Should You Put Your Advanced Practice Providers on Physician-Type Compensation Plans?

Medical groups are wondering if the time has come to put their Advanced Practice Providers (APPs) on value-based compensation plans partially subject to performance and productivity measures. Could that be the right move for you?

Traditionally, medical groups have compensated APPs differently from physician providers. APPs have been left out of the shift to value-based, quality-focused compensation models in favor of simpler, flat salaries.

But the world of healthcare is not as simple as it once was: new challenges and requirements are making medical groups and organizations consider moving their APPs to physician-type compensation plans.

Consider that a group with 1,500 providers could have hundreds of APPs who have direct, measurable impacts on patient experience, as well as other factors that affect reimbursement and revenue. In fact, their impact in this area is primed to skyrocket as a significant shortage of physicians increases over the next decade. All of this is happening as healthcare organizations struggle to bring down the total cost of care and increase accountability among providers.

The net result is a rising interest in infusing quality of care and service into future compensation for APPs. The good news is that such a shift can bring benefits to medical providers: it has real potential to decrease the cost of care while expanding capacity to provide care.

But is such a shift really worth the effort? And if it is, how should organizations structure this change to maximize the benefits and minimize or eliminate any potential downsides?

Those are the questions this paper will address.
Why are organizations increasingly transitioning APPs to value-based compensation?

To soften the blow of the future physician shortage.

The healthcare industry in the United States is facing a shortage that the Association of American Medical Colleges (AAMC) believes could reach up to nearly 120,000 physicians by 2030 (see chart).¹

Such a shortage will dramatically affect the availability and accessibility of care. Worse, this scarcity will be hitting as demand for care surges, especially among older patients. The AAMC projects that demand will increase by 38% for patients over 65 and by as much as 55% for those over 75.²

Together, these issues will put physician providers in a bind. A report from UnitedHealth Group warns, “A primary care physician with a panel of 2,000 patients would need to spend an estimated 17.4 hours each day to provide recommended preventive, chronic, and acute care” to their patients.³

APPs can help medical groups navigate this shortage by enabling physician providers to be more efficient and productive.

Given that the APP workforce of nurse practitioners, physician assistants, and similar providers will increase by around 36% by 2026, according to the U.S. Bureau of Labor Statistics, they can help to fill gaps in care. In a few places that are especially hard hit, they may actually replace the physician providers exiting the workforce.⁴

However, in most situations, APPs will fill critical care gaps by attending to the lower acuity, less complex patients who can often weigh down a physician’s call schedule. That, in turn, enables the physician provider to see more appropriate patients and allows the group as a whole to operate more efficiently (and, for that matter, profitably) while meeting rising patient demand.

“These advanced practice clinicians practice independently or as part of multidisciplinary care teams [and can] help primary care practices care for more patients,” writes UnitedHealth Group.⁵
To manage risk from the increasing impact of APPs on quality metrics and outcomes.

If APPs will be having an increased impact on patient outcomes, as seems likely under a physician shortage, then organizations will have to hold these providers accountable to the quality of care they administer.

In other words, as APPs care for more patients, they will have a larger impact on the quality and value-based metrics by which the entire organization is judged. Moreover, if APPs are providing a sufficient level of care to affect metrics like hospital readmissions, they are also impacting reimbursements (or, on the flip side, potential penalties).

As more APPs are called in to support fewer physicians, they will wield greater power to affect the organization as a whole. If these providers are not tracked in the same manner as physicians nor incentivized according to the same metrics, the organization can be exposed to significant risk.

If an APP provides care at substandard levels for whatever reasons that result in increased readmissions, the organization as a whole is hurt.

A value-based compensation model gives organizations a tool to mitigate this risk.

To get ahead of expected reimbursement changes and meet productivity goals.

When groups ignore APP performance measures, they can miss significant productivity gaps. For example, just because physicians are hitting work relative value units (WRVU) targets, the team as a whole could still fall short if APPs’ effective WRVU production is below average. Without tracking the appropriate metrics, the organization will never know.

