Advanced Practice Provider (APP) Utilization: Compliance, Compensation, and Care Models

HMS Valuation Partners

February 24, 2025

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25 YEARS 1996 - 2022

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1996 - 2024

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- Physician Compensation Valuation & Plan Design
- Value-Based Compensation
- Hospital Coverage & ER Call Services
- Telemedicine
- Management Services Valuations
- Practice Acquisitions
- Fixed Asset Valuations
- Real Estate Valuations
- Medical Office Timeshares

CAPTURING HEALTHCARE VALUE WITH CLARITY

Introductions

Joe Aguilar, MBA, MPH, MSN, CVA
Partner, HMS Valuation Partners

- 30 Years of Healthcare Valuation Experience
- His primary focus is on overseeing:
  - Physician/ Hospital Transactions
  - Fair Market Value /
  - Commercial Reasonableness
  - Provider Compensation Design
  - APP Compliance
- Clinical Experience – 20 years
  Family / Women's Health Nurse Practitioner

Introductions

Chip Hutzler, JD, MBA, CVA
Partner, HMS Valuation Partners

- 20 Years of Healthcare Valuation Experience
- His primary focus is on overseeing:
  - Physician/ Hospital Transactions
  - Fair Market Value / Commercial Reasonableness
  - Provider Compensation Design
  - Value-Based Arrangements
- 30+ Years as a lawyer and avid national speaker on topics including Stark, AKS, and FMV/CR

Introductions

Natalie Bell, MBA, CVA
Partner, HMS Valuation Partners

- 15 Years of Healthcare Valuation Experience
- Her primary focus is on overseeing:
  - Physician/ Hospital Transactions
  - Hospital-Based Arrangements
  - Employment/PSA's/Coverage Arrangements
  - Provider Compensation Design
- 25+ Year Career including positions in the banking industry and the financial side of the legal industry.

While you are enjoying New Orleans, consider this (motivational question):

- As the “baby boomers” retire, we will need to provide healthcare to more patients with multiple chronic disease
- We will need to do that with far fewer physicians per patient than we have now, AND
- The government wants to significantly reduce the cost of that care per patient.

Can that math add up?

Agenda

- Current Market Conditions for APPs
- Compensation Trends and Care Delivery Models
- Billing Issues with APPs
- Supervision of APPs
- Questions and Answers

Where are we today?

Current Market Factors Influencing APP Practice

Increasing Volume & Acuity of Patients

- Aging population
- Increasing Chronic Disease Care
- Greater Medical / Surgical Sub-specialization

Provider Supply Shortage

- Burnout & Turnover
- Limited training slots MDs & APPs
- Non-traditional roles with PE
- Closing the gap due to MD shortage

