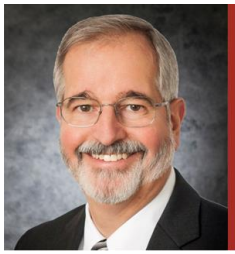
Advance Practice Providers:
Employment, Compensation, and Utilization Models

Webinar Recorded Live on June 25, 2020

HSG **Presenters**



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Today's **Objectives**

1. Understand the benefits of APP employment contracts.
2. Recognize the need to align APP compensation with same-specialty physicians and the organizational goals and objectives.
3. Focus on adjusting care delivery models to maximize the APPs' talents and capabilities

APPs

APPs – Who are we talking about?

- APP = Advanced Practice Providers
  - APRNs = Advanced Practice Registered Nurses
    - NPs, CNSs, CNMs, CRNAs
  - PAs = Physician Assistants

- Not referring to other non-physicians direct care providers
  - Psychologists
  - Mental Health Counselors
  - Registered Dieticians
  - Physical Therapists

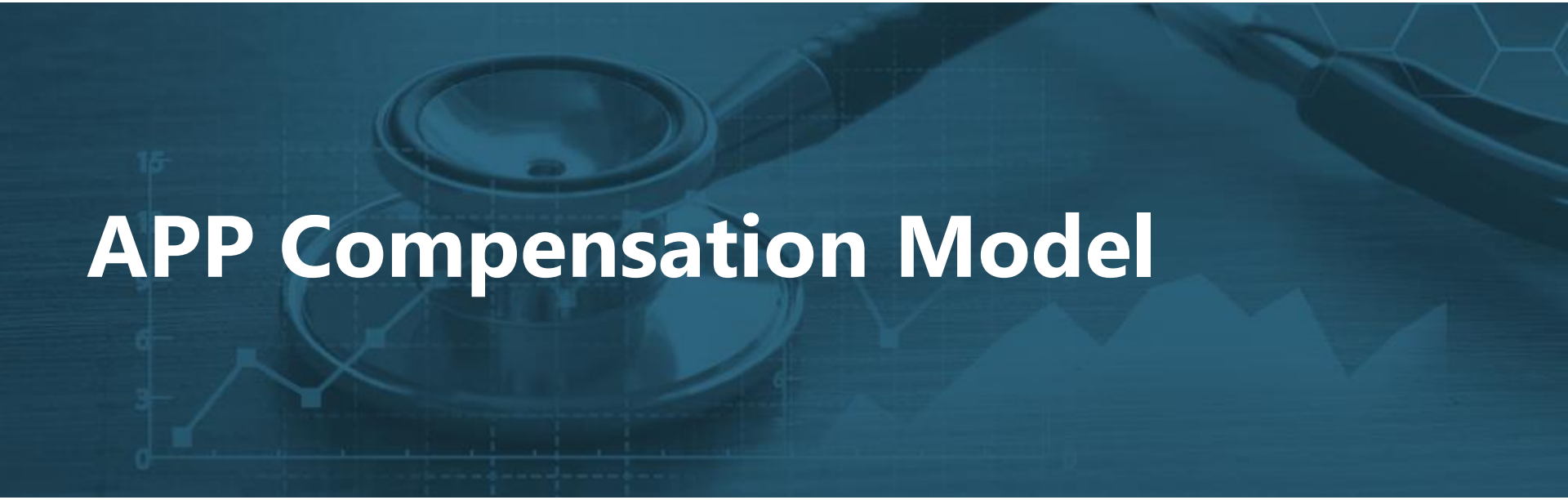
APP Employment Model

APP Employment Model

- Traditional model – Straight Human Resources exempt employee relationship
- Advantages
  - Simple relationship without need for individual, "legal" opinions or review
- Disadvantages
  - "At will" employee required to only provide "2 week notice"
    - Insufficient time to conduct recruitment and onboarding to avoid gaps in service
  - Details re: explicit roles/responsibilities/expectations usually lacking in exempt employment relationship
  - Does not convey status comparable to physicians
    - Physicians commonly employed via detailed contractual relationship with explicit roles/responsibilities/expectations
    - Exempt employee status perpetuates "second class" perception / stereotype