This principle remains true under any performance standards. Many health groups are already moving away from WRVUs and toward panels and other patient-population measures. They’re learning how to manage panels, risk adjust, and use a patient population as the basis for managing productivity and compensation.

If APPs are optimally utilized by physician providers, they’ll be seeing some of these patients and thus be an active part of a larger care team.

If organizations are moving physicians to value-based compensation plans, it only makes sense to move the other providers who also affect productivity and quality the same way.

In turn, going toward panels allows these organizations to get ahead of the curve on other expected reimbursement changes.
To reduce the overall cost of care.

The overall funding pool should remain at neutral after shifting to value-based compensation, so the APP’s paycheck will be the same at the end of a year if they hit all expectations. Further, not all of the paycheck will be subject to value-based metrics; moving to a different type of plan would simply put some percentage of the base salary at risk. Thus, the transition is not necessarily a change in total dollars paid out, just in how it’s structured. In fact, the changeover may be more a matter of behavioral changes.

By holding more people accountable to the quality of care that is delivered, organizations can:

- Reduce the cost of care.
- Expand capacity for care and therefore see more patients.
- Potentially reduce costly readmissions.
- Provide a low-cost alternative for less complex care.
- Enable physicians to use their time for more complex care, increasing efficiency.

On that last point, APPs reliably improve physician productivity.

This also speaks to the second issue described above (i.e., APPs’ impact on organizational risk). Used appropriately to complement physician providers, APPs can help the group as a whole to improve on quality and patient outcomes.

If the group is more efficient in working with their patient panel, they can respond faster to patient needs, spend more time with individual patients, and be more thorough in their work.

“That will ensure that the patient doesn’t bounce back into the hospital,” says Tommye Austin, Senior Vice President and Chief Nursing Executive at University Health System in San Antonio.

Especially for low-complexity cases, APPs are absolutely the right cost-effective alternative; however, to achieve these outcomes, groups must ensure that they’re using APPs effectively. Most are not.

- Many organizations use APPs as glorified nurses, secretaries, or residents, but they’re more expensive than nurses.
- APPs are providers and their role “should be equivalent with provider responsibilities.”
- If they’re not used effectively, the whole model fails.
How should organizations pursue this transition? Two critical pieces are needed: the right technology and a smart strategy.

One of the barriers to establishing value-based care is the lack of suitable technology.

In order to manage these performance-based incentives, medical groups must be able to track metrics like response time, readmission rate, patient satisfaction, and much more.

As with physicians, without the technology piece in place, it’s prohibitively difficult to manage; you can’t pay on what you can’t measure. “Value-based care is not just about capturing data to meet requirements,” says Gerald Maccioli, MD, Chief Quality Officer of Envision Healthcare, a provider of physician, home health and ambulatory surgical services. “It’s about ensuring we’re capturing the right data and analyzing it in a way that drives continuous quality improvement, increased efficiencies and cost savings.”

Without the right technology, the complexity of compensation will undermine any effort.

Paying physicians is no simple task; while a compensation plan geared toward an APP will not be as complicated as a physician-type plan, it will certainly have some degree of complexity that must be managed. With physicians, different pay elements end up living in some combination of divergent places—email, spreadsheets, PDF files, calendar entries, and even plain paper notes. That approach is prone to error, delays, and confusion; an organization’s APPs will not thank their employers if they are moved to a compensation plan that is more difficult, less reliable, or less transparent than their previous experience. A consolidated platform that can capture and present all relevant information is crucial (see figure below).

The right technology can help groups capture and manage all relevant pay elements within a single, consolidated system.
It’s key to be able to track all pay elements in a transparent and accessible manner.

