

# 2017 Health Care Transactions Resource Guide



# Compliance Risk Considerations with the Integration of APCs

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In today's rapidly changing environment, health care organizations must understand how to effectively integrate and optimize advanced practice clinicians (APCs)<sup>1</sup> to support the achievement of the “quadruple aim”<sup>2</sup>—higher quality, lower costs, improved population health, and better work life of health care providers. A successful strategy includes implementing care delivery models that maximize the capabilities of each team member within the framework of federal and state laws, regulations, and accreditation standards. Coordination with a knowledgeable compliance team can inform the integration strategy and mitigate risk.

This article addresses the growing demand for APCs as well as three regulatory requirements that pose challenges that are essential to a successful APC integration strategy:

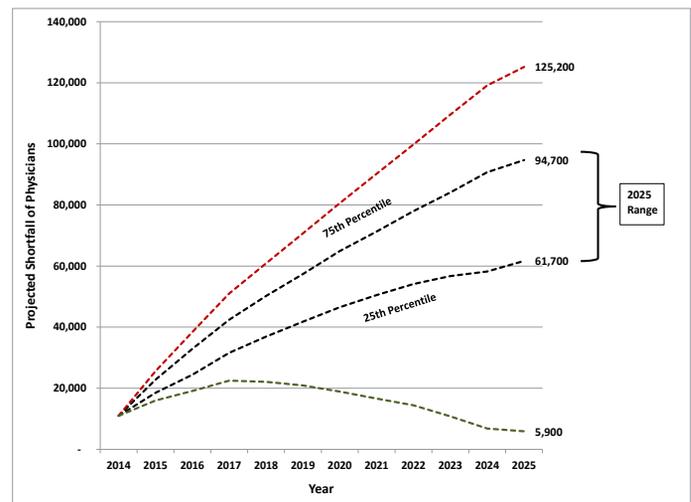
- » Evaluation of APC competency standards
- » Third-party payer policies related to billing for services provided by APCs
- » Appropriate attribution of APC productivity in production-based physician compensation plans

This article is not intended as a comprehensive review of all the risks associated with APC integration; rather, it focuses on three elements that may represent unique challenges.

## Growing Demand for APCs

According to an IHS Inc. (currently dba IHS Markit) report released by the Association of American Medical Colleges (AAMC), a projected physician shortage is expected by 2025 (see Figure 1).<sup>3</sup> Concurrently, the U.S. Bureau of Labor Statistics projects the number of APCs to grow significantly between 2014 and 2024 (see Figure 2).<sup>4</sup> While Figure 2 provides data for nurse anesthetists, nurse midwives, and nurse practitioners, a review of data from the U.S. Bureau of Labor Statistics reveals nearly identical growth within the physician assistant profession.

**Figure 1: Total Projected Physician Shortfall Range, 2014–2025<sup>3</sup>**

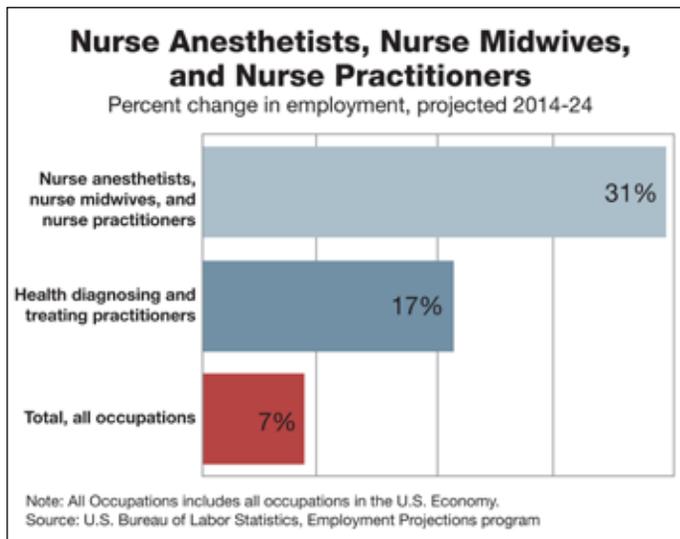


According to the IHS Markit report, physician demand will significantly outpace supply due to such factors as:<sup>5</sup>

