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When His Doctor Was Unavailable, He Saw a Nurse Practitioner. A Physician Billed for the Visit.

Robert M Kaplan, Clinical Excellence Research Center, Stanford University School of Medicine, and Barak Richman, Duke University School of Law and Clinical Excellence Research Center, Stanford University School of Medicine

Contact: bob.kaplan@stanford.edu

Abstract

What is the message? Nurse practitioners cannot merely substitute or extend physician-based care if they are to make care more affordable. They should instead offer services through which they excel as independent providers, offering an alternative to the traditional delivery model.

What is the evidence? A review of randomized trials, clinical trials, and other studies on patient outcomes and costs involving nurse practitioners.

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Policy experts widely agree – and with greater urgency with rising healthcare costs and workforce shortages – that nurse practitioners (NPs) can make care more affordable and accessible. A systematic review of 11 randomized trials suggested that nurse practitioners

achieve equivalent or better outcomes in comparison to physicians and potentially save costs,[1] and another review of 13 clinical trials indicated that in comparison to physician lead care, advanced practice nurse practitioners achieved better outcomes for patient satisfaction, waiting times, control of chronic disease, and cost effectiveness.[2]

Yet despite the rosy picture that appears in the nursing literature, healthcare costs continue to rise, even for patients who only see NPs. To illustrate, a colleague of one of the authors visited an NP for digestive problems after an indulgent holiday season of overeating. Following a physical exam, history, a series of blood tests, and abdominal MRI images (and a clean bill of health), the total bill came to $4,824.

Parsing both this bill and the broader practices of employing NPs reveals some faults in the theory that using less expensive personnel reduces the cost of care. NPs cannot meaningfully reduce costs if they merely expand the service reach of more expensive physicians. Many NPs, including the one seen in the illustration above, are chiefly being used as “physician extenders,” such that they are agents that advance a physician’s work. Moreover, less experienced NPs in this role have actually shown to increase the total cost of care by ordering more tests to compensate for a lower confidence in their diagnosis.[3] Other studies have similarly shown that use of NPs in VA emergency rooms were associated with higher costs and longer lengths of stay.[4]

If we want to harness NPs to make care more affordable, they cannot merely substitute or extend physician-based care. We instead need them to offer services in which they excel as independent providers so they can offer an alternative to the traditional delivery model.

NPs as Physician Extenders

Nurse practitioners earn about $110,000 per year[5] while the average primary care physician earns about $255,000.[6] Presumably because lower salaries could lead to efficiencies, Medicare currently gives nurse practitioners their own National Provider Identifier (NPI) and allows them to bill at 85% of the rate allowed for physician visits.[5] On the margin, steering patients toward nurse practitioners and away from physicians generates more revenue for the Medical Group

(they get 85% of the revenue while paying about 43% of the costs).

However, there are ways to bill NP services at more than the allowed 85% rate. Medicare permits medical groups to bill NP services at the same rate billed by a physician. This "Incident to" billing permits physician-level billing if the clinical services provided by a nurse practitioner or a physician's assistant can be considered part of a treatment plan initiated by a physician. One estimate suggested that 30.6 million NP or PA visits in 2018 were billed indirectly.[7]

This use of NPs therefore shadows and reinforces the primary role of a physician, who has seen the patient, defined a treatment plan, and scheduled an NP for follow-up care in the same facility. Even the "same facility" has been interpreted flexibly to include the same office, the same building, or the same large medical group. Moreover, the billing physician often has little to do with the care. In the California Medicaid Program (known is MediCal), the supervising physician is required to review only 5% of the records of patients treated by an NP or PA.[7]

Within this framework, labor savings are unlikely to be passed on to patients. Financial arrangements are made between the payers and the supervising medical group, either at regulated rates or within a capitated payment. There are, of course, strong justifications for these regulated or capitated arrangements, and we do not decry profit that accrues to medical groups for providing primary care, but this does explain why services by NPs bill at high rates and do not restrain healthcare costs.

Even when patients see NPs, they often are billed for physician services. In our case example, the actual bill for the service was from a supervising physician that the patient had never met. Interestingly, this often requires two sets of accounting: the patient's medical records indicate that the nurse practitioner provided the care, yet the commercial insurance claim lists only the physician.

The takeaway from these billing shenanigans is that when NPs replicate and extend physician care, they remain a fixture in physician care. They are dependent on the physician's enhanced licensure authority and, therefore, expand the physician's financial and medical reach. These may be admirable policy outcomes, but it is no surprise that they do not bend the cost curve of physician care.

NPs as Independent Providers

None of this means that policymakers are wrong that NPs can reduce the cost of healthcare. It more likely means that they are being used in the wrong way. If they are agents of physicians, they can do little to enhance affordability.

The need for expanding the capacity of primacy care has been described in several influential publications[8]. However, the capacity to meet the demand for primary care services remains limited. Instead of serving as physician extenders, NPs could be allowed to provide care on their own, to the degree that their skills allow, as alternatives to traditional physician care. Preventive care, behavioral interventions, and rehabilitation are all areas in which non-physician providers can excel and provide a competitive alternative to MD-based care.

The policy question, therefore, is not so much what NPs should be paid, but rather, what can they do on their own? States determine the services that paraprofessionals are legally permitted to provide ("scope of practice"), and only a few states permit NPs to practice independently.[9] A policy compromise usually requires that NPs are under the supervision of a physician. But if the "extender" model only expands the reach of physician care while losing some of the benefits, this compromise might offer the worst of all alternatives.

Preliminary evidence suggests that the few states that allow NPs and PAs to run their own practices have achieved improvements in both the access and cost of primary and ongoing care.[10,11] These independent NP practices appear to be attentive stewards of patients with chronic conditions and savvy managers of healthcare dollars, finding ways to reduce overall costs without sacrificing quality. Further, the costs of starting a practice are modest[12] in comparison to medical specialty practices that are becoming increasingly dependent on private equity investment. The primary barrier to NP standalone practices is regulatory rather than financing. But very few states allow these paraprofessionals to set up their own shop, and much more needs to be known.

Next Steps

In order to gain a better foundation for policy change, we need more evidence. Even though there are randomized trials comparing nurse practitioner to physician care, few studies

systematically evaluate the quality and costs of truly independent nurse practitioner care. Randomization is important because patients with more serious illnesses might gravitate toward physician care, thus creating a bias toward poorer outcomes for those treated by MD's. Further, we need additional independent evaluations from the 27 states that now allow nurse practitioners to practice independently.

In addition to outcome studies, we need more information on whether and how independent nurse practitioners change healthcare delivery. Understanding how NPs generate savings can reveal who ultimately enjoys those savings. Although it is possible that cost savings are passed on to payers and patients, billing maneuvers and practice protocols appear to favor the entities that employ NPs rather than the patients.

In fairness, most medical groups want to provide good care for their patients, and NPs are essential components of quality care teams. But these providers are limited in how much they can generate savings for patients if they are limited to being cogs in the current delivery system. In the end, short-sighted cost-saving measures rarely pan out, and schemes to increase healthcare revenue hurt us in ways that are not the most obvious.

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