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Transitioning APP Compensation: Aligning incentives with performance beyond traditional compensation bands

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Amanda Jones, the physician compensation director of a regional health system, has just left a meeting with multiple department managers discussing compensation terms for a few APPs across various specialties requesting additional compensation. The amounts requested are consistent with offers they are receiving from competing health systems, however, the amounts exceed the compensation bands put forth by human resources. Each of the APPs are making the case that their patient outcomes, productivity, excess hours worked, and/or other services provided to the health system are in excess of norm when compared to other APPs within the organization.

So, what are Ms. Jones' options?

Ms. Jones is not alone in her challenge to recruit and retain advanced practice providers (APPs).[1] APPs have experienced significant growth in numbers and in specialization across the country working in small private practices to large multinational health systems. According to the Bureau of Labor statistics, the job outlook for nurse anesthetist, nurse midwives, and nurse practitioners is expected to grow by 40% and for physician assistants by 28% between 2021 and 2031, outpacing the national average for other job categories.[2] In addition, the growth in population and an aging patient base has created a shift in demographics that has served to fuel increase utilization of APPs across more specialties beyond primary care, such as medical specialties, surgical specialties, and inpatient/hospital-based specialties. In 2019, MGMA reflected this trend in the data by reporting an increase in the APP-to-physician ratio "from 0.42:1 in 2012 to 0.60:1 in 2019".[3] Lastly, there have been numerous studies that have been conducted over the last several decades supporting APP practice as a cost-effective model to providing high quality care with high patient satisfaction and demonstrable patient outcomes.[4]

Given the demand for APPs, health systems are seeing a rise in APP compensation with some APPs requiring higher than typical compensation for exceptional performance and/or workloads

[1] Advanced practice providers (APPs) is a term that is meant to encompass licensed individuals who perform clinical service in particular specialties providing billable services. They consist of primarily nurse practitioners (NPs), physician assistants (PAs), certified nurse-midwives (CNMs), and certified registered nurse anesthetists (CRNAs).

[2] 2022 Bureau of Labor Statistics Occupational Outlook Handbook. Nurse Anesthetists, Nurse Midwives, and Nurse Practitioners : Occupational Outlook Handbook: : U.S. Bureau of Labor Statistics (bls.gov) ; Physician Assistants : Occupational Outlook Handbook: : U.S. Bureau of Labor Statistics (bls.gov)

[3] 2020 MGMA Datadive Cost and Revenue dataset.

[4] Buerhaus, P., Perloff, J., Clarke, S., O'Reilly-Jacob, M., Zolotusky, G., & DesRoches, C. M. (2018). Quality of primary care provided to Medicare beneficiaries by nurse practitioners and physicians. *Medical Care, 56*(6), 484-490.; Everett, C.M., Morgan, P., Smith, V.A., Woolson, S., Edelman, D., Hendrix C.C., Berkowitz, T., White, B., & Jackson, G.L. (2019). Primary Care provider type: Are there differences in patients' intermediate diabetes outcomes*? Journal of the American Academy of Physician Assistants, 32*(6), 36-42.; Kippenbrock, T., Emory, J., Lee, P., Odell, E., Buron, B., & Morrison, B. (2019). A national survey of nurse practitioners' patient satisfaction outcomes. *Nursing Outlook, 67*(6), 707-712.

in excess of norms. Current compensation models are being stretched to accommodate these different circumstances, however, many are not built to capture outliers. Traditionally, APP compensation has been governed by pre-set compensation bands based on specialty group. While compensation bands can certainly be a part of an effective compensation model, they are often set based on market survey data and represent more of a static range rather than one that is dynamic. As a result, they are not flexible enough to account for any facts and circumstances that would lead to a higher compensation amount for the APP. A one-size-fits-all approach will continue to be challenging given the variability in APP work associated with different practice settings, distinct clinical practice across specialties, and the utilization of team vs individual care models. Market forces are already driving some of this change within private practice medical groups. Given the direct connection between revenues, expenses, and compensation within private practice, these groups have already begun to incorporate and recognize APP outliers who generate financial returns based on their performance. As health systems look to recruit and retain talented providers, many are considering transitioning APP compensation from a traditional compensation band model to more of a performance-based model. In this article, we will lay the foundation by examining the traditional APP compensation model, review the components of a performance-based compensation model, and end with exploring two examples of aligning APP contribution to their compensation.