- » Shifting population demographics relative to age
- » Increased access to medical insurance under the Affordable Care Act
- » A decline in the average hours worked per week by younger physicians in contrast to their predecessors

SullivanCotter's research shows that this pressure has resulted in new hiring patterns. Seventy-two percent of participating health care organizations have hired APCs in the past year, and 62 percent plan to add more in the upcoming year.<sup>6</sup> Some organizations employ more than 1,000 APCs in at least fifty different specialties, yet some are still in the early stages of integration. As a result, APC roles are changing rapidly and vary by specialty in different models of care. As such, assessing competency is an important first step in optimizing utilization.

**Figure 2: Nurse Anesthetists, Nurse Midwives, and Nurse Practitioners Percent Change in Employment, projected 2014–2024<sup>4</sup>**



### APC Competency Assessment

Providing safe, high-quality care is at the core of every health care organization’s mission, making it essential to ensure the competency of every provider. While having an effective competency assessment program is important to providing high quality patient care, it is also necessary to meet the regulatory and accreditation requirements set forth by the Centers for Medicare and Medicaid Services (CMS) and The Joint Commission. Across the country, the maturity and effectiveness of APC competency assessment programs varies significantly. Organizations that carefully structure their programs are positioned to improve provider performance and identify and manage provider competency issues. This ensures compliance with CMS requirements, which state “the organization’s governing body must ensure that all patient care is provided by practitioners who have been evaluated by the medical staff and are practicing within the scope of their privileges.”<sup>7,8</sup> Additionally, CMS requires the medical staff conduct periodic appraisals of its members.<sup>9</sup>

The Joint Commission bolsters the CMS requirements with standards defined in the Focused Professional Practice Evaluation (FPPE)<sup>10</sup> and Ongoing Professional Practice Evaluation (OPPE).<sup>11</sup> The OPPE/FPPE process standards, which function as an assessment protocol, apply to all privileged providers, including APCs providing a medical level of care. These standards also mandate that competency assessment data must be collected and reviewed more frequently than once a year.

Despite requirements coming from both CMS and Joint Commission, organizations find challenges in implementing competency assessment programs. Data from the 2016 findings from The Center for Advancing Provider Practices (CAP2<sup>TM</sup>) indicate that only 81 percent of respondents have a uniform medical staff competency evaluation process for APCs and physicians,<sup>12</sup> and only 59 percent report they assess APC competency more than once a year,<sup>13</sup> both of which are Joint Commission requirements.

During a Joint Commission visit, surveyors will review a hospital’s OPPE/FPPE policies to ensure the inclusion of APCs. They will also review APC files for privileges granted and evidence that the OPPE/FPPE assessments are tied to those privileges. Sample Joint Commission findings related to APCs include

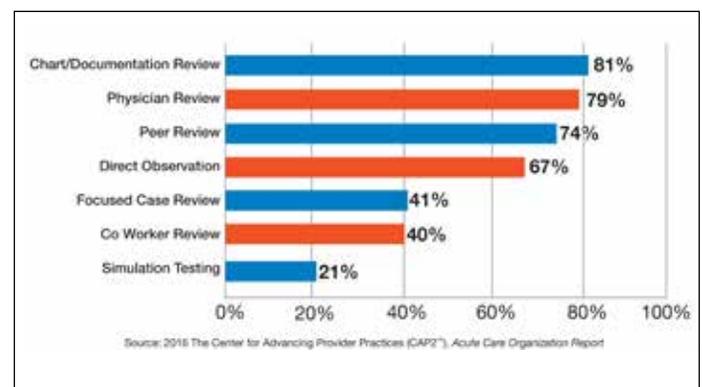
- » Underdeveloped or lack of OPPE/FPPE process for APCs
- » Lack of definition of data to be reviewed for APCs or use of generic measures despite specialization
- » Inability to collect data due to attribution of activity to the physician
- » Use of subjective evaluation only by supervising/collaborating physician
- » No FPPE criteria have been developed when a focused review was required for an identified issue of competence

Source: Doreen Finn, RN, MBA. “The Regulatory Perspective: Recent Regulatory Findings Trends and Best Practices.” 5th Annual 2015 CAP2<sup>TM</sup> National Summit: The Essential Role of the Advanced Practitioner in the Transformation of Healthcare, 19 Nov. 2015. Conference Presentation.