Increasing Costs

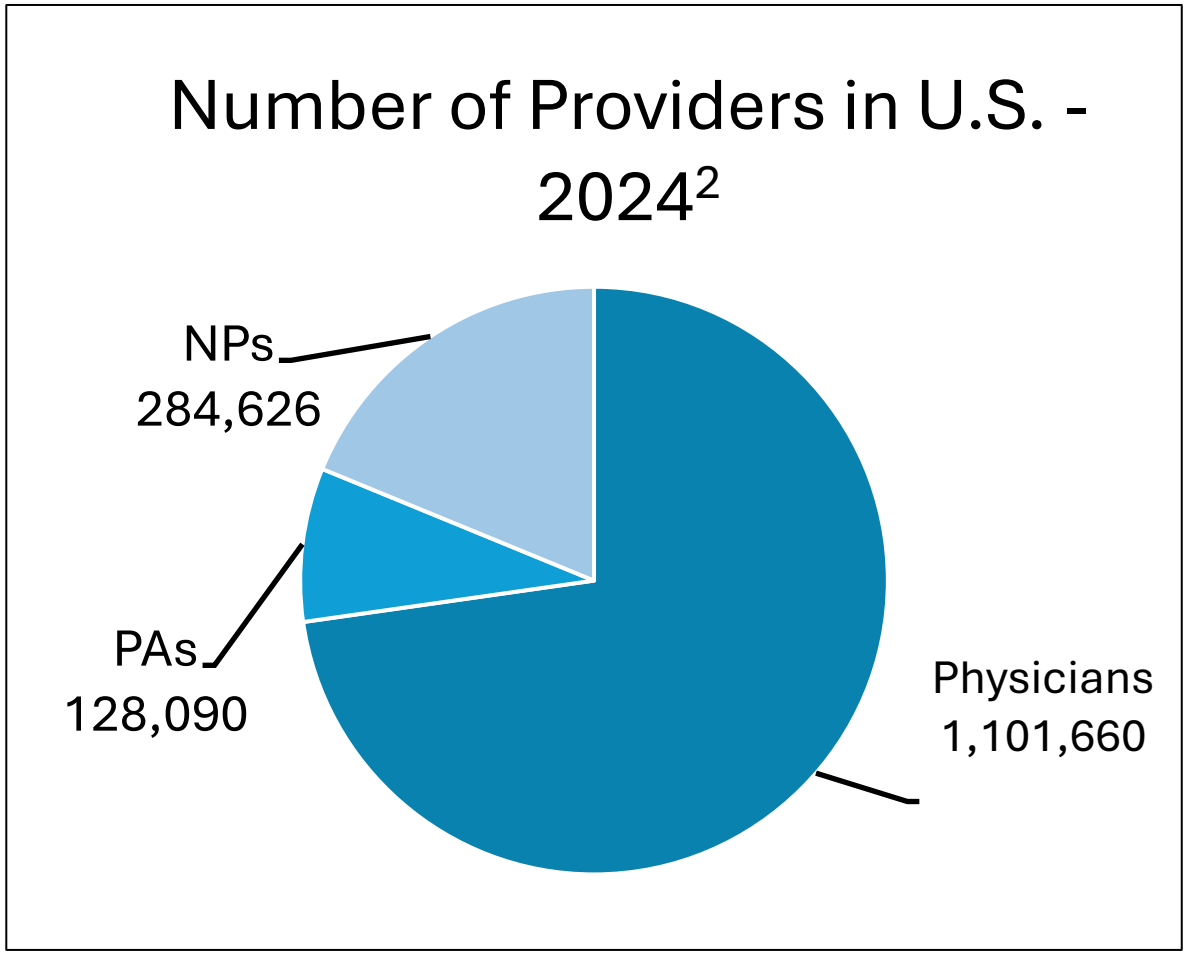
- Increasing volumes and patient demands are driving compensation up.
- Provider shortages are resulting in locums as a costly alternative
- Shrinking reimbursement

Expanding Scope of Practice

- Greater Utilization of APPs across the care continuum
- 27 States with Full Practice Authority for NPS
- 30+ States with Adaptable Supervision for PAs

NP's/PA's By the Numbers

- BLS projects 40% growth for NPs, 28% growth for PAs, and 4% growth for MDs (2023-2033)[1]
- 48% of MDs reported burnout in 2023[3]
- Growing shortfall of physicians in the U.S.[4]
  - 2021 – 40k shortfall
  - 2024 – 50k – 60k shortfall
  - 2030 – 60k – 90k projected shorftall
- Many states have limits on Number of PAs a Physician can supervise[5]



1 Bureau of Labor Statistics, Occupational Outlook Handbook, (Nurse Practitioner, Physician Assistant, & Physician)
2 https://www.kff.org/other/state-indicator/total-active-physicians/?currentTimeframe=0&selectedDistributions=total&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D
3 Berg.S. Physician burnout rate drops below 50% for first time in 4 years. AMA July 2, 2024
4 AAMC, The Complexities of Physician Supply and Demand: Projections from 2021 to 2036, March 2024
5 Barton Associates, Interactive PA Scope of Practice Law Guide

NP's/PA's Practice Patterns

- NP / PAs work in over 70 specialties and subspecialties
- 27 States, DC, and two US Territories have adopted Full Practice Authority for NPs[1]
- Fourth of all visits in U.S. seen by NP / PA in 2019, an increase from 14% in 2013[2]
- 44% of NP / PA visits in the U.S. were billed indirectly (2010-2018)[3]
- 41% of MDs report not having ever worked with an NP or PA and most MDs who do report a favorable impact on their workload and quality of care[4]

1 AANP Nurse Practitioner Survey
2 Sadiq, et.al. Provision of evaluation and management visits by nurse practitioners and physician assistants in the USA from 2013 to 2019. BMJ. Sept. 14, 2023
3 Ibid.
4 Hu, X et.al. Physicians working with physician assistants and nurse practitioners: perceived effects on clinical practice. Health Affairs. 2024 2(6).

