Alternative Employment and Compensation Structures for Advanced Practice Clinicians

Focus Paper

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Introduction

The role of the Advanced Practice Clinician (APC) in a primary care practice is critical to ensure cost effective services, improved access to care, and a satisfying practice environment. APCs can add value through direct patient care activities (i.e. patient visits, treatments, face-to-face or telephonic counseling) and indirect services (i.e. chart review, quality improvement).

This paper will compare, contrast, and evaluate alternative employment and compensation models for APCs in primary care within larger health systems. While an APC in primary care can be either a Nurse Practitioner or a Physician Assistant, this paper will not address the relative benefits of the two professions. Rather the author will review strategic considerations of: 1) which legal entity employs the APC, 2) which legal entity is responsible for the APC expense, 3) how APC reimbursement credits are applied, 4) how the employment and compensation models influence APC productivity, and 5) how the overall economic model affects APC satisfaction and retention.

Research methodologies employed included a literature search, interviews with health system and medical group leaders, interviews with APC, review of APC production data, and analyses of employee satisfaction results.
**Background/Context**

The role of APC in the United States' healthcare delivery system has evolved over the past forty to fifty years. Over this period, APC fought and achieved State and Federal recognition as a valued and essential health profession. Major milestones of the profession included the introduction of APCs as primary care extenders in rural areas in the late 1950's and early 1960's

- Enactment of Medicare and Medicaid in 1965 which expanded access to and the demand for primary care services
- Establishment of the first formal training program for Nurse Practitioners at the University of Colorado in 1965
- Formation of the Council of Primary Care Nurse Practitioners in 1974.

This evolution included physician and patient acceptance and perhaps most importantly, reimbursement for APC services from Medicare, Medicaid, and private insurers.

APC are key resources in a primary care practice. Their relative value has increased over time as the supply of primary care physicians has decreased. This trend coupled with increasing demand from a growing and aging population has resulted in the increased demand for primary care services. The addition of APCs to a primary care practice can help address patient access and wait times as well as overall patient outcomes and satisfaction.

APC come at a lower price point than physicians and can perform a multitude of services in a primary care office. Those services include diagnosing and treating acute and chronic conditions; ordering, performing, and interpreting certain diagnostic tests; telephonic triage; prescribing medications and other treatments; managing overall care; and providing preventative education and counseling.

There are various considerations in a primary care practice on the use and integration of APC. Factors such as practice philosophy, MD and APC resource availability, scope of practice
guidelines within the respective State\textsuperscript{8}, and patient acceptance influence the use and prevalence of the APC within the medical practice.\textsuperscript{9}

This paper evaluates various factors around the use of APC in the primary care practice setting. Three practice systems have been studied and evaluated. The study period occurred in the last nine years (2008-2016), in the State of California, and under the Medical Foundation, 1206(l) model-an arrangement between a not for profit health system parent sponsor and a medical group professional corporation.\textsuperscript{10} The Medical Foundation model serves as a health delivery model as an alternative given the California corporate practice of medical prohibition.\textsuperscript{11}

This paper uses the following terms to define the Medical Foundation and its parties:

- Practice System-Overall Medical Foundation partnership
- Health System-Not for profit system sponsor, in this case a 501(c)(3) hospital
- Medical Group-Professional corporation providing medical services

The stakeholders in the APC employment models include the administrative and practice leadership of the sponsoring health system; the physician executives, shareholders, and management of the professional corporation; the APC employees; and the patients served by the Medical Foundation.
Employment and Economic Risk Considerations

In a practice system, the parent health system or the affiliated medical group professional corporation can employ the APC. A number of factors may influence the employing agency decision including wage and benefit structure of the two organizations, unionization status, retirement plan design (specifically the ERISA nondiscrimination rules around highly compensated employees), maintenance of professional control of the APC, shareholder rules for the medical group, and employee alignment strategies.\(^\text{12}\)

A second consideration in the APC employment model is the allocation of APC revenue and expense to the affiliated medical group. The allocation of revenue or collections and the expense of the APC determines the economic risk falling to the medical group. For example, a scenario where the health system assumes full responsibility for revenue and expense of the APC would result in no economic risk for the medical group.

Revenues are the collections related to the APC activity. The APC is able to bill and collect (subject to credentialing criteria from the respective health plans) for services rendered.\(^\text{13}\) While the reimbursement is generally less than what a medical physician will receive for the same service, the cost factor is lower (e.g. relative compensation level) so the economic benefit in terms for the overall effect on the practice "bottom line" requires careful consideration.\(^\text{14}\) An additional consideration beyond the direct costs of wages and benefits is the allocation of indirect costs for overhead. The underlying contract between the health system and medical group ("Professional Services Agreement" in a Medical Foundation model) determines the overhead allocation.\(^\text{15}\)

A third factor involves the compensation structure for the APC. The exempt/non-exempt status\(^\text{16}\) and any bonus or incentive payment structure are both compensation elements to
consider. The design of an incentive program is an important aspect of the practice philosophy and values.\textsuperscript{1718}

The employment and cost allocation decisions have direct influences in how the primary care practice uses the APC. Additionally, the APC can perform a wide variety of duties within his/her scope of practice as noted above and some of those activities are reimbursable from third party payors and others are not. However, even non-reimbursable activities can have benefits for the practice including opportunity costs for the physicians, patient care activities around education and counseling, and patient perceptions of the care experience.