### Improving APC Competency Assessment Programs

The first step in operationalizing an APC competency assessment process is to identify the necessary data to collect and review. To inform that decision, organizations should consider starting with the criteria used to assess physicians. The type of data to be collected is determined by individual departments and then approved by the medical staff. Organizations may also want to consider a common set of data for all APCs, such as the number of patient contacts, volume of procedures, and patient satisfaction data. Including APCs in the development of the competency program and allowing experienced APCs to assess the competencies of new APCs should also be considered. Multiple other approaches to assess APC competency are shown in Figure 3.

**Figure 3: Approaches to APC Competency Assessment<sup>14</sup>**



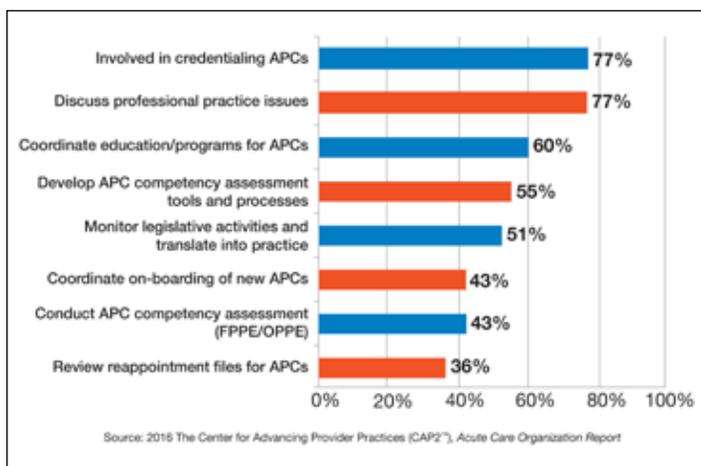
Processes for each approach should be clearly defined. For example, if chart reviews are to be completed, the process should state how many charts should be reviewed and the criteria to be assessed. This could include such elements as history and physical, medication reconciliation upon discharge, and a complete discharge summary. A paper or automated checklist can be

developed to capture the correct elements and drive consistency throughout the organization.

As the APC workforce has grown, organizations have started adding APC representation to their Medical Staff Credentialing Committee. CAP2™ data show 36 percent of organizations have an APC representative on the credentialing committee, and 55 percent of those have the right to vote.<sup>15</sup> APC representatives work closely with the medical staff office to help coordinate the credentialing, privileging, and competency assessment processes for APCs. APC representatives also provide expertise about state and federal laws and regulations as well as the APC education, certification, and licensure requirements.

Many organizations have developed a separate APC Committee to address important APC issues, including credentialing, privileging, competency assessment, and so on. CAP2™ data indicate that 46 percent of organizations utilize such a committee.<sup>16</sup> Figure 4 provides an overview as to the scope of responsibility of these committees.

**Figure 4: APC Committee Scope of Responsibility<sup>17</sup>**



Ensuring the effectiveness of an APC competency assessment process is dependent upon a thoughtful approach and an appropriate allocation of time and resources from the medical staff office, IT, and quality departments for support.

### Third-party Payer Policies and APC Billing

The operational challenges of a growing APC workforce are compounded by the complexities of billing and third-party payer policies related to APCs. Because the rules vary by payer (government or commercial) as well as the setting, health care organizations must ascertain the policies for each payer with whom they contract, including policies for every setting in which they provide services and every practitioner type providing those services.

Claims instructions, enrollment procedures, and reimbursement rates vary widely. While claims for services provided by physicians are always submitted under the physician's National Provider Identifier (NPI) and reimbursed at 100 percent of the fee schedule, claims instructions for services provided by APCs

vary by payer and setting, with reimbursement ranging from 60 to 100 percent of the physician fee schedule. Identification of these requirements serves as a starting point to mitigate billing risk and avoid allegations of fraud and abuse.