NP/PA Compensation

- Compensation shifting away from being under Human Resources, more toward the Medical Group
- Increased alignment with physician compensation models
- Production Bonus complicated with the different roles APPs play in the care team and how it relates to billing / wRVU credit
- Physician pay for supervising APP is a related area of complexity

5 Year Compensation Trends

	Total Compensation - 2023			5 Year Growth Rate		
Specialty	**Median**	**75th**	**90th**	**Median**	**75th**	**90th**
Physician Assistant (Primary Care)	**$136,240**	**$162,860**	**$191,916**	**20.65%**	**22.44%**	**23.16%**
Physician Assistant (Surgical)	**$140,762**	**$160,197**	**$195,635**	**8.96%**	**5.01%**	**11.91%**
Physician Assistant (Nonsurgical/Nonprimary Care)	**$137,036**	**$160,237**	**$208,077**	**17.47%**	**22.11%**	**38.62%**
Nurse Practitioner (Primary Care)	**$129,422**	**$150,931**	**$181,129**	**17.74%**	**17.76%**	**17.21%**
Nurse Practitioner (Surgical)	**$132,654**	**$149,244**	**$170,132**	**13.41%**	**12.27%**	**16.54%**
Nurse Practitioner (Nonsurgical/Nonprimary Care)	**$133,189**	**$156,467**	**$190,061**	**22.35%**	**26.40%**	**34.65%**

Significant Growth

Increasing demand for providers is driving growth in overall compensation across each percentile.