Traditional APP Compensation Bands

Unlike physicians, APP compensation is set within a pre-determined compensation range or band largely based on their specialty and years of experience. Most health systems have 3 to 5 compensation bands based on the APP specialty – Primary Care Specialty, Medical Specialty, Surgical Specialty, Hospital-Based Specialty, and Other. These bands are derived from a review of the market compensation for each specialty and are meant to encompass differentiating factors such as education, experience, and performance quality. In order to develop a band by specialty, the range spread is typically calculated based on the maximum and minimum compensation amounts. Range spreads will vary based on the position. Ideally, APP positions or those that demand a higher skill set will often have a wider range spread. Some organizations use the market positions of 25th percentile and 75th percentile as the minimum and maximum points for establishing ranges. However, this approach can lead to an arbitrarily tight or wide range. Consideration of the differentiating factors should be the key driver along with compensation survey results in determining the range spread for a particular compensation band.

While the compensation bands are sufficient to cover the majority of APP compensation, there are occasions when the facts and circumstances require greater compensation to the APP in order to recognize and differentiate their work effort when compared to their peers. Some of the positives and negatives of this compensation model is shown on Table 1.

Table 1: Compensation Band Model

Positive	Negative
Simple and transparent to APPs	Not in alignment with physician compensation models
Easy to administer and operationalize	Inflexible outside of compensation band. Benefit is derived from strictly adhering to the bands.
Able to support the majority of APP compensation	Sensitivity for differentiation is limited for outliers.
Structured compensation design	Value of provider not always linked to their tenure or years of experience

While many health systems set the maximum compensation at the 75th percentile, recent commentary from The Centers for Medicare & Medicaid Services (CMS) in conjunction with the new Stark rules that took effect on January 19, 2021 is paving the way to compensation in excess of the 75th percentile based on each APP and their unique practice.

- CMS and exceeding 75th percentile compensation

In redefining fair market value (FMV) under the new Stark rules, CMS provided some useful commentary and insight into its thoughts on determining the appropriate compensation range for a transaction. Specifically, the new definition of FMV requires health systems to evaluate the general market value in the context of "the subject transaction" and not solely depend on the utilization of particular survey data or specific percentiles within the data for the determination of FMV. While these comments reference physician compensation and FMV, they can certainly serve as a proxy when evaluating APP compensation.

CMS' comments to this end, included the following:

- "…We continue to believe the fair market value of a transaction — and particularly, compensation for physician services — may not always align with published valuation data compilations, such as salary surveys. In other words, the rate of compensation set forth in a salary survey may not always be identical to the worth of a particular physician's services."[5]

- "It is not CMS policy that salary surveys necessarily provide an accurate determination of fair market value in all cases. … Consulting salary schedules or other hypothetical data is an appropriate starting point in the determination of fair market value, and in many cases, it may be all that is required. … In our view, each compensation arrangement is different and must be evaluated based on its unique factors."[6] As an example, CMS indicated that securing a sought after physician with a unique skillset may warrant a compensation level higher than typically expected for the specialty in the particular geographic area. On the flip side, hospitals who may be in a more tenuous economic state need not feel compelled to pay higher than financially prudent simply because salary surveys would suggest such a payment.