#### » Medicare

Professional services provided by PAs, NPs, CRNAs, CNMs, and CNSs are covered under Medicare Part B. The aforementioned APCs must be enrolled in the Medicare program.<sup>19</sup> Reimbursement is at 85 percent of the physician rate when claims are submitted under the APC's NPI. Some provisions, known as "incident to"<sup>20</sup> and shared/split visit billing, allow for claims to be submitted under the physician's NPI for 100 percent reimbursement; however, strict requirements must be met. As an example, a hospital may not bill APC work effort as "incident to" in a facility setting. Failure to satisfy the requirements means that claims must be submitted under the APC's NPI.

#### » State Medicaid

Each state Medicaid program promulgates its own rules, and these vary widely by practitioner type. While every state Medicaid program pays for services provided by PAs and NPs and enrolls PAs and NPs as ordering/referring providers,<sup>21</sup> the claims' methodologies are often different. Enrollment applications for APCs are not uniform, nor are policies for services covered or reimbursement rates. Additionally, many states have managed Medicaid products that are essentially commercial payers who also may promulgate their own rules.

#### » Commercial Payers

Commercial reimbursement rates for APC services vary widely. Many commercial payers do not enroll the APCs into their systems for billing purposes, and APC services are billed under the physician's NPI. On occasion, coverage for certain services may not be covered when provided by APCs. As organizations negotiate with commercial payers, they must ascertain policies for each payer with whom they contract.

Organizations implement operational business decisions in an effort to maximize reimbursement; however, these may actually negate their intended purpose. Examples of such decisions include requiring that new patients only be seen by a physician, or that the physician must also see every patient seen by an APC. Such redundancies, when not necessary, can actually increase costs and decrease patient access.

### Improving APC Billing Practices

In recent years, there has been increased scrutiny of APC billing practices by the Office of Inspector General of HHS and the U.S. Department of Justice (DOJ).

In 2016 alone, the DOJ settled with three organizations related to APC billing claims for a total in excess of \$6M. In today's environment of heightened scrutiny, the emergent settlements bring to mind this Arabian idiom: "If the camel once gets his nose in the tent, his body will soon follow."

If concerns over potential audits or the avoidance of allegations of fraud and abuse that may span beyond mere billing

are not compelling enough, it is still worth a closer look from a business perspective to make sure providers are actually providing the services they are authorized to provide and are able to perform and receive payment for the services rendered.

The complicated rules and regulations set at the federal, state, and payer contract level suggest that provider education, assessment, and feedback are needed. The following considerations provide approaches for APC billing compliance:

1. Conduct an evaluation of current APC billing practices within the organization. The following provide a series of questions to assist in navigating the evaluation:
  - a. Has each APC provider been enrolled in the Medicare, Medicaid, and commercial payer systems as applicable?
  - b. How has the organization ensured compliance with government payers' billing and reimbursement policies?
  - c. Has the organization ascertained the payment policy for each commercial payer with whom they contract?
  - d. Is the organization billing for services rendered by APCs? If so, how are the associated work relative value units (wRVUs) being attributed?
  - e. Is the organization billing the Medicare program under the "incident to" and/or shared/split visit provisions for work provided by APCs? If so, how does the organization ensure that the physician participation requirements for those provisions have been met? What is the process for claims adjudication when a physician has participated (e.g., signed a note) but has not met these requirements?
2. Provide initial and ongoing education to key stakeholders to improve adequate documentation and coding of APC work effort.
  - a. Key stakeholders should include both physicians and APCs as well as clinical operations managers and billing and coding staff.
  - b. Training should be specific to specialty and practice setting.
  - c. Training should also include education on regulations and guidelines, including a review of specialty-specific case studies for common and unique situations.
  - d. Audits should be conducted and feedback delivered to providers regularly.
  - e. An organizational resource should be identified to address questions and concerns.

The implementation of a compliance program focusing on billing practices is a key strategy for risk mitigation. Training and ongoing feedback to improve documentation and billing can improve compliance with the regulations, capture proper revenue for services provided, and mitigate the risk of improper claims.