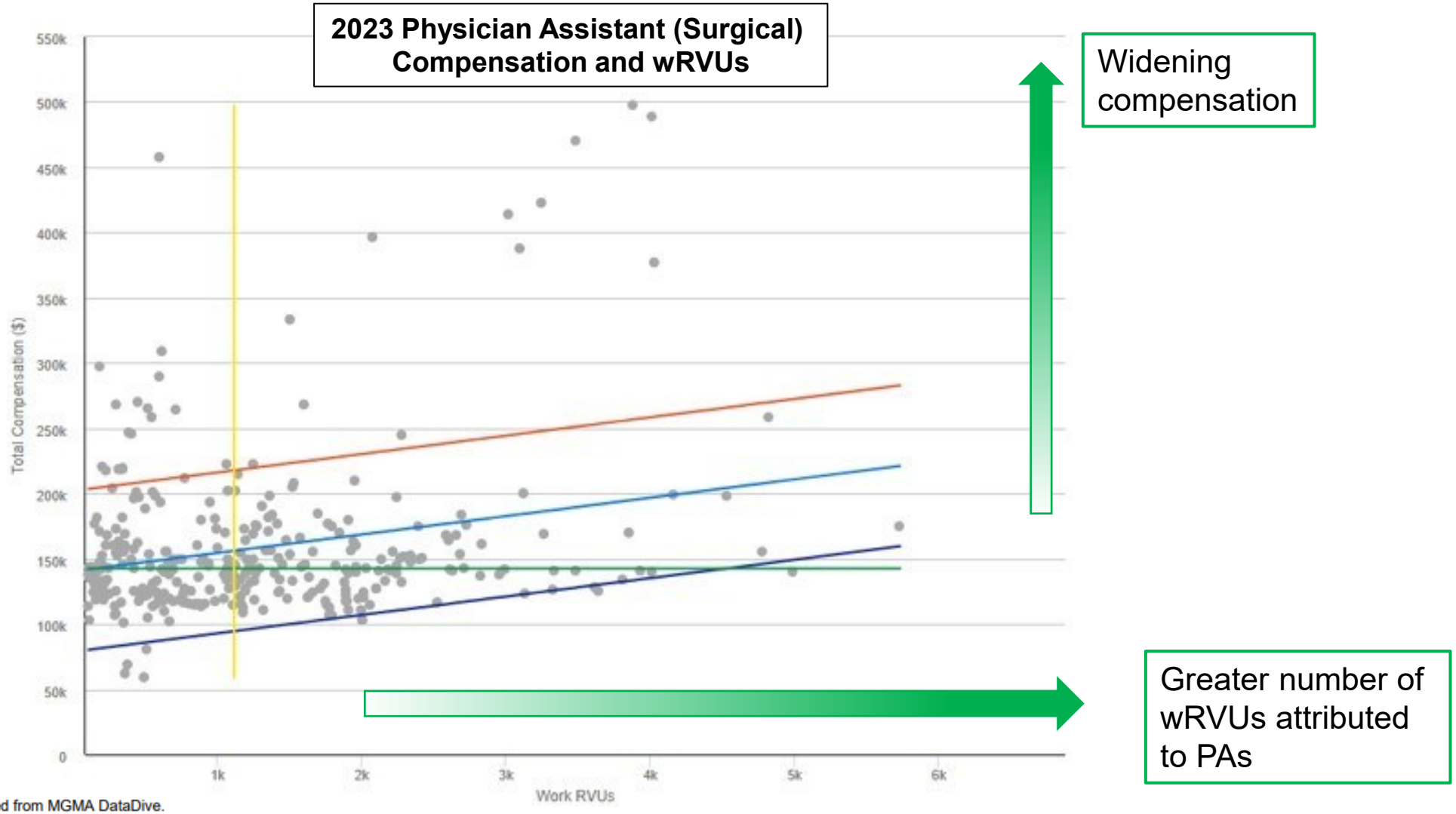
Compensation Widening

Standard Deviation appears to be widening across the past 5 years and may be reflecting the variety of practice patterns for APPs

