PAYING EMPLOYED PHYSICIANS TO SUPERVISE ADVANCED PRACTICE CLINICIANS

Health Care Compliance Association – Web Conference

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AGENDA

- Why Organizations Pay Employed Physicians to Supervise APCs
- APC Billing
- Physician Supervision Requirements
- Supervision Compensation Methodologies
- Legal Guidance
- Valuation Approaches
- Cost Approach Example
- Compliance

3 WHY ORGANIZATIONS PAY EMPLOYED PHYSICIANS TO SUPERVISE MIDLEVELS

BACKGROUND

Types of Advanced Practice Clinicians or "Non-Physician Practitioners"

- Clinical Nurse Specialist (CNS) - Advanced practice registered nurse, with graduate preparation from a program that prepares CNSs
- Nurse-Midwife (CNM) - Advanced practice registered nurse who has specialized education and training in midwifery
- Nurse Practitioner (NP) - Nurse who is qualified to treat certain medical conditions without direct supervision of a doctor
- Physician Assistant (PA) - Mid-level medical practitioner who works under licensed doctor (an MD) or osteopathic physician (a DO) supervision

https://med.noridianmedicare.com/web/jeb/specialties/nonphysician-practitioners

TRENDS

Growth in the Number of APCs

- Advanced Practice Nurses (nurse anesthetists, nurse midwives, and nurse practitioners):
  - Projected growth – 31% from 203,800 in 2016 to 268,000 in 2026
- Physician Assistants
  - Projected growth – 37% from 106,200 in 2016 to 145,900 in 2026, much faster than the average for all occupations.
- Increased emphasis on preventive care and demand for healthcare services from the aging population
- Physician Shortfalls
  - Projected shortfalls - 42,600 to 121,300 physicians by 2030 (Association of American Medical Colleges 2018 Study)

https://www.bls.gov/ooh/healthcare/nurse-anesthetists-nurse-midwives-and-nurse-practitioners.htm#tab-6

https://www.bls.gov/ooh/healthcare/physician-assistants.htm#tab-6

TRENDS

APCs Add Value

- Healthcare Financial Management Association (HFMA) Article
  - MGMA 2017 DataDive Cost and Revenue Survey - practices with higher APC to Physician ratios earn more in revenue after operating cost than practices with fewer APCs, regardless of specialty. https://www.hfma.org/Content.aspx?id=55135
- Health Leaders Article - Nurse Practitioners Increase Low-Income Access to Care
  - Researchers at the University of Michigan, published in the Journal of General Internal Medicine, find that physicians tend to practice in more affluent communities while NPs practice in areas of higher socioeconomic need. http://www.healthleadersmedia.com/nurse-leaders/nurse-practitioners-increase-low-income-access-care#
- National Association of Community Health Centers Fact Sheet:
  - The use of nurse practitioners (NPs), physician assistants (PAs), and nurse midwives (CNMs) can improve access to care, improve patient outcomes, and reduce health disparities, all while promoting a more efficient and cost-effective primary care system. http://www.nachc.org/wp-content/uploads/2016/02/Workforce_FS_0913.pdf
- Pennsylvania Coalition of Nurse Practitioners Press Release:
  - Five separate studies concluded that nurse practitioners (NPs) expand access to care, improve patient health outcomes, boost rural health care, lower primary care costs and reduce emergency room admissions. http://www.pacnp.org/news/277542/Five-New-Studies-Nurse-Practitioners-Expand-Access-to-Health-Care-Lower-Costs-Improve-Outcomes.htm

TRENDS

Physician Motivation

- Physicians may not have a financial motivation to utilize APCs without payment of a supervision fee.
- Reduced emphasis on productivity metrics and movement toward value/quality pay in many employed physician compensation plans.
- Supervision is personally performed work.
- Physicians take on additional risk with supervision responsibilities.

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APC BILLING

Options

- APC's own provider number
- Incident-to physician's service
- Shared/split visit

Distinctions: NPs can be paid directly. PA's payment must go directly to employer

APC BILLING

Own Provider Number

- Any services allowed under the APC's state scope of practice
- 85% of the physician fee schedule
- 100% for midwives

APC BILLING

Incident-to Physician's Service

- APC must be eligible
- Billed under the physician's number
- 100% of the physician fee schedule
- Provided in the physician's office
- Under the physician's direct supervision
  - In the office suite and immediately available
  - Can be provided by another physician in the group practice (billed under supervising physician number)
- W2 or contracted employee
  - Must represent an expense to the physician, group practice, or legal entity

APC BILLING

Shared Billing

- Hospital inpatient/hospital outpatient or emergency department E/M
- Physician and an APC from the same group practice
- Physician provides any face-to-face portion of the E/M encounter with the patient
- Service may be billed under either the physician's or the APC's UPIN/PIN number.