For these reasons, CMS declined to establish a bright line rule based on a particular survey percentile. Specifically, CMS' policy of determining appropriate compensation is not based on salary data at or below the 75th percentile, nor is it outside of FMV range for compensation set above the 75th percentile.[7]

While survey data provides valuable information, the appropriate application to each subject transaction is crucial. The importance of reviewing each transaction in the context of its unique factors (Table 2) is affirmed in CMS' commentary above and consistent with the standards of valuation practice.

[5] 85 Federal Register 77492
[6] Ibid.
[7] Ibid.

Table 2: Factors To Review When Considering Compensation	
Compensation Terms	• Base Salary • Production-Based • Value-Based • Stackable Compensation (ER call, administrative, GME, etc.)
Provider-Specific Characteristics	• Unique Clinical Skills • Additional Certifications • Services Offered
Position-Specific Requirements	• Hours Worked • Patient Volume • Other Work Requirements
Geographic-Specific Factors	• Cost Of Living • Patient Demographics • Payor Sources
Employer Considerations	• Practice Economics • Organizational Mission • Specific Business Purpose

Transitioning to a performance-based compensation model

Many health systems are facing similar pressures across the various APP specialties as Ms Jones. While the traditional compensation bands can satisfy most of the APP compensation challenges faced by Ms. Jones in our example at the outset of this piece, there are generally enough APP outliers that a more comprehensive model should be considered. One such model is a performance-based compensation model where APP compensation is set in a similar manner as physicians. The performance will not only be associated with quantity of hours worked or patients seen but will also encompass quality outcomes and patient satisfaction. The relative weight assigned to each performance category mitigates against the model valuing quantity over quality. For compliance purposes, the transition to a new model is important to ensuring equitable compensation for all APPs.

An effective transition will start by reflecting on the APPs role within the clinical care team and move to identifying the compensatory services / performance metrics achieved by the APP.

- Defining the APP clinical role within the care team

As APPs have grown in number, they have expanded into different specialties beyond primary care and general surgery. This expansion has led to an evolution in the clinical role they play. Today, there are two distinct clinical roles that APPs serve within a care team which largely hinges around their level of independence in caring for patients.

- *Independent Provider*

  APPs that function as independent providers will manage a patient's care from diagnosis to treatment plan per their scope of practice and in collaboration with a physician as needed. The APP will typically bill under their provider number and receive the wRVU / professional collections credit under their provider name.

  Specialties where APPs typically function independently are primary care, urgent care, women's health (non-surgical), and some medical sub-specialties contingent upon experience.

- *Physician Extender*

  APPs that function as physician extenders will often manage patients with their collaborating physician. These APPs function in a variety of ways. Some will see patients concurrently in the outpatient setting with a physician. They may initiate the history taking and diagnostic work-up while the physician comes in and performs an exam and determines the plan of care at disposition. Alternatively, these APPs may serve as surgical assistants in the operating room as well as seeing post-op patients. The physician will typically bill under their provider number and receive the wRVU / professional collections credit under their provider name.

  Specialties where APP serve more of an extender role are usually found in medical sub-specialties and surgical specialties.

Understanding these roles is important for compensation design given the differences in how the APPs contribute to the practice and health system at large along with the differences in workload metrics. With APPs who function as "independent" providers, they often will bill for their professional services under their own provider number. This allows for individual tracking of performance, whether it be for quality or production-based metrics. For those APPs who function as "extenders", team-based performance models along with hours or shifts worked are a better measure of workload for the purposes of compensation.

- <u>Identify all compensatory provider services</u>

In developing a compensation model, an inventory should be taken of all the services performed by the providers. These could include clinical, academic, and/or administrative services. Each service performed should be assigned a separate and distinct compensation value. Once identified, the model should incorporate each of the compensation values to ensure that incentives align with performance goals and the provider understands how they are compensated. Compensatory services can vary based on specialty as well as the clinical role played by the APP. Designing a model that provides a clear pathway that can be followed from work performed to compensation is a key component to provider satisfaction and retention.