Case Studies

Over the past ten years, the author has been involved in three Medical Foundation practices in California with large primary care components. Each of the delivery systems utilized APC in the respective primary care practices including internal medicine, family practice, and pediatrics. Each practice setting had variations in the APC employer agency, economic credit for the APC production, allocation of the APC expense, and the compensation structure for the APC. The models in each of the Medical Foundations were a result of historic precedents as well as joint discussions between the health system and the medical group about cost, quality, and cultural expectations. The table below summarizes the characteristics of the APC arrangements in the three systems with the following definitions/explanations:
<table>
<thead>
<tr>
<th>Practice System</th>
<th>A</th>
<th>B</th>
<th>C</th>
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<tr>
<td>Observation Period</td>
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<tr>
<td>APC Employer</td>
<td>Health System</td>
<td>Health System</td>
<td>Health System</td>
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<td>APC Collection Credit</td>
<td>Health System</td>
<td>Shared 50/50 Health</td>
<td>Medical Group</td>
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<td>System/ Medical Group</td>
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<tr>
<td>APC Expense Responsibility</td>
<td>Health System</td>
<td>Shared 50/50 Health</td>
<td>Medical Group</td>
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<td>System/ Medical Group</td>
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<tr>
<td>APC Compensation Methodology</td>
<td>Hourly, no incentive program other than annual performance based merit</td>
<td>Hourly, no incentive program other than annual performance based merit</td>
<td>Performance-based merit</td>
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<td></td>
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<td>Quality and programmatic incentives</td>
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<tr>
<td>Performance (Production) Evaluation</td>
<td>Below MGMA median</td>
<td>Rising, but below MGMA median</td>
<td>At or above MGMA median</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Below MGMA median</td>
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<tr>
<td>APC Employee Satisfaction</td>
<td>Top Quartile</td>
<td>Top Quartile</td>
<td>Top Quartile</td>
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<tr>
<td>APC Retention (Annual Turnover Rate)</td>
<td>5% (1 in 20)</td>
<td>5% (1 in 20)</td>
<td>Varied between 5% and 12% with 20-24 employees</td>
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<td>Varied between 6% and 12% with 12-13 employees</td>
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<td>0% each year with 8 employees</td>
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Table Legend

- **Observation Period**-Practice Systems A, B, and C were observed for five, two and one year, respectively
- **APC Employer**-Legal employer for the APC
- **APC Collection Credit**-Entity receiving economic credit for the APC patient care collections
- **APC Expense Responsibility**-Entity financially responsible for APC compensation (wages and benefits, other allocated expenses)
- **APC Compensation Methodology**-Base pay method and incentive program
- **Performance (Production) Evaluation**-Average annual wRVU production compared to the respective annual MGMA Physician Compensation and Production Survey benchmarks for APC production\(^9\)
- **APC Employee Satisfaction**-APC cohort satisfaction compared to respective Practice System Employee Satisfaction vendor benchmarks
- **APC Retention (Annual Turnover Rate)**-Total terminations/average monthly employment for the APC cohort

For Practice System A, the initial set up had the health system employing the APC, receiving all collections for the APC, and being responsible for the APC wage and benefit costs. Since the ambulatory practices were set up as hospital outpatient departments for reimbursement (cost reporting) purposes, this was the selected arrangement. Additionally, pay to the physicians and APCs working in the practices was on an hourly basis. There were no incentives for physicians or APCs to be productive or efficient. Not surprisingly, patient access was poor with long delays for new and return patient visits. The leadership of this practice system and the associated medical group recognized the shortfalls of the APC employment arrangement and agreed to migrate economic responsibility to the affiliated medical group over a three-year period.
This migration was concurrent with a shift in the economic arrangement with the physicians, moving from an hourly reimbursement to a split-billing arrangement in which the physicians billed for their services independently and retained any associated collections. The hospital billed a facility fee and retained any associated collections.

Year 1 retained the employment, reimbursement, and expense responsibilities for the APC with the health system but also involved an increased sharing of production data with the relevant physicians and APCs. This data included production data with relevant MGMA norms, patient access data in the form of third next available, patient satisfaction data, and an overall economic analysis of the APCs contribution to the bottom line. Year 2 involved a 50/50 sharing of APC reimbursement credits and expenses between the health system and medical group. The practice system continued to share and track the same data to review production and patient access. Years 3 and beyond completed the transition such that the medical group assumed full reimbursement credit and wage and benefit expense liability for the APC even though the APCs remained as health system employees. Again, the practice system reviewed the same data and all parties (health system, medical group, and APCs) shared the data.