### **APC Productivity Attribution and Physician Compensation**

As health care organizations expand their APC workforce, they may look to maximize the reimbursement associated with services provided by APCs (e.g., Medicare's "incident to" and shared visit billing).<sup>22</sup> Technical billing requirements aside, submitting bills to Medicare under the physician's NPI for work performed by APCs, either in part or in total, presents potential

#### **Key Questions for Consideration Relative to APC Billing:**

- » Who is providing the service?
- » Who is documenting services? How has the service been documented?
- » By whom is the APC employed?
- » In what setting is the APC providing the service?
- » By which payer is the patient covered?

risks specific to physician compensation arrangements. Such risks are related to ensuring these compensation arrangements are fair market value and commercially reasonable, as required by numerous exceptions within the physician self-referral law (hereinafter referred to as Stark).<sup>23</sup>

#### **Improving Awareness of the Risks in Production Models under the Bona Fide Employment Exception**

Many health care organizations that enter into direct employment relationships with physicians avail themselves of the bona fide employment exception within Stark. To satisfy that exception,<sup>24</sup> an employed physician's financial arrangement must satisfy the following conditions:

- » Employment is for identifiable services.
- » Amount of the remuneration under the employment is
  - Consistent with fair market value of the services, and
  - Not determined in a manner that takes into account (directly or indirectly) the volume or value of any referrals by the referring physician.
- » Remuneration is provided under an arrangement that would be commercially reasonable, even if no referrals were made to the employer.

The exception permits a productivity bonus based on services personally performed by the physician (or an immediate family member of the physician). While there is a shift underway in physician compensation design to integrate value-based metrics, physicians continue to be compensated under production-based models. According to a recent annual survey of physician compensation,<sup>25</sup> physicians' personally performed wRVUs or professional collections comprise a significant portion of their total cash compensation. Approximately three-quarters of respondents use productivity-based metrics for their primary care, medical, and surgical physicians. Overall, productivity-based compensation can often comprise 50–65 percent of the total cash compensation.

The prevalence of production-based plans coupled with growing APC utilization leads to inevitable tension: Who should receive the productivity credit when certain types of services are provided, the physician or the APC? This inherent tension cannot be overlooked with regard to the regulatory compliance risk it may create relative to physician cash compensation in an employed, production-based compensation model.

A hypothetical case study sheds light on the potential risks associated with the productivity attributions in production-based plans.

Returning to the statutory exception for bona fide employment under Stark, although legal opinions in the market may be

### Case Study: A Production-based Plan for an Employed Primary Care Physician

A family medicine physician has built a busy practice that has two dedicated APCs. To the extent all applicable payer requirements are satisfied, the practice bills APC work as “incident to” for Medicare patients and under the physician’s NPI for commercial payers (as required and/or accepted by the payer).

The family practitioner is on a productivity-based compensation plan whereby she receives a market median rate per wRVU for all personally performed services. Her total cash compensation approximates the 90th percentile, which is consistent with the productivity billed under her NPI. The wRVU productivity levels for the three providers are as follows:

- » Physician: 8,000 wRVUs
- » APC A: 1,500 wRVUs
- » APC B: 1,000 wRVUs

Upon review, it is apparent that the APCs have low wRVU productivity because the majority of services were billed under the physician’s NPI. The physician’s overall level of productivity and, correspondingly, her total cash compensation are being driven, at least in part, by the work effort of the APCs. Based on these figures, it is conceivable that the physician’s wRVUs could be overstated by about 3,500 wRVUs (assuming the APCs produce at or around the market median of approximately 3,000 wRVUs). In addition, the physician does not have any financial accountability for the APCs in her practice, as the costs are covered by the employer.

mixed, the prevailing position is that neither “incident to” nor the APC’s portion of the shared visit billing meet the “personally performed” requirement.

Practically speaking, it can be very challenging for organizations that utilize this type of billing to track work efforts in either the EMR or by means of the bill to Medicare. Moreover, those charged with administering employed physician compensation plans and/or ensuring the compliance of those plans may not fully understand the implications of the “personally performed” requirement.