- *Base Compensation*

Base compensation represents the bulk of the APP compensation and should be set at a level commensurate with the work requirements of the position. It may also vary based on certain quantitative and qualitative characteristics of each APP. These include educational background (i.e. MSN vs DNP), certain certifications, unique skills, and years of experience. A rubric should be created to provide guidance regarding the impact on compensation from any of the

characteristics (See Table 3). Most organizations primarily differentiate based on years of experience.

Table 3: Sample Base Compensation Rubric			
Characteristic	**Low (90% of Midpoint)**	**Midpoint**	**High (110% of Midpoint)**
Education	MSN	MSN	MSN / DNP
Certifications	Single Board Certification	Single Board Certification	Double Board Certification
Experience (Yrs)	0-5 Years	5-10 Years	15+ Years

- *Production-based or excess work*

Production-based or excess work consists of compensation associated with the APPs level of productivity measured in the form of either collections, wRVUs, patient visits, panel size, and/or excess shifts worked. The metric used will be dependent upon the APP specialty along with how the APP is utilized within the care team.

APPs that manage patients and bill for the professional services that they perform will be best suited for a production bonus model based on such metrics as wRVUs, and/or collections. APPs who function more as physician extenders and who do not significantly bill for the professional services performed require a different metric to determine their production / excess work compensation. Within these circumstances, the APP workload is inextricably tied to the physician's workload and/or any excess shifts covered. Things to consider for reasonability are:

a. Panel sizes should be risk-adjusted and set at an amount that considers the APP scope of practice.
b. Bonus thresholds should be set in the context of the base compensation and at achievable levels to incentivize the provider.
c. Production bonus models can be individualized or team-based depending upon the way the physician-APP work as a team.
d. Excess hours worked should be monitored for appropriateness to ensure quality patient care. It is typical that these excess hours be paid at between 100-110% of the base hourly rate for the APP.

- *Quality Incentive*

Ensuring that each APP provides quality care to each patient is critical for each health system. Given the rise of value-based care, quality incentive compensation is becoming more prevalent. Under this incentive compensation, various metrics are identified, and goals are set for each. These metrics often involve patient satisfaction, clinical outcomes, and/or cost/utilization targets. This mirrors the goals set forth by the Institute of Healthcare

Improvement.[8] Within these three broad categories, the metric could be stratified further based on care management for a specific illness (i.e. diabetes management, heart failure management) or for the general population. To the degree that the goals are met, the APP will receive a percent of their base compensation (usually between 5 - 15% of base compensation).

Patient satisfaction measures can be based upon static targets and/or improvement over a particular time period. Examples of patient satisfaction tools are:

a. Press-Ganey
   Healthcare company focused on providing patient satisfaction surveys across specialties. It was founded in 1985 and as of November 2016, is being used in over 10,000 medical institutions.[9]
b. Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)
   This survey provides patients recently receiving hospital care a means to share their experiences through a set of 29 questions asked at discharge.
c. Consumer Assessment of Healthcare Providers and Systems (CAHPS)
   The Agency for Healthcare Research and Quality developed the CAHPS survey in 1995 to serve as a means to understand patient experiences across primary and specialty care.

Quality outcomes measures should be meaningful to the specialty and only be compensated for if the APP exceeds the 90-95th percentile for the particular metric. Quality metric tools and systems include, but are not limited to:

a. CMS Measures Inventory Tool (CMIT)
b. National Quality Forum (NQF)
c. Merit-Based Incentive Payment System (MIPS)
d. Qualified Clinical Data Registry (QCDR)
e. Health system specific metrics

- *Call Coverage*

Call coverage services can vary based on the burden of the call. The burden of the call pertains to the number of phone calls received as well as the likelihood of returning to the facility to evaluate a patient emergently in-person or perform a procedure. APPs typically provide two types of call coverage services: practice call and ER call. Practice call pertains to the after-hours coverage of a practice to handle any emergent/urgent needs of those patients within the practice. ER call involves emergent patient cases that come through the hospital emergency department and require evaluation by the APP specialty.