Internet Only Manual section 30.6.1.B

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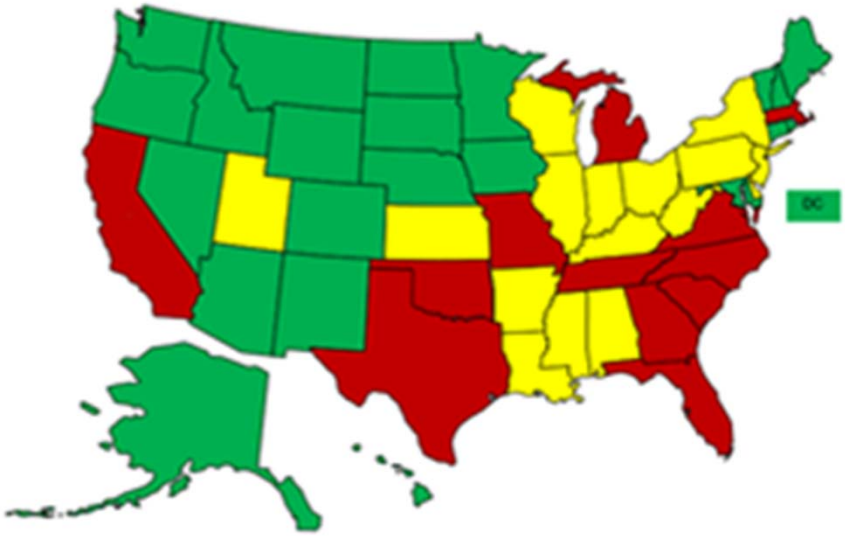
PHYSICIAN SUPERVISION REQUIREMENTS

STATE REQUIREMENTS

Nurse Practitioners



Source: State Nurse State Practice Acts And Administration Rules, 2017
American Association of Nurse Practitioners, 2017
https://www.aanp.org/images/documents/state-leg-reg/stateregulatorymap.pdf

GREEN - Full Practice

State practice and licensure laws provide for nurse practitioners to evaluate patients, diagnose, order and interpret diagnostic tests, initiate and manage treatments—including prescribe medications and controlled substances—under the exclusive licensure authority of the of the state board of nursing.

YELLOW - Reduced Practice

State practice and licensure law reduces the ability of nurse practitioners to engage in at least one element of NP practice. State requires a career-long regulated collaborative agreement with another health provider in order for the NP to provide patient care or limits the setting of one or more elements of NP practice.

RED - Restricted Practice

State practice and licensure law restricts the ability of a nurse practitioner to engage in at least one element of NP practice. State law requires career-long supervision, delegation or team management by another health provider in order for the NP to provide patient care.

STATE REQUIREMENTS

Physician Assistants

Supervision – 46 states and DC require PAs to be supervised by physicians.

- In 2 states (AK, IL), PAs are subject to collaborative agreements with physicians
- In 2 states (NM, MI), alternate arrangements are allowed
  - NM calls for supervision for PAs with <3 years of clinical experience
  - MI requires specialty PAs to work under a participating physician

Co signature – 20 states require a certain percentage or number of PA charts to be co-signed by a physician

Ratio requirements – 39 states have established limits on the number of supervised PAs per physician

Prescriptive authority – 44 states allow PAs to prescribe Schedule II-V medication

https://www.ama-assn.org/sites/default/files/media-browser/public/arc-public/state-law-physician-assistant-scope-practice.pdf

PAYER REQUIREMENTS

Medicare – Nurse Practitioners

Collaboration is a process in which a NP works with one or more physicians (MD/DO) to deliver health care services, with medical direction and appropriate supervision as required by the law of the State in which the services are furnished. In the absence of State law governing collaboration, collaboration is to be evidenced by NPs documenting their scope of practice and indicating the relationships that they have with physicians to deal with issues outside their scope of practice. The collaborating physician does not need to be present with the NP when the services are furnished or to make an independent evaluation of each patient who is seen by the NP