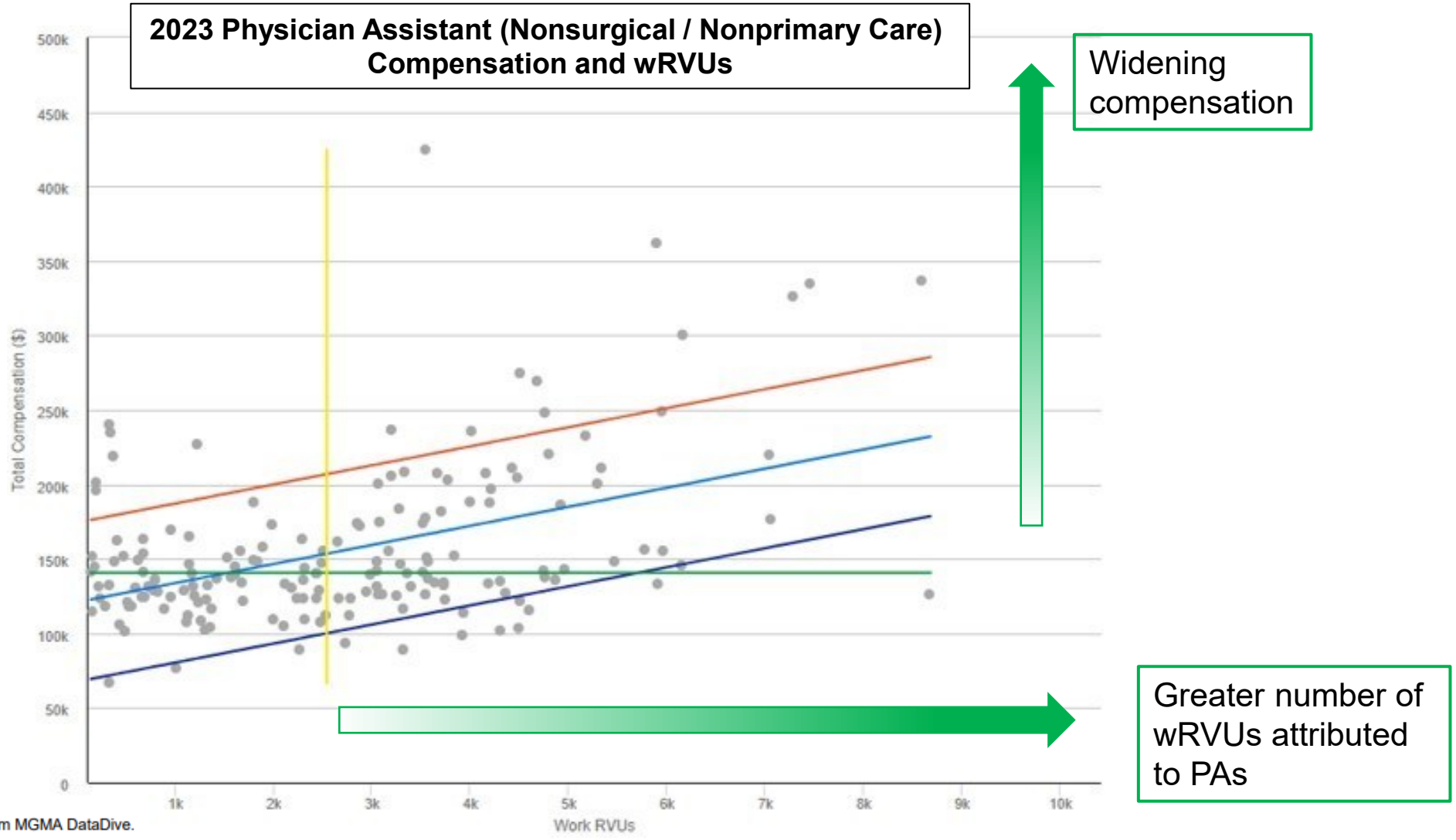
Primary Care Steady

Total Compensation is increasing at a steady rate across percentiles

Compensation-to-Production Plotter



Compensation-to-Production Plotter



Billing Issues – "Split/Shared" Visits

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What are Split/Shared visits:

- Facility setting – where "incident to" billing is prohibited
- Physician and APP in the same group
  - Otherwise separate billing required for services each provider actually rendered
- E/M visit could otherwise be billed independently by either the physician or APP

Billing rules:

- **Only the provider who performs the "substantive portion" can bill for the visit**
- Substantive Portion means:
  - Historically: All or some portion of the three components of the visit:
    - History, exam, or medical decision making (MDM).
  - Proposed (but delayed): Provider who spends more than half the total time spent on the visit
  - Temporary policy for CY 2022, 2023 and 2024: Either of ---
    - Provider performs one of the 3 components (history, exam or MDM), OR
    - Provider spends more than half of the total time spent on the encounter
- Modifier FS required for split/shared billed visits

Billing Issues – "Split/Shared" Visits

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When is Split/Shared allowed – special cases:

- New Patients for initial and subsequent split/shared visits
- Critical care visits performed in an institutional settings
  - Subject to complex rules which allow certain time to be aggregated
- Certain SNF/NF E/M visits
- Prolonged E/M visits (exceptions: critical care/ED)

Split/Shared - Pitfalls and Issues:

- Same group requirement
- Documenting what each practitioner separately contributed
- Substantive portion requirement – time-based policy challenging
  - Does it make sense that 51% of time = 100% of reimbursement?
- Both MD and APP services must be medically necessary, not duplicative

Billing Issues – "Incident-to" Services

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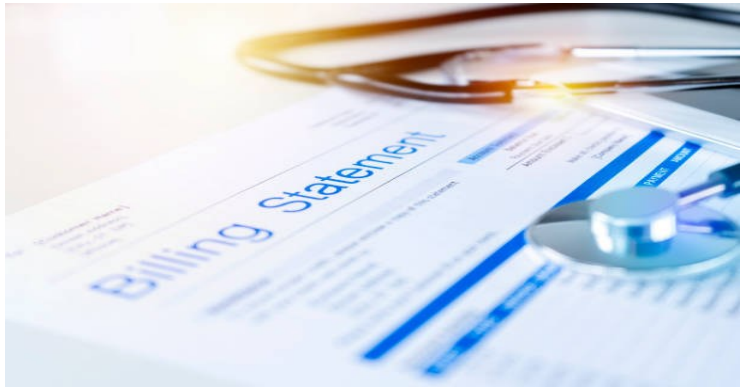
What are "incident-to" services:

- Furnished in a noninstitutional setting to noninstitutional patients.
- An **integral, though incidental, part** of the service of a physician (or other practitioner) in the course of diagnosis or treatment of an injury or illness.
- Commonly furnished without charge or included in the bill of a physician (or other practitioner).
- Of a type that are commonly furnished in the office or clinic of a physician (or other practitioner).
- Under the direct supervision of the physician/qualified practitioner with limited exceptions.
- Furnished by the physician, practitioner with an incident to benefit, or auxiliary personnel.
- Furnished in accordance with state law.