Practice call is usually for primary care and/or medical specialties and does not typically involve anything more than telephonic responses. As such, the value for this call tends to be slightly less than for ER call. ER call usually involves the medical and surgical specialties,

[8] Stiefel M, Nolan K. *A Guide to Measuring the Triple Aim: Population Health, Experience of Care, and Per Capita Cost*. IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2012. (Available on www.IHI.org)
[9] Etier, Brian E.; Orr, Scott P.; Antonetti, Jonathan; Thomas, Scott B.; Theiss, Steven M. (November 2016). "Factors impacting Press Ganey patient satisfaction scores in orthopedic surgery spine clinic". *The Spine Journal*. 16 (11): 1285–1289. doi:10.1016/j.spinee.2016.04.007. ISSN 1529-9430. PMID 27084192.

with the surgical specialties having a higher probability of an emergent call resulting in an emergent procedure / case.

Call compensation can be paid through the base or separately on a per call shift basis. We recommend compensating the APP separately so that work and the corresponding pay is tangible and recognized by both the APP and the employer. The range of pay for call is generally between 7-15% of the APP's hourly rate (or $3.00 to $10.00 per hour on call). However, it can be higher than those ranges depending upon the work requirements (i.e. rounding on patients on service, weekends/holidays, volume of calls, and number of emergent cases).

- *Administrative / Leadership / Research / Education*

  APPs are increasingly serving in leadership roles as well as members of the graduate medical education teams within their organizations. Since these services are usually performed within the normal hours required of the APP, we recommend recognizing this additional duty via the base compensation. However, if these services are performed outside of the APP's full-time requirement, we recommend that this be paid separately so that it is identifiable. We recommend that the services be documented using timesheets and that it not be compensated concurrently with any billable professional services.

Aligning APP Contribution to Compensation: Two examples

So, let's delve deeper into what Ms. Jones is facing.

In talking with her market managers, she has identified two primary compensation concerns – a. how to compensate an APP outlier compared to their peer group and b. how to compensate a group of APPs who are working in excess of norms within the same specialty.

- APP performance outlier within their peer group

  In this example (Table 4), the group consists of 3 APP FTEs, however, there is one who is functioning as an outlier from the perspective of production volume and hours worked. The compensation band goes from $100,000 to $140,000 and each of the APPs are paid a base salary differentiated by their years of experience. This group works very well together and recognize each other's distinct contribution to the group as a whole. Currently, APP #2 is compensated $115,000 per year compared to the others at $125,000 and $138,000 per year. Each of the APPs are currently paid within their specialty-specific compensation band, however, APP #2 is concerned that her contribution to the group is not reflected in her compensation. Specifically, based on her current compensation, APP #2 is substantially lower than her peers, despite generating 2,000-2,500 more wRVUs, working additional hours, and taking more than 20 additional ER call shifts.

Table 4: Medical Specialty APP – Group Compensation Comparison			
Compensation Band for Medical Specialty APP			
Minimum $100,000 ⟷	**Midpoint $120,000**	⟷ **Maximum $140,000**	
Component	**APP #1** **10 years experience** **2080 annual hours** **4,000 wRVUs** **12 ER call shifts**	**APP #2** **5 years experience** **2200 annual hours** **6,000 wRVUs** **32 ER call shifts**	**APP #3** **15 years experience** **2080 annual hours** **3,500 wRVUs** **8 ER call shifts** **APP Leadership Role**
Current Compensation	**$125,000**	**$115,000**	**$138,000**

Table 5 illustrates a proposed compensation model that is performance-based recognizing the contribution that each APP provides to the group. Under this model, compensation to each of the APPs is based on their performance and contribution in terms of their production, quality metrics, ER call coverage, and administrative services. As is highlighted below, the proposed compensation for APP #2 is higher than the current compensation bands. As a result, the current compensation model is incapable of reflecting the full value of services APP #2 is providing. Transitioning to this new proposed model allows for each APP to receive compensation in alignment with the services provided.