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1734B3.pdf

PAYER REQUIREMENTS

Medicare - Physician Assistants

Physician Supervision.--The PA's physician supervisor (or a physician designated by the supervising physician or employer as provided under State law or regulations) is primarily responsible for the overall direction and management of the PA's professional activities and for assuring that the services provided are medically appropriate for the patient. The physician supervisor (or physician designee) need not be physically present with the PA when a service is being furnished to a patient, unless State law or regulations provide otherwise. However, if the physician supervisor (or physician designee) is not physically present with the PA, he or she must be immediately available to the PA for consultation purposes by telephone or other effective, reliable means of communication

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1734B3.pdf

ORGANIZATION REQUIREMENTS

Example Policy

Policy:

The Physician Assistant and their Supervising Physician will adhere to Section 1399.345 of the Physician Assistant Regulations requiring the supervising physician countersign a minimum of 5% of the medical records of patients treated by the physician assistant functioning under the Specialized Procedures and Protocols for Midlevel Providers (SPPML).

Procedure:

The Physician Assistant will forward (using instant messaging function) their signed entries in the medical record to the supervising physician for countersigning (or cosigning), usually within 24 hours, and always within one week of entry according to the following guidelines:

- Cases where MD consultation is documented in the case note
- Cases in which a Schedule II controlled substance is prescribed by Physician Assistant
- Cases in which a repeat visit seen by Physician Assistant for same problem without expected improvement
- Cases of significant illness or potentially unstable or dangerous conditions (patients transferred to hospital or patients requiring intravenous hydration or medication)
- Cases with unusual or atypical findings on examination or testing
- Cases in which non-standard treatment is recommended by the Physician Assistant

To ensure compliance with the Physician Assistant supervision regulations, a minimum of 2 cases per 8 hour work day will be forwarded by the Physician Assistant to the supervising physician for cosigning (even if none of the above 6 criteria apply to the Physician Assistant case load for that day).

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SUPERVISION COMPENSATION METHODOLOGIES

COMPENSATION METHODOLOGIES

Considerations

- APC Billing
  - Incident-to
  - Direct
  - Both
- Components
  - Base salary
  - Incident-to wRVUs
  - Proxy wRVUs
  - Conversion factor
  - Thresholds
  - Stipends

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LEGAL GUIDANCE

Regulatory Standards

- Anti-Kickback Statute
- Stark Law
- False Claims Act
- Non-Profit and Tax Exemption
- State Laws

LEGAL GUIDANCE

Legal Concepts

- Enforcement Climate
  - Rigid and technical (e.g., Stark Law) regulatory framework
  - Aggressive government enforcement
  - Substantial Penalties = Enterprise Risk
- Considerations for Managing Risk
  - Supervision payments must be legally defensible
  - Must focus on demonstrating the 3 Tenets of Defensibility:

    Fair market value, commercial reasonableness and not taking into account referrals
  - Contracting and compensation processes (e.g., business planning, valuation, approval processes, etc.) should support defensibility

LEGAL GUIDANCE

Anti-Kickback Statute Framework

- Criminal Statute
  - Prohibits paying remuneration to induce items or services payable under federal health care programs
  - Intent is required (case law allows for inference of intent)
  - Broad and subjective statute
- Safe Harbors - Protection requires strict compliance with all conditions of the applicable safe harbors

LEGAL GUIDANCE

Anti-Kickback Employment Safe Harbor § 1001.952(i)

- Protects amounts paid by an employer to an employee, who has a bona fide employment relationship with the employer.
- "Employee" has the same meaning for purposes of satisfying the safe harbor as it has for federal employment tax purposes under the Tax Code.
- Paying greater than fair market value for items or services can support an inference that improper remuneration was paid to induce referrals.
- Compensation paid in excess of fair market value arguably will not be protected by the employment safe harbor.

LEGAL GUIDANCE

Stark Law Framework

- If a Physician has a Financial Relationship with an Entity:
  - Then the Physician **may not make a referral** to that Entity for the furnishing of designated health services ("**DHS**") for which payment may be made under Medicare; and
  - The Entity **may not bill Medicare**, an individual, or another payor for the DHS performed pursuant to the prohibited Referral…… ***unless the arrangement fits squarely within a Stark exception***
- Strict liability – no intent required.

LEGAL GUIDANCE§

The Stark Employment Exception § 411.357(c)

- The employment must be for identifiable services.
- The amount of the remuneration under the employment must:
  - Be consistent with the fair market value of the services; and
  - Not be determined in a manner that takes into account (directly or indirectly) the volume or value of any referrals by the referring physician.
- The remuneration must be provided under an arrangement that would be commercially reasonable even if no referrals were made to the employer.