Over the three year transition period to the medical group for the APC expenses, there were clear upward trends in the average APC wRVU production both in absolute numbers and as compared to MGMA production benchmarks. The elements of the production improvements included increased patient care hours in clinic and time adjustments of the patient appointment templates to shorter visit intervals. Those changes improved patient access and the gains were held in years 4 and 5.

Throughout the five-year period, the APCs maintained very high employee satisfaction scores, measured as part of the overall health system process. Turnover was initially very low but did increase slightly during the period when the production levels were part of the annual
incentive bonus. Additionally, exit interviews with two of the APCs who terminated employment in Years 4 and 5 indicated their concern about he added "pressure" of the production incentive.  

Practice System B had a model of the health system employing the APC and receiving all collection credits for the APC services. The medical group had neither the collections benefit nor the wage and benefit expense. Overall, the production levels of the APC fell below their respective medians in each fiscal year. A review of the typical APC effort indicated a focus on office tasks such as disease management counseling, post procedure care, and follow up visits, and other non-reimbursable duties. Their respective supervising physicians would bill the majority of the Evaluation and Management codes. Again, the health system and medical group openly discussed this division of duties between reimbursable and non-reimbursable between the physicians and APC. Both the health system and medical group agreed that a more aligned economic incentive model would benefit overall APC production, satisfaction, and retention. As this author was leaving that practice, there were ongoing discussions of re-assigning the collections credits and expense responsibilities to the medical group similar to the transition that occurred in Practice System A.

Practice System C had the model of medical group employment of the APC, but with the health system receiving all collection credits and incurring all of the APC expense. The medical group had been in private practice setting employing the physicians and APCs. During the due diligence process for the practice acquisition into the Medical Foundation, data review indicated very high production levels, quality performance, and patient satisfaction data for the APCs. The practice system elected to leave the APC as employees of the medical group but assumed the collections and expenses for the APC. It is very early (less than one year) to review the effects of the financial responsibility for the APC s and the health system will continue to monitor cost and quality metrics for the practice. There is concern that without the economic responsibility for the APC expenses that overall APC production levels will fall.
Discussion

These three practice system case studies demonstrate that the use of APCs in primary care appear in various employment and economic arrangements. In Practice System A, there was a transition from health system economic risk to medical group economic risk over a three-year period. The transition resulted from recognition on the part of both the health system and the medical group that financial incentives were not aligned. Originally, the health system assumed full risk for the APC services and the medical group practice had no incentive to use the APCs productively (in terms of billable services). During the transition period, the APC duties changed from non-reimbursable activities to reimbursable tasks (e.g. office visits) as the economic "risk" (reimbursement collections less APC expense) transferred to the medical group. Additionally, the overall productivity level of the APC as measured in wRVU’s increased to a level at or above the respective national NP and PA medians as indexed against the respective MGMA Annual Provider Compensation and Production Report. Leadership at both the health system and medical group, and the APC themselves agreed to the changes. There was a concern that the emphasis on production for the APCs would be detrimental to their work environment. To support this change, the medical group implemented an APC incentive system with quality and production metrics as the measurable goals.

One of the corollary effects of the change was pressure from the medical group for the health system to increase RN staffing to take over the non-reimbursable duties the APC had previously performed. Duties such as telephone triage, electronic medical record in basket management, and other non-reimbursable duties were common in the original economic model. The APCs were now focused on billable activities and the non-reimbursable duties were not as
consistently performed. The health system was able to provide nursing (RN) support to help address this situation.

In Practice System B, the employment and economic arrangements for the APCs were similar to the scenario in Year 1 of Practice System A. The health system and medical group were aware of the situation in terms of below median production and lack of incentives for APCs to perform billable services. While a topic of concern during the annual Professional Services Agreement (PSA) negotiations, no changes were made for the three-year study period. In retrospect, the value and benefits of changing employment and the economic risk to the medical group were not as material as other changes in each of the contract negotiation years. As noted above, discussions continued around a transition of APC economic risk to the medical group.

The APCs in Practice System C were employees of the medical group in a private practice setting prior to the acquisition by the health system. As private practice employees, the medical group retained the full economic risk for the APCs. Because of the high production levels, the practice system elected to leave the employment arrangement in place but did assume the economic risk for the APCs. This Practice System is less than one year old and both the health system and medical group have agreed to monitor these key metrics on an ongoing basis to maintain the current high performance levels.
Summary and Conclusions

The employment and financial responsibility for APCs in a primary care practice associated with a health system can be set up in a number of ways. Factors to consider include the employment precedents for APCs, practice philosophies of the participating entities, which entity assumes the economic risk for the APCs, APC work satisfaction and retention rates, and patient access and satisfaction indicators. Discussion and agreement among the health system, the medical group, and the affected APCs are critical in deciding the employment and economic arrangements. Those discussions and decisions should also include agreement on the metrics to be measured and reviewed in an ongoing effort to ensure the overall cost, quality, and access metrics are achieved. The economic alignment of the APC production, revenue credits, and expenses is a strategic and operational decision that requires careful consideration and on-going evaluation.
Citations

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