It follows that there is potential risk that “incident to” and/or shared visit billing may, either knowingly or unknowingly, be attributed to the physician in a production-based model that falls under the bona fide employment exception. Given that potential risk, organizations should consider these actions:

- » Conduct a legal analysis on the application of the “personally performed” provision within the bona fide employment exception relative to production-based models
- » Review existing production-based compensation plans to determine how “incident to” and shared visit services are being billed and how the work effort is being attributed
- » Educate physicians and APCs, as well as staff responsible for managing the compensation plan, as to the implications of “incident to” and shared visit billing

- » To the extent that the legal analysis determines that “incident to” and shared visit production does not meet the “personally performed” requirements, implement the following processes:
  - Develop a methodology to identify and exclude “incident to” production from physician compensation plan calculations
  - Apply a consistent methodology to identify the relative work effort for shared visits such that shared visit work effort can be appropriately attributed between the physician and APC

Regardless of the ultimate legal position on the “personally performed” provision of the exception, organizations should be aware of the need to exclude “incident to” and/or shared visit productivity when assessing physician cash compensation for fair market value. Most physician compensation surveys, at least by definition, exclude wRVUs attributed to APCs from the physician productivity and payout rates that they publish.<sup>20</sup> As organizations conduct internal or external fair market value analyses, they should exclude “incident to” and/or APCs’ allocation of shared visit production when assessing the competitive position of effective payout rates relative to the market to ensure an “apples to apples” comparison.

### Improving Awareness of the Risks to Consider in Production Models within an Employed Group Practice

Physician groups that meet the qualifications of a group practice under Stark<sup>21</sup> are not subject to the same limitations relative to “personally performed” productivity, as evidenced in the following description of permissible productivity bonuses:

A physician in the group practice may be paid a productivity bonus based on services that he or she has personally performed, or services “incident to” such personally performed services, or both, provided that the bonus is not determined in any manner that is directly related to the volume or value of referrals of DHS by the physician (except that the bonus may directly relate to the volume or value of DHS referrals by the physician if the referrals are for services “incident to” the physician’s personally performed services).<sup>26</sup>

In contrast to the bona fide employment exception, Stark’s definition of a group practice expressly allows an organization the ability to credit physicians with “incident to” and shared visit wRVUs. The ability to provide such credit in the context of a production-based compensation plan in a hospital-owned medical group raises potential risks that often go unnoticed.

Take, for example, an office-based primary care practice in which a family medicine physician is paid on a simple wRVU-based model. The physician currently works with one APC. Because the employed group satisfies the group practice definition, the physician is credited with all of the “incident to” productivity generated by the APC. At present, the hospital subsidizes the family medicine physician’s practice on the basis of his professional revenue and practice expenses at approximately \$100,000 annually.

The physician is currently in such high demand that he is booking three months out. In an effort to reduce the wait time for new appointments and improve access for established

patients, the practice hires another experienced APC. The employer maintains responsibility for the costs associated with hiring that APC; in other words, the physician bears no economic risk related to the expense of the APC. The following illustration provides an overview of the potential challenge with the addition of this new APC.

Based on the assumptions in the illustration above, the physician has the opportunity to earn approximately \$76,000 more in cash compensation just by adding the APC to his practice.

Additional APC Cost Projections	
<b>APC – Family Medicine</b>	
Total Cash Compensation (TCC) – Median <sup>1</sup>	\$104,753
Benefits – Median <sup>2</sup>	\$28,636
<b>Total Compensation</b>	<b>\$133,389</b>
APC wRVUs – Median <sup>2</sup>	3,261
<b>Physician (Impact of APC Attributed Production)</b>	
50% of APC wRVUs	1,630.5
TCC per wRVU <sup>3</sup>	\$47.16
<b>Additional Cash Compensation</b>	<b>\$76,894</b>
<b>Cost of APC Compensation and Increased Physician Compensation<sup>4</sup></b>	<b>\$210,283</b>

<sup>1</sup>Reflects family medicine median TCC.  
<sup>2</sup>Reflects primary care median benefits and wRVUs.  
<sup>3</sup>Reflects family medicine TCC per wRVU.  
<sup>4</sup>Reflects a conservative cost estimate as no indirect expenses.