LEGAL GUIDANCE

Stark Phase II CMS Commentary (PG 16087)

In addition, nothing in the [Employment] exception precludes a productivity bonus based solely on personally performed supervision of services that are not DHS, since that bonus would not take into account the volume or value of DHS referrals.

Productivity bonuses based on supervising DHS raise a different issue. We are concerned that, in some cases, a payment for supervision services may merely be a proxy payment for having generated the DHS being supervised. In many cases, especially in hospitals, the supervision required under Medicare rules is minimal, and the supervisor need do nothing more than be present in the facility while conducting other work. Accordingly, we are concerned that such payments could mask improper cross-referral or circumvention schemes. We note that any payment for supervision services must meet the fair market value standard in the exception.

LEGAL GUIDANCE

Stark Phase II CMS Commentary (PG 16088)

- Comment: Two commenters asked whether the employment exception would be satisfied if an employer paid an employed physician a flat fee for each mid-level provider he or she supervises in order to compensate the physician for the time spent on supervision.

- Response: We see nothing in the exception that would bar flat fee compensation based on the number of mid-level providers under the physician's supervision, as long as the compensation is fair market value for actual time dedicated to supervision services and is not determined in any manner that takes into account, directly or indirectly, the volume or value of DHS referrals generated by the physician. The burden of proving the time will be on the DHS entity.

LEGAL GUIDANCE

3 Tenets of Defensibility

- Fair Market Value
  - Narrow Regulatory Definition – 42 CFR § 411.351
  - Best Regulatory Position: FMV is supported by the quantity and intensity of a physician's work effort
  - Reference multiple, objective, independently published salary surveys
- Commercial Reasonableness
  - No statutory or regulatory definition
  - Should document non-referral based supporting business factors
- Not "Taking Into Account" Referrals of DHS
  - Compensation cannot be calculated in a manner that takes into account a physician's referrals of DHS
  - Health care organizations should avoid actions that may be misconstrued as "taking into account" DHS referrals (e.g., documentation referencing DHS referrals, referral projections, etc.)

VALUATION APPROACHES

VALUATION APPROACHES

Income Approach

- Less likely to be used

Market Approach

- Where are the data?
- How comparable are the data?

Cost Approach

- More defensible?

COST APPROACH EXAMPLE

A Cost Approach May Consider:

- Type of APC
- Setting where services are provided
- APC billing
- State, payer, employer requirements
- Provider's level of experience, training, and need for supervision
- Clinical specialty
- Type of patient (inpatient or outpatient) and patient acuity
- APC productivity
- Among others

COST APPROACH EXAMPLE

Physician Supervisor Duties and Responsibilities:

- Determining the Appropriate Level of Supervision: Often a written document is produced that outlines the drugs, devices, medical treatment, tests and procedures that may be prescribed, ordered, and performed by the APC along with a list of procedures for emergency situations.
- Communicating and Consulting with the APC: The supervisory physician meets periodically with the PA or NP, provides telephone and in-person consultations, and is available for emergency situations.
- Providing Oversight and Reviewing Quality of Care: The supervisory physician will review and co-sign (when necessary) the APC's chart notes and orders, monitor performance to ensure protocols and procedures are being met, and evaluate APC competency.

APPLYING A COST APPROACH

Itemize the physician's duties and responsibilities under the supervision arrangement and estimate the time requirements. Apply an FMV hourly rate to the annual time estimates.

Duties	Hours Per Year	FMV Hourly Rate	Annual Stipend
Review and update supervisory agreement	4	$125	$500
Monthly in-person meeting with NP	12	$125	$1,500
Telephone consultations (10 per month, 15 minutes @)	30	$125	$3,750
Chart review (10% of all charts = 276 chart reviews, 10 minutes @)	46	$125	$5,750
Annual evaluation and feed-back sessions with management	4	$125	$500
	96		**$12,000**

The aggregate amount is an indication of the FMV for the supervisory services.

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COMPLIANCE

Compliance Considerations

- Understand State Law Requirements for Collaboration and Supervision
- Document the Services that Physicians Perform
- Document the FMV and CR of the Supervision/ Collaboration Services that are Performed
- Develop Policies/ Procedures for Assigning APC Oversight to Individual Physicians

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