APP Employment Model

- Contractual model
- Advantages
  - Elevates perception of status
  - Confers status and respect afforded to physician colleagues
  - Permits specific delineation of roles/responsibilities, compensation incentives, expectations
  - Allows inclusion of longer "without cause" departure
    - Usually 120 to 180 days (consistent with physician parameters)
- Disadvantages
  - Greatest conversion concern is "non-compete clauses"
    - Especially foreign to APRNs



APP Compensation Model

APP Compensation Model

- Traditional Model – Straight salary
- Advantages
  - Straight forward
  - Understandable
  - Predictable
  - Easily comparable
- Disadvantages
  - Does not incentivize alignment with organizational goals and objectives
  - Does not necessarily align team-based performance

General Compensation Frameworks

Model	Incentivizes	Potential Pitfalls
Straight Salary	• Minimum contractual requirements	• If provider is not internally driven, only meets (or marginally exceeds) minimum expectations of contract • May require centralized management of patient scheduling • May not encourage engagement in organizational initiatives
Revenue minus expenses	• Increase revenue (effort) • Minimize expenses	• Tends to be favorable for "bottom line" • Disincentives provider from spending time on any non-revenue generating activities • Requires proper expense tracking and allocation • May cause provider to micromanage practice • Providers could be penalized if payer mix is unfavorable or revenue cycle is inefficient

Straight productivity
 	
Compensation = $/wRVU
	• Increased effort/ productivity	• Tends to be favorable for "bottom line"
		• Focus on individual disincentivizes
		  ○ Spending time on any non-revenue generating activities
		  ○ Recruiting, onboarding, and supporting new colleagues
		  ○ "Investing" in expense control or practice operations improvement
		• May lead to over coding encounters or overly recommending or providing care
		  ○ Regular audits may be recommended

Salary + Incentives	• Increased effort/ productivity
	• Dependent on specific incentives and targets – and whether group vs individual basis
		• Highly flexible model … but
		  ○ May lead to overcomplication
		  ○ May behave like other models
		• Requires right mix of base salary, productivity targets/rates, and non-productivity incentives
		  ○ Will not provide proper incentives if targets are unrealistic
		• Organization must be willing to adjust base salaries to ensure continued alignment between provider effort and organizational expectations

APP Compensation Model

- General Rules of Thumb
  - Would ideally align APP and physician efforts, incentives, and rewards
    - With organization
    - With each other
      - Linkage with physician compensation model
        - Ally or competitor
        - Collaboration requirements
  - Would often vary by specialty
  - Would need to reflect realities of the care delivery model
  - Options may be dictated or guided by business and clinical operations, processes, and workflows
    - Workload capture
      - … including "shared visits"
- Bottom line … will likely depend on how utilized

APP Utilization

Aligning Compensation & Utilization Models

Compensation design must align with utilization model

Aligning Compensation & Utilization Models
APPs Seeing Their Own Patients

- Seeing own patients (Example – Primary Care)
  - Permits individual determination of effort and workload capture
  - Can readily parallel applicable physician compensation model
  - Options
    - **Base plus individual and group incentives**
      - Direct linkage between compensation and productivity
      - Downward adjustment of base if do not meet base wRVU expectations
      - Productivity and non-productivity incentives aligned with organizational goals/ objectives and realistic stretch/ improvement targets
    - Straight wRVU
    - Revenue minus expense
    - Straight salary
  - Care delivery model reflects relative autonomy determined by individual skill set and assisted by risk stratification of patients