Table 5: Medical Specialty APP – Group Compensation Comparison			
Proposed Compensation under Performance-Based Model			
Component	**APP #1** **10 years experience** **2080 annual hours** **4,000 wRVUs** **12 ER call shifts**	**APP #2** **5 years experience** **2200 annual hours** **6,000 wRVUs** **32 ER call shifts**	**APP #3** **15 years experience** **2080 annual hours** **3,500 wRVUs** **8 ER call shifts** **APP Leadership Role**
Base Salary	**$115,000**	**$110,000**	**$120,000**
Production	**$5,000**	**$30,000**	**$5,000**
Quality Metrics	**$5,000**	**$5,000**	**$5,000**
ER Call Coverage	**$3,000**	**$8,000**	**$2,000**
Administrative Services	**N/A**	**N/A**	**$6,000**
Proposed Compensation	**$128,000**	**$153,000**	**$138,000**

- APPs working in excess of norms within the same specialty

This second example (Table 6) illustrates a hospital-based surgicalist program at various APP staffing levels. Under a staffing shortage scenario, the surgicalist program may have to run short as the compensation bands may limit the health system's ability to pay additional compensation to the current APPs for excess shifts worked. The example shown on Table 6 shows a fully staffed program at 6 APP FTEs at an average compensation per AAP FTE of $148,400 (approximately 105% of the midpoint of the compensation band). The program requires each APP to provide a minimum of 5 uncompensated 24-hour weekend shifts and pays $3,200 per 24-hour restricted on-site shift in excess of the requirement. As a result, the lower the number of APPs within the group, the greater the compensation associated with excess weekend coverage on a per FTE basis. While the figures below are based on averages per FTE, there are typically only a few providers who are willing and able to take the excess call. As a result, compensation problems may arise at higher APP staffing levels with outlier APPs taking a disproportionate share of the excess weekend coverage and thereby exceeding the maximum compensation under the band.

Table 6: Surgical Specialty APP – Situational Compensation Comparison				
Compensation Band for Surgical Specialty APP				
Minimum $125,000		Midpoint $140,000		Maximum $155,000
Component	**3 APP Model: Per FTE**	**4 APP Model: Per FTE**	**5 APP Model: Per FTE**	**6 APP Model: Per FTE**
Base Salary	**$130,000**	**$130,000**	**$130,000**	**$130,000**
Quality Metrics	**$5,000**	**$5,000**	**$5,000**	**$5,000**
Weekend Coverage	**$39,467**	**$25,600**	**$17,280**	**$11,733**
Administrative Services	**$3,333**	**$2,500**	**$2,000**	**$1,667**
Total Compensation	**$177,800**	**$163,100**	**$154,280**	**$148,400**
Eff. Hourly Rate	**$85.98 / hr**	**$80.90 / hr**	**$77.73 / hr**	**$75.56 / hr**

Note that this example can be for excess hours worked in other specialties that require the coverage (i.e., including but not limited to urgent care, emergency medicine, intensive care, primary care, etc.).

Summary

APPs have become a critical member of the health care delivery team. Given their role in providing clinical professional services, their contribution and performance can vary across providers within the same specialty. With compensation bands static, this variability in APP work has made it challenging for provider compensation professionals to meet the compensation demands and still stay within the pre-set compensation band. As such, more or looking to performance-based compensation models in order to meet the following goals of the health system:

- Align business goals with provider incentives
- Pay for performance
- Establish equity across providers
- Ensure financial viability for the healthcare system overall
- Mitigate compliance risk

Transitioning APP compensation to a performance-based model accomplishes these goals, while giving provider compensation professionals the flexibility to address APP compensation consistent with their physician peers, organizational needs, as well as recruitment and retention strategies.

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