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Rural Implications of the Primary Care Incentive Payment Program

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Key Findings

- Both the number and proportion of providers eligible to receive Primary Care Incentive Payments in 2011, 2012, and 2013 increased during the years used to determine eligibility (2009, 2010, and 2011).
- For most practice types, rural providers were more likely to be eligible for Primary Care Incentive Payments. However, rates of eligibility varied between provider types.
- Rural Family Practice physicians were less likely to be eligible for Primary Care Incentive Payments than their urban counterparts.

Structure of the Program

During Senate Finance Committee considerations of US health care system reform, a proposal emerged to create additional payment for primary care providers. The proposal's intent was to strengthen the role of primary care in a new, high-performing health system.[1] It followed a recommendation from the Medicare Payment Advisory Commission that there be a budget-neutral payment for primary care services.[2] The Patient Protection and Affordable Care Act of 2010 (ACA) established the Incentive Payment Program for Primary Care Services,[3] also known as the Primary Care Incentive Payment (PCIP) Program. The Program pays a 10% incentive payment (i.e., a bonus payment in addition to Medicare fee-for-service payments) for primary care services provided by eligible primary care providers during calendar years 2011–2015. The Program defines *primary care provider* as a physician with a Medicare specialty designation of Family Medicine, Geriatric Medicine, Internal Medicine, or Pediatric Medicine (Medicare Specialty Codes 08, 38, 11, and 37, respectively). The Program also includes Clinical Nurse Specialist (CNS), Nurse Practitioner (NP), and Physician Assistant professionals practicing as primary care providers (Medicare Specialty Codes 50, 89, and 97, respectively).

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Primary care providers as defined above are eligible for the 10% incentive payment if their allowed charges for primary care services equal or exceed 60% of their Physician Fee Schedule (PFS) allowed Medicare charges during the previous two calendar years. The Program defines *primary care services* as the following Current Procedure Terminology (CPT) Codes:

- 99201 through 99215 for new and established patient office or other outpatient Evaluation and Management (E/M) visits;
- 99304 through 99340 for initial, subsequent, discharge, and other nursing facility E/M services; new and established patient domiciliary, rest home (e.g., boarding home), or custodial care E/M services; and domiciliary, rest home (e.g., assisted living facility), or home care plan oversight services; and
- 99341 through 99350 for new and established patient home E/M visits.[4]

The PCIP Program was amended (effective July 1, 2011) to provide for participation of "newly enrolled Medicare primary care physicians and non-physician practitioners who do not have a prior two-year claims history with which to determine eligibility."[5]

Methods Used in this Analysis

We based our analysis of how many physicians declare their specialty to be one of the types of primary care specified in the ACA on data from the National Provider Identifier (NPI) files. Health care providers must obtain an NPI for use in all Health Insurance Portability and Accountability Act transactions. As part of this process, providers are required to use a set of codes (the Healthcare Provider Taxonomy Codes [HPTCs]) to identify their practice type. Similarly, to enroll as a Medicare provider, health care providers must specify a single code indicating their medical specialty.

Between 2011 and 2013, the Centers for Medicare and Medicaid Services (CMS) provided Medicare contractors with lists of NPIs of providers eligible to receive the PCIP. The lists are based on qualifying data from 2009 through 2011. For this analysis, we used NPI data to identify the practice location and primary care provider specialty for all providers (those on the CMS lists and all others).[6] The HPTCs and code descriptions that health care providers select when applying for NPIs may or may not be the same as the categorizations used by Medicare and other health plans during enrollment and credentialing activities.[7] We therefore used a taxonomy crosswalk developed by CMS to link NPI HPTCs to Medicare Specialty Codes.[8] Some providers identified by CMS as eligible for PCIP (and therefore indicated as "Primary Care") listed some other specialty type(s) in the NPI database. Those cases are identified in this report as having "unknown specialty." We combined CNS and NP provider counts due to small numbers.

Practice location was determined using practice ZIP code (listed in the NPI data) and classified according to its Rural Urban Commuting Area (RUCA) code. Providers specifying a ZIP code for the NPI database that could not be linked to a RUCA are identified in this report as having an "unknown" location.

Results

Table 1 shows the distribution of providers eligible for PCIP payments across medical specialty for years 2009, 2010, and 2011. As might be expected, more Family Medicine and Internal Medicine providers qualified for the PCIP than other medical specialties. Overall, the number of qualifying providers increased significantly (from 170,920 to 202,454) from qualifying years 2009 to 2011. The proportion of qualifying providers identified as Family Medicine decreased slightly during that period, while the proportion of qualifying providers identified as non-physician provider (i.e., CNS, NP, or Physician Assistant) increased slightly.

Table 1. Number and Percentage of PCIP Eligible Providers by Medical Specialty and Qualification Year

Medical Specialty*	2009		2010		2011	
Family Medicine	62,312	36.5%	66,345	34.1%	67,384	33.3%
Internal Medicine	52,545	30.7%	60,224	31.0%	59,318	29.3%
Pediatric Medicine	2,427	1.4%	3,028	1.6%	3,503	1.7%
Geriatric Medicine	2,661	1.6%	3,021	1.6%	3,013	1.5%
CNS and NP	25,826	15.1%	33,506	17.2%	37,145	18.3%
Physician Assistant	12,367	7.2%	16,826	8.7%	18,682	9.2%
Unknown Specialty	12,782	7.5%	11,478	5.9%	13,409	6.6%
TOTAL	170,920	100%	194,428	100%	202,454	100%

*Practitioners are allowed to enroll in Medicare specifying a different medical specialty than that they indicate in the NPI.

