic conditions. APRNs and PAs help to fill this critical void. Terminating incident to billing could exacerbate access issues to primary care services and widen existing inequities for at-risk patient populations, as well as risk worsening health outcomes and increasing downstream costs due to less effective case management.

The College appreciates the Commission's continued attention to adequate reimbursement for primary care services. For many years the College has made it a top priority to draw attention to the undervaluing of cognitive services which threatens the future of primary care. While we support efforts to improve transparency and tracking of Medicare payments in the interest of isolating the breakdown of Medicare spending to ensure reimbursement for primary care services is adequate and proportional, **we fear terminating incident to billing would have a more immediate and damaging impact on the viability of primary care practices across the country that employ more non-physician clinicians than specialty practices.** We urge the Commission to explore other ways to track the clinicians that render services, including creating a separate category for the rendering clinician on claims, as was suggested in the hearing, or leveraging new patient relationship codes.

Conclusion

We appreciate the opportunity to submit these comments and the Commission's ongoing work to ensure the solvency of future Medicare trust funds and address primary care workforce and payment issues. We look forward to continuing to support the Commission in this important, ongoing work. If you have any additional questions about the contents of this letter, please contact Suzanne Joy at sjoy@acponline.org or 202-261-4553.

Sincerely,

A handwritten signature in black ink that reads "Jacqueline W. Fincher MD". The signature is written in a cursive, flowing style.

Jacqueline W. Fincher, MD, MACP
Chair, Medical Practice and Quality Committee
American College of Physicians