Sources:  
2016 Advanced Practice Clinician Compensation and Pay Practices Survey Report  
2016 Physician Compensation and Productivity Survey Report

Before any consideration of indirect expenses and/or projected professional revenue attributable to the APC, additional compensation cost is projected at \$210,283.

This scenario presents two challenges.

- » First, the increase in cash compensation attributable to the work effort of the APC is rather significant at \$76,000. As noted in the prior hypothetical, the fair market value analysis of the physician’s cash compensation requires that he be able to support his total cash compensation based on his own productivity, exclusive of any wRVUs attributed to him by virtue of the APCs.
- » Second, the hospital was already subsidizing this physician’s professional practice at approximately \$100,000 per year. To the extent that the professional revenue attributable to all of the new APC’s work effort is insufficient to cover the full cost of that APC and the additional cash compensation paid to the physician, it stands to reason that the hospital’s support of the physician’s practice will increase beyond \$100,000.

A cursory look at current regulatory trends highlights the underlying concerns with this example. For some time, government regulators have been increasingly focused on the practice loss argument as one approach to arguing that a physician’s financial arrangement is not commercially reasonable. This argument finds support from Judge Gregg Costa of the Southern District of Texas in his opinion on the motion to dismiss the plaintiff’s False Claims Act allegations against Citizens Medical Center of Victoria, Texas. Judge Costa noted the following:

Court notes Relators’ allegations that the cardiologists’ income more than doubled after they joined Citizens, even while their own practices were costing Citizens between \$400,000 and \$1,000,000 per year in net losses. Even if the cardiologists were making less than the national median salary for their profession, the allegations that they began making substantially more money once they were employed by Citizens is sufficient to allow an inference that they were receiving improper remuneration. This inference is particularly strong given that it would make little apparent economic sense for Citizens to employ the cardiologists at a loss unless it were doing so for some ulterior motive—a motive Relators identify as a desire to (sic) induce referrals.<sup>27</sup>

The practice loss theory is not intended to suggest that losing money on a physician practice is necessarily unreasonable; rather, it effectively mandates that organizations document the business justification for the financial arrangements they enter into with their physicians. It also encourages careful consideration in the development of physician and APC cash compensation plans.

Organizations in a similar fact pattern to the example above should consider the following. First, by reviewing and documenting goals for integrating APCs into clinical practice, an organization can focus on proposed outcomes, such as improving access, quality, cost efficiency, and patient experience. Second, organizations must understand the financial implications of integrating additional APCs. The question to answer is whether the totality of the arrangement, including the physician compensation arrangement, the cost of adding the APC, and the projected professional revenue exceeds anticipated expenses. At this point, the organization can properly weigh benefits against costs and document a persuasive business justification to support their strategic decisions regarding enhanced APC integration. Stated slightly differently, if the addition of an APC simply serves to increase the compensation of the physicians while increasing the employer’s costs, then the employer’s practice loss just increased, potentially implicating concerns regarding the commercial reasonableness of that staffing change and the corresponding physician compensation.

## Conclusion

Amidst the unending changes in today’s health care market, one thing is certain: if the physician shortage projections are accurate, organizations must begin developing alternative staffing strategies to meet escalating demand for professional services. Strategies for success include implementing mindful care delivery models that maximize the capabilities of each member of the team within the framework of federal and state laws, regulations, and accreditation standards. Coordination with an established compliance team can inform the integration strategy and mitigate risk.

As organizations embark on the journey toward the future of integrated staffing models, the following considerations can provide a sound foundation for better compliance:

- » Develop a process for assessing the competency of APCs that

mirrors the process used for physicians, and ensure the assessment frequency is more than once per year.