The infusion of the new model will likely raise some discomfort with the APP group. Proactively sharing the benefits of the new model through modeling their new plan against the existing will be essential. That requires transparency, which makes all the difference in successfully moving APPs to physician-type compensation plans. It is only through leveraging the appropriate technology that a group will be able to ensure this “new normal” is appropriately communicated, measured, and adjudicated. Groups must eliminate the opportunity for error, build complete auditability, and deliver total transparency into this new world through technology.

Then, to be effective, the transition needs to be handled strategically.

The end result of moving APPs to value-based compensation should be that doctors are made more efficient and productive with their time. The new situation should allow them to see the highly complex patients while appropriately deployed APPs focus on managing lower acuity patients, routine follow-ups, and other critical practice activities. However, this requires (1) care in planning, (2) balancing the current structure of the team, and (3) preparing and appropriately incentivizing all providers to function well as a team. A poorly implemented changeover could result in unhappy physicians and underutilized APPs who fail to meet their potential in a value-based reimbursement situation.

Every case will be different, but a rough strategic approach requires a multistep process. Foundationally, groups should start by reviewing and understanding how APPs are being used now, so a standardized process can be created around the job description to ensure they’re being utilized effectively. Currently, APPs are utilized in a variety of ways in the healthcare industry, many of which are suboptimal. APPs may not be able to replace physicians, but neither are they just glorified secretaries or nurses. Complicating matters, APPs frequently function inconsistently even within the same organization. Similarly, it’s important to look at physician providers as well. Physician behavior and incentives will also need to change, particularly in how they use their assigned APPs, and their interests will need to be considered. For example, in most organizations where APPs are paid a flat salary, physician providers can bill for services that are actually rendered by the APPs. Thus, physicians may be wary of any program that could potentially take dollars out of their pockets.

To alleviate such concerns, incentives should be introduced to physician providers that allow them to focus on other important activities, such as organizational and financial sustainability, patient management and panel management, expense management, and any other criteria that can reduce the focus on WRVUs.

Once the APP and physician roles have been clarified, it’s time to craft documentation and an implementation timeline around the change management. With that in mind, administrators should meet individually with APPs and collaboratively develop value-based performance criteria that are important to them and benchmarks they feel they can meet in the first three years.

These changes should not be rushed; that would increase the risk of error and damaged morale. Instead, a carefully plotted multi-year rollout can ease the process tremendously and facilitate a successful outcome. Consider the following breakdown:

**Year One:** Begin by simply tracking the proposed measures, creating a shadow model to identify any changes at the individual physician and APP level through a technology component.

**Year Two** Phase in the identified, tracked components, after a full year of just monitoring and getting comfortable with the measures.

**Year Three:** Achieve full implementation for both the physicians and APPs.
Regardless of how APPs are compensated, medical groups need to start monitoring quality in this group of providers because they are affecting overall revenue.

Indeed, the impact of APPs on the financial fortunes of their employers will only grow as they are used more meaningfully throughout organizations to complement the shrinking population of physician providers.

That may be unsettling on the surface, but this situation is an opportunity for medical groups to pull all their providers in alignment with their quality- and value-driven expectations. In the process, organizations may well be able to reduce the overall cost of care while simultaneously expanding their capacity to see more patients in a timelier way and making the remaining physicians more efficient and productive. After all, in a physician shortfall, the remaining physicians become more valuable than ever. Their employers should do everything possible to ensure they can focus on the work that only they can do, like spending their time with the higher-acuity, higher-complexity patient cases.

But bringing APPs into this form of compensation model is not as simple as flipping a switch. It requires laying the right groundwork, implementing the right technology, and phasing in the changes in a provider-friendly way that generates buy-in rather than turnover.

The only question is, when your organization choose to transition to a value-based approach to APP compensation, will you be prepared?
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ECG Management Consultants addresses the critical challenges facing the healthcare industry. Simply put: we’re problem solvers. Through more than four decades of experience, we’ve learned that successful problem solving requires deep industry knowledge and expertise, rigorous data and analytics, strategic foresight, political and organizational savvy, and most important of all — practical solutions that get implemented.

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References