42 CFR § 410.26.



Billing Issues – "Incident-to" Services

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Key Details on "incident-to" services:

- Includes HOPD services, critical access hospital services (but not inpatient services)
- Includes services provided by a PA, NP, clinical nurse specialist, certified nurse midwife, licensed clinical social worker (LCSW) or clinical psychologist.
- Person providing the "incident-to" services can be anyone under the supervision of the billing physician. Need not be in the same group.
- "Direct supervision" required with limited exceptions:
  - Certain behavioral health services – general supervision okay
  - Designated care management services (RPM, CCM) – general supervision okay
  - Other exceptions

"Incident-to" services – Pitfalls and Issues:

- No "Incident-to" billing in institutional setting
- Services must be **integral, though incidental, part** of the services of a physician
- Supervision requirements – direct supervision (requires specific level of supervision)
- State law requirements

Billing Issues – Summary Table

	Split/Shared	Incident-To
POS/Setting	Hospital/PBD (POS 21/POS 22)	Office (POS 11)
Practitioners	Physician & APP	Physician & Auxiliary Personnel
Billing Practitioner	Depends on who performed the substantive portion	Physician who provides supervision
Key Requirements	Performing Substantive Portion	Integral, though incidental, part of the physician's service (generally only for established patients/problems)
Supervision requirement	N/A- jointly rendered	Generally, direct supervision with limited exceptions
Modifier	Modifier- FS	No Modifier

Supervision of APPs

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Full Practice Authority:

- APPs have authority to evaluate, diagnose and treat illness, order and interpret laboratory tests and prescribe medications independently
- States: Arizona, Connecticut, Montana, Oregon

Collaboration:

- Characterized by collaboration and open communication between APP and physician, with shared decision-making
- Focus is integrating perspectives and expertise of each person
- Relationship further defined in Collaboration Agreement
- States: New York, Indiana, Arkansas, Illinois

Supervision:

- Physician retains final authority regarding diagnosis and treatment
- Physician oversees APP practice through on-site supervision or prompt chart review
- Requires Supervision Agreement
- States: South Carolina, Georgia, Tennessee, Massachusetts

Supervision of APPs

What is entailed in supervision of an APP by a Physician:

- Availability to assist with issues the NPP may have
  - Similar to being on-call – forbearance obligation (when APP is working), plus need to respond when called
- Chart review
  - What percent is sufficient to ensure quality of care meets or exceeds objectives?
  - Some states may have specific minimum requirements
- Coordination with NPPs to ensure care is provided according to protocols, etc.
  - Likely requires some regular interaction – meetings, calls, etc.

How many NPPs can be supervised by one Physician?

- Is there a legal maximum? – (maybe in some states).
  - Some states allow up to 10 APPs to be supervised by a single doctor.
- Is there a practical maximum?
- Can 2 or more physicians split supervision duties? – absolutely (but it impacts pay)

Supervision of APPs

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Possible Changes:

- Immigration policy may affect availability of APPs to provide care
  - In California, licensing boards are not permitted to deny licensure to an applicant based on his or her citizenship status or immigration status
  - What about APPs that have renewable work authorization under DACA?

- In first administration, President Trump issued an Executive Order to investigate payment based on time spent with patients, without consideration of role.
  - Intended to address pay disparities between APPs and physicians
  - Raises questions of scope and independence
  - Also supported legislation to permit Nurse Practitioners to practice to the full scope of their license
  - Will this initiative be revived now?

Predictions and Final Thoughts…

Things to pay attention to in 2025 (and beyond):

- New regime at HHS – what impact will it have on supervision requirements and billing rules?
- State law changes – will states further relax supervision rules?
- Will more APP training program slots be created and approved? Who will lead this effort?
- Will there be legal challenges to these efforts – from relators and others?

Some take-aways/thoughts:

- Increasing care shortages can likely only be resolved with additional increased APP usage
- Increased APP usage could improve quality of care, or it could reduce it – jury is out on that question
- Supervision and Billing is a complex maze/mine field – not likely to get much better short-term
- Will upcoming changes to government (HHS) impact care provider usage rules, changing the math yet again?


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