- » Ensure compliance with, awareness of, and education on the complexities of billing and third-party payer policy, to include the following:
  - An understanding of current requirements with government and commercial payers, and
  - An ongoing education series aimed at both providers and nonproviders focused on documentation and appropriate coding.
- » Closely monitor the attribution of APC work effort in the context of physician compensation plans and ensure physician compensation arrangements are fair market value, commercially reasonable and financially sustainable. Additionally, develop a consistent process for assessing and documenting the business rationale for adding additional APCs to a physician practice. ♦

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- 1 For purposes of this article, the term APC includes Physician Assistant (PA), Nurse Practitioner (NP), Certified Registered Nurse Anesthetist (CRNA), Clinical Nurse Specialist (CNS), and Certified Nurse Midwife (CNM).
- 2 Thomas Bodenheimer, MD, and Christine Sinsky, MD, "From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider," *Annals of Family Medicine*, 12, No. 6 (November/December 2014): 573-576, <http://www.annfammed.org/content/12/6/573.full>.
- 3 IHS Inc., "The Complexities of Physician Supply and Demand 2016 Update: Projections from 2014 to 2025," April 5, 2016, [https://www.aamc.org/download/458082/data/2016\\_complexities\\_of\\_supply\\_and\\_demand\\_projections.pdf](https://www.aamc.org/download/458082/data/2016_complexities_of_supply_and_demand_projections.pdf).
- 4 US Bureau of Labor Statistics, "Occupational Outlook Handbook: Nurse Anesthetists, Nurse Midwives, and Nurse Practitioners," December 17, 2015, <https://www.bls.gov/oooh/healthcare/nurse-anesthetists-nurse-midwives-and-nurse-practitioners.htm#tab-6>.
- 5 IHS Inc., "The Complexities of Physician Supply and Demand".
- 6 Sullivan, Cotter and Associates, Inc., "2016 Advanced Practice Clinician Compensation and Pay Practices Survey," 2016.
- 7 Survey and Certification Group, "Centers for Medicare & Medicaid Services (CMS) Requirements for Hospital Medical Staff Privileging," S&C-05-04, November 12, 2004, <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/SCletter05-04.pdf>.
- 8 Regulations 42CFR§482.12 and §482.22, <https://www.gpo.gov/fdsys/pkg/CFR-2015-title42-vol5/xml/CFR-2015-title42-vol5-part482.xml#seqnum482.22>.
- 9 Medicare Condition of Participation: 42CFR §482.22(a)(1).
- 10 Joint Commission Comprehensive Accreditation Manual for Hospitals Medical Staff Standard MS.08.01.01.
- 11 Joint Commission Hospital Accreditation Manual, Medical Staff Standard MS.08.01.03.
- 12 CAP2™ is a comprehensive database that has helped 300 health care organizations nationwide assess, manage, and optimize the use of APRNs and PAs on their care provider teams. CAP2™ data and findings help these health care organizations in 31 states, representing over 25,000 APRNs and PAs in 50 specialty areas.
- 13 CAP2™
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- 15 CAP2™
- 16 CAP2™
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- 18 Services provided by PAs are covered under Part B: Section 1861(s)(2)(K)(i) of the Social Security Act and 42 CFR § 410.74. Nurse Practitioner: Section 1861(s)(2)(K)(ii) of the Social Security Act and 42 CFR § 410.75 nurse practitioners as covered Part B services.
- 19 CMS, "Medicare Enrollment Guidelines for Ordering/Referring Providers,"

- Provider–Supplier Enrollment Series, ICN 906223, November 2016, [https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/medenroll\\_orderreferprov\\_factsheet\\_icn906223.pdf](https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/medenroll_orderreferprov_factsheet_icn906223.pdf).
- 20 CMS, "MLN Matters," Number SE0441, August 23, 2016. <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/se0441.pdf>.
- 21 CMS, "Medicare and Medicaid Programs; Changes in Provider and Supplier Enrollment, Ordering and Referring, and Documentation Requirements; and Change in Provider Agreements," Federal Register, 77, no. 82 (April 27, 2012): 25283–25318, <https://www.gpo.gov/fdsys/pkg/FR-2012-04-27/pdf/2012-9994.pdf>.
- 22 CMS, "Medicare Benefit Policy Manual," Chapter 15 § 60, <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf>.
- 23 §1877 of the Social Security Act (42 C.F.R. 1395nn).
- 24 42 C.F.R. §411.357.
- 25 Sullivan, Cotter and Associates, Inc. "2016 Physician Compensation and Productivity Survey," 2017.
- 26 42 C.F.R. § 411.352(h)(1).
- 27 United States of America ex rel. Parikh v Citizens Medical Center, 977 F.Supp.2d 654 (S.D. Tex. 2013).