Table 2 shows the total number of primary care providers (as defined by CMS and described above) parsed by practice location. The vast majority of qualifying providers were found in urban locations, reflecting the larger number of providers found in urban areas. The increasing number of qualifying providers over the three-year period is relatively constant across urban and rural areas. Between 2009 and 2011, the overall percentage of NPI-identifiable primary care providers eligible for the PCIP increased from 26.4% to 27.6% (data not shown).

Table 2. Number and Percentage of PCIP Eligible Providers by Practitioner Location and Qualification Year

Practitioner Location*	**2009**		**2010**		**2011**	
Urban	139,330	81.5%	160,833	82.7%	166,805	82.4%
Large Rural City/Town	15,929	9.3%	17,999	9.3%	18,392	9.1%
Small Rural Town	8,238	4.8%	9,060	4.7%	9,146	4.5%
Isolated Small Rural	4,385	2.6%	4,786	2.5%	4,850	2.4%
Unknown	3,038	1.8%	1,750	0.9%	3,261	1.6%
TOTAL	170,920	100%	194,428	100%	202,454	100%

*Based on primary practice location ZIP code, classified by 2006 Rural Urban Commuting Area (RUCA) code. RUCA coding:

Urban focused: 1.0, 1.1, 2.0, 2.1, 3.0, 4.1, 5.1, 7.1, 8.1, 10.1
Large Rural City/Town (micropolitan) focused: 4.0, 4.2, 5.0, 5.2, 6.0, 6.1
Small Rural Town focused: 7.0, 7.2, 7.3, 7.4, 8.0, 8.2, 8.3, 8.4, 9.0, 9.1, 9.2
Isolated Small Rural Town focused: 10.0, 10.2, 10.3, 10.4, 10.5, 10.6

Table 3 shows that Family Medicine physicians were more likely to be eligible for the PCIP than were all other primary care provider specialties in almost all practice locations. The single exception is Geriatric Medicine in Isolated practice locations. However, as practice location becomes more rural (i.e., Urban to Isolated), the percentage of Family Medicine physicians eligible for the PCIP *decreases* while in general the percentage of other primary care provider types (including Internal Medicine) eligible for the PCIP *increases*.

Table 3. Percentage of Total Primary Care Providers Eligible for PCIP by Practice Location and Provider Type

Practice Location	Family Medicine	Internal Medicine	Pediatric Medicine	Geriatric Medicine	CNS and NP	Physician Assistant
2009						
Urban	49.9%	22.9%	3.1%	48.3%	24.4%	17.5%
Large Rural	49.5%	27.3%	5.0%	44.7%	30.5%	26.4%
Small Rural	44.9%	34.1%	6.3%	43.9%	32.8%	27.9%
Isolated	39.8%	33.6%	9.4%	57.4%	33.5%	32.6%
Unknown	26.7%	20.1%	1.0%	50.5%	11.7%	8.4%
2010						
Urban	49.5%	24.3%	3.6%	50.8%	26.3%	20.7%
Large Rural	49.0%	28.0%	5.4%	45.4%	33.9%	29.5%
Small Rural	44.4%	34.5%	6.4%	49.1%	35.5%	31.1%
Isolated	39.9%	33.9%	11.8%	52.7%	34.7%	34.5%
Unknown	29.1%	22.6%	1.1%	50.0%	15.4%	8.9%
2011						
Urban	49.3%	23.5%	4.1%	49.5%	27.8%	22.3%
Large Rural	48.1%	26.3%	6.3%	45.2%	35.8%	31.0%
Small Rural	43.2%	32.7%	6.3%	43.2%	36.6%	32.1%
Isolated	38.9%	32.1%	12.6%	48.2%	36.0%	36.1%
Unknown	29.9%	22.1%	1.3%	51.4%	19.6%	8.7%

Discussion

The intent of the PCIP Program, reflected in Senate Finance Committee documents, is to increase the value of primary care services. It is unlikely that legislators considered that Family Medicine physicians practicing in rural locations would be less likely than their urban counterparts to be eligible for the PCIP. Although we did not complete a detailed comparison of rural and urban primary care practices for this analysis, we believe that rural Family Medicine physicians are more likely to deliver a broad range of clinical services (e.g., procedures) that effectively decreases the proportion of primary care services in a practice. Thus, by offering patients local access to comprehensive clinical services, rural Family Medicine physicians become less likely to be eligible for the 10% PCIP. Assuming the policy objective is to increase the value of primary care services in all locations, consideration could be given to modifying the eligibility criteria in rural places, where primary care providers perform more non-qualifying (for payment) services because they are the sole source of care. Further research would help develop refined criteria, for example by modifying the percentage of Medicare payment tied to designated primary care service codes needed to meet a threshold requirement.

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1 Baucus, Max (2008) "Call to Action: Health Reform 2009." US Senate Finance Committee. November 12.

2 Medicare Payment Advisory Commission (2008) *Report to the Congress: Reforming the Delivery System*. June. Accessed June 18, 2013: http://www.medpac.gov/documents/Jun08_EntireReport.pdf.

3 Patient Protection and Affordable Care Act. Section 5501(a).

4 http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7060.pdf. Accessed August 27, 2012.

5 http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7267.pdf. Accessed March 7, 2013.

6 From the web site of the National Plan and Provider Enumeration System (NPPES): https://nppes.cms.hhs.gov

7 http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Taxonomy.html. Accessed August 24, 2012.

8 http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/JSMTDL-08515MedicarProviderTypetoHCPTaxonomy.pdf. Accessed August 24, 2012.