Aligning Compensation & Utilization Models
APPs Seeing Their Own Patients

- Seeing own patients (Example – Primary Care) (continued)
  - Can be complicated by "shared visit" concept
    - Defined by Medicare Part B payment policy as a medically necessary encounter with a patient where the physician and a qualified APP each personally perform **a substantive portion of an E/M visit** face-to-face with the same patient on the same date of service
      - A **substantive portion of an E/M visit** involves all or some portion of the history, exam or medical decision making key components of an E/M service.
    - Physician level of involvement must be explicitly documented
    - 2019 Medicare Physician Fee Schedule permits the explicit documentation be completed by others and attested to by the physician (often via co-signature of the encounter document)
    - May be billed under physician NPI and reimbursed at physician rate
      - 100% MPFS rate vs. APP rate of 85% MPFS
    - Often designate physician as the "billing" provider and the APP as the "rendering" provider to track yet permit proper billing
      - Should audit to ensure that participation requirements are met and documented
    - Required "split" of workload (wRVU) credit

Aligning Compensation & Utilization Models
APPs Seeing Their Own Patients

Example Framework:
Base + Incentives

- **Non-Productivity Incentive**
- **Productivity Incentive**
- **Base Salary**

Base Salary

- Departmental standard based on market factors

Productivity Incentive

- Based on departmental standard APP compensation per wRVU rate
- Productivity threshold equals Base Salary divided by the rate
- Productivity incentive calculated for all wRVUs above the threshold

		Notes/Details	Example #s
A	Base Salary	Example Only	$90,000
B	Rate per wRVU	Example Only	$29
C	Productivity Threshold	A / B	3,103
D	wRVUs Produced	Example Only	3,500
E	**Productivity Incentive**	**(D - C) * B**	**$11,513**
F	**Total Productive Compensation**	**A + E**	**$101,513**

Non-Productivity

- Fixed amount per provider FTE
- Example: $12,000 per provider spread over 3-4 metrics
- Could include: quality, patient satisfaction, operational, citizenship

Aligning Compensation & Utilization Models
APPs Covering Shifts

- Covering shifts (Examples – Urgent Care, ER, Hospital Medicine)
  - Lack direct impact on volume/productivity – except to insure that door stays open and all patients that present within the stated business hours are appropriately cared for
  - Set expectation re: numbers of shifts (hours) per month or year
  - Incentivize covering extra shifts
    - Perhaps at a greater rate
  - Emphasize non-productivity incentives – individual or group
    - Individual – Citizenry (e.g., meeting attendance; chart completion)
    - Group – Quality, Patient Satisfaction, time to be seen
  - Options
    - **Base plus incentives**
    - Straight salary

Aligning Compensation & Utilization Models
APPs Covering Shifts

Example Framework: APP Shift Based with Incentive

- Full-time requirement: 12 shifts per month
  - Achieves base expectation over 12 months
  - Spreads shifts over course of year (avoids "front loading" process)
- Each 12-hour shift paid at 14 hours
  - Based on $55 per hour
  - Accounts for potential overage
- Each extra shift covered paid at 18 hours (essentially time and a half)
- No true PTO but accept requests and schedule shifts to permit desired "time away"
  - Hourly rate is higher than would be if PTO was accrued
  - Full time standard of 2,080 hours would translate to 173 12-hour shifts, 29 more shifts than required to earn full-time base salary.
- Non-wRVU incentive at $12,000 total per full-time providers. (Quality + Operational Metrics)

Compensation Calculation Example Based on Above Parameters

Base compensation (assuming 12 shifts per month)	144 total shifts $770 per shift (14*$55.00)	$110,880
Non-wRVU Incentive	Assumes all targets met	$12,000
Total Compensation		**$122,880**

Aligning Compensation & Utilization Models
APPs Part of a Care Delivery Team

- Part of a care delivery team (Example – Orthopedics)
  - Individual attribution of workload and effort difficult or impossible to determine
    - Billing and workload usually captured under physician member of team
      - Potential risk of physician being compensated for services that were not "personally performed"

        [Stark requirement is that physician be only compensated for services that are personal performed]
    - Capturing effort as a team provides a mechanism to promote efficient and effective team performance
      - Can be applied to productivity and non-productivity incentives
    - Ensure individually attributable items are captured for revenue generation – such as first assistant fees, procedures performed
  - Options
    - **Base plus incentives**
      - Group productivity and non-productivity incentives for both physicians and APPs to promote team concept of care
      - Individual citizenry (and other) incentives also may be applicable
    - Straight salary

Aligning Compensation & Utilization Models
APPs Part of a Care Delivery Team

- Orthopedic practice with an orthopedic surgeon and two PAs
- Office
  - Schedule patients to individual PA's schedules
    - Orthopedist sees each patient – after PA evaluation – and PA completes the visit and patient education
  - PA schedule design
    - Alternates patient arrival times
    - Permits adequate time to complete encounters
    - Permits same day access
  - Creates essentially two full schedules of patients covered by single orthopedist
    - Significantly enhanced patient access to the practice
  - PAs trained in splinting and casting techniques
    - Formal hands-on course followed by on-the-job mentoring
    - Applicability in office, emergency department, inpatient unit, and operating room

Aligning Compensation & Utilization Models
APPs Part of a Care Delivery Team

- Inpatient
  - Assist with rounding functions
- Operating Room
  - One PA in case while 2nd available to perform perioperative assessment (update H&P, address issues) and be available to triage/address issues from office, ED, inpatient unit
  - PA in operative case stays with patient through end of case and initial post operative interval (including templated order entry while surgeon and 2nd PA move on to next case which the 2nd PA prepped and is familiar with)
- Outcomes
  - Professionally fulfilled orthopedist and PAs
  - Enhanced patient access
  - Increased practice revenue (outperforms increased expense)

Aligning Compensation & Utilization Models
APPs Part of a Care Delivery Team

Example Framework:
Base + Incentives

Non-Productivity Incentive

Productivity Incentive

Base Salary

Base Salary

- $102,500 per departmental standard based on market factors

Productivity Incentive

- Group wRVU threshold based on each provider producing at the MGMA 65th percentile.
- Excess wRVUs above threshold are split equally among care team members and paid at specialty-specific rates per wRVU.

Provider	MGMA Specialty	wRVUs at MGMA 65th Percentile
Physician #1	Orthopedic Surgery: General	9,832
APP #1	PA: Orthopedic (Surgical)	2,739
APP #2	PA: Orthopedic (Surgical)	2,739
	Group Total	**15,310**

If group produces 18,000 wRVUs → 2,690 excess wRVUs (18,000 -15,310) →

Provider	Distribution of Excess wRVUs	Rate	Productivity Incentive
Physician #1	897	$65	$58,305
APP #1	897	$30	$26,910
APP #2	897	$30	$26,910

Non-Productivity

- Fixed amount per provider FTE
- Example: $9,000 per provider spread over 3 metrics
- Could include: quality, patient satisfaction, operational, citizenship

Aligning Compensation & Utilization Models
APPs Part of a Care Delivery Team

- Cardiology practice with mix of interventional cardiologists, noninvasive cardiologists, and NPs
  - Practice has in-office stress testing capabilities
- NP Role(s)
  - Office
    - Initial evaluation of patients with presentation and evaluation by cardiologist
    - Follow up with established plans of care
    - Perform in-office stress testing after cardiologist screening
    - Engage patients in secondary and tertiary prevention efforts
    - Conduct patient education of cardiology conditions
  - Inpatient
    - Assist with rounding
    - Provide assistance with initial consultations
    - Conduct patient education of cardiology conditions
- Outcomes
  - Professionally fulfilled cardiologists and NPs
  - Enhanced patient access
  - Increased practice revenue (outperforms increased expense)

Aligning Compensation & Utilization Models
APPs Part of a Care Delivery Team

Example Framework:
Base + Incentives

Non-Productivity Incentive

Productivity Incentive

Base Salary

Base Salary

- $105,000 per departmental standard based on market factors

Productivity Incentive

- APP receives incentive equal to percentage of base salary if total group wRVUs exceed tiered thresholds

	Group Target	Productivity Incentive Per APP (% of Base Salary)	Productivity Incentive Per APP (In $ assuming $105,000 base)
Tier 1	40,936	5%	$5,250
Tier 2	46,713	10%	$10,500
Tier 3	52,491	15%	$15,750

Provider	MGMA Specialty	wRVUs at MGMA Percentiles			
		25th	50th	75th	90th
Physician #1	Cardiology: Noninvasive	5,821	7,683	9,623	12,185
Physician #2	Cardiology: Invasive-Interventional	7,915	9,853	12,072	15,872
Physician #3	Cardiology: Invasive-Interventional	7,915	9,853	12,072	15,872
Physician #4	Cardiology: Invasive-Interventional	7,915	9,853	12,072	15,872
APP #1	NP: Cardiology	608	1,232	2,218	3,071
APP #2	NP: Cardiology	608	1,232	2,218	3,071
APP #3	NP: Cardiology	608	1,232	2,218	3,071
	Group Total	**31,391**	**40,936**	**52,491**	**69,013**

Non-Productivity

- Fixed amount per provider FTE
- Example: $12,000 per provider spread over 3-4 metrics
- Could include: quality, patient satisfaction, operational, citizenship

Conclusion

Conclusion

- APPs have traditionally been employed, compensated, and utilized differently than physicians
- Often led to consideration as “not as good” or “second class”
- Perceptions, utilization, and culture have been evolving
- “Structural support” needs to also evolve to recognize the value APPs bring to the care delivery team
- Creating employment contracting processes and aligned compensation arrangements can reap significant operational benefits and team-based transformation that is not possible under the traditional business models

Conclusion

If nothing else, remember this:

Compensation design must align with utilization model

Utilization/Practice Model	Considerations	Application to Compensation
Seeing own patients	Permits individual determination of effort and workload capture	• Can readily parallel applicable physician compensation model; often via individual wRVU-based productivity incentives
Covering shifts	Lack direct impact on volume/productivity	• Set expectation regarding numbers of shifts (hours) per month or year • Incentivize covering extra shifts • Emphasize non-wRVU incentives – individual or group
Part of care delivery team	Individual attribution of workload and effort difficult or impossible to determine	• Utilize group productivity and non-productivity incentives for both physicians and APPs to promote team concept of care

Conclusion

- Additional APP Resources from HSG
  - Articles
    - APP Employment and Compensation

      https://hsgadvisors.com/articles/app-employment-and-compensation-models-to-optimize-alignment/
    - APPs - Who are we talking about

      https://hsgadvisors.com/articles/advanced-practice-providers-apps-who-are-we-talking-about/
    - APP Collaboration and Physician Compensation

      https://hsgadvisors.com/articles/advanced-practice-provider-collaboration-and-physician-compensation/
    - Incorporating APPs into Patient Care Delivery

      https://hsgadvisors.com/articles/incorporating-npps-into-patient-care-delivery/
    - Why we are reluctant to embrace APPs

      https://hsgadvisors.com/articles/reluctant-embrace-npps/
  - Webinar
    - Assimilating APPs in Your Practice

      https://hsgadvisors.com/webinars/webinar-assimilating-non-physician-providers-practice/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HSG Summer 2020
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Thursdays; Bi-weekly in July and August – 2:00pm EDT

Register Here

Join HSG for our summer 2020 series of four physician network webinars. Live webinars will be hosted bi-weekly by HSG subject matter experts. We have focused webinars on four subjects that have been the core focus of our clients the past few months. All webinars will be live recorded at 2pm ET on the dates identified below.

By registering for the entire series of webinars you will automatically receive all recordings and presentation materials following the live broadcasts, even if unable to attend the live events.

Upcoming Webinars

- **July 9th** – Physician Network Revenue Cycle Optimization
- **July 23rd** – Employed Physician Networks: A Guide to Building Strategic Advantage, Value, and Financial Sustainability
- **August 13th** – Building Differentiated Service Lines
- **August 27th** – Virtual Health: Optimize Patient Access, Capture, and Retention

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HSG builds high-performing physician networks so health systems can address complex changes with confidence.

Headquarters: Louisville, KY

Formed: 1999

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