ADVANCED PRACTICE CLINICIAN PAY – WHAT’S HAPPENING AND WHAT’S COMING
As health care organizations prepare to respond to physician shortages and a shift to outcomes versus productivity-based reimbursements occurs, a common response is to employ more Advanced Practice Clinicians (APCs):

- In theory, APCs can be “more cost efficient” than physicians on a straight salary basis or even when paid base salaries and incentive compensation.

- Because their time is less expensive, they can be leveraged to do more time-consuming patient education, patient monitoring and follow-up tasks that can improve outcomes while freeing physician time for direct care or managing more complex patients.

In fact, demand is increasing. According to Sullivan, Cotter and Associates, Inc.’s 2011 Physician Compensation and Productivity Survey, over half (59 percent) of survey participants have increased the size of their APC workforce within the past 12 months. Of these, the average increase was seven APCs. Sixty-one percent of survey participants indicated that they plan to increase the size of their APC workforce in the next 12 months. Of these, the average increase will be six APCs.

Salaries are trending up as well. For example, data from the American Medical Group Association’s (AMGA’s) 2011 Medical Group Compensation and Financial Survey show salaries for primary care Nurse Practitioners (NPs) went up approximately 8 percent at the market median over the two-year period between 2009 and 2011 (from $86,841 to $93,642); Physician Assistants (PAs) in medical specialties salaries went up approximately 9 percent over the same period (from $90,151 to $96,575).

These salary increases, however, stand in contrast to what NPs and PAs just entering the workforce are expecting. An organization that attended graduations this spring for large PA and NP programs reported that PAs were being told to expect a starting salary of $120,000. The NP graduates were told a less optimistic starting salary of $98,000.

The different expectations being set by the two programs are almost as disconcerting as the salary levels quoted – both well above reported salary range medians. These expectations are frequently reinforced by APC professional associations in articles and on websites.
For hiring authorities, this creates real challenges when balancing the need to hire more and more APCs while dealing with salary levels of current staff which may, despite years of experience, lag the expectations of the new graduates. In these situations it is critical to be prepared with accurate market competitive data and a strong recruitment strategy that focuses on additional factors (beyond base salary) for choosing your organization.

So what are those additional factors?

**TO PROVIDE INCENTIVES OR NOT TO PROVIDE INCENTIVES?**

While the majority of health care organizations do not offer individual performance bonuses to APCs (less than 15 percent of organizations according to the Integrated Healthcare Strategies’ 2011 Advanced Practice Clinician Survey), the data are likely affected negatively by the number of hospitals that responded to the survey compared to the number of physician group practices. Overall, hospitals are less likely to provide incentives than group practices.

**It may seem that, with the movement from encounter-based to outcomes-based reimbursement, offering or developing productivity based incentive plans is counterintuitive. However, SullivanCotter cautions against abandoning these programs or rewards too quickly. There is still significant value in measuring and rewarding for productivity as long as the following conditions are true:**

1. Productivity isn’t the only incentive plan measure. The best plans include measures and rewards for other components such as patient satisfaction, compliance with established protocols, participation in process improvement activities and good citizenship (timely charting, referrals, etc.).

2. The plans make economic sense. You would think this would be intuitive, but we have seen plans that have paid PAs 80 percent of the pay and incentive provided to their supervising physician – even when the physician was a neurosurgeon.

3. The plans don’t set up a competition between the physicians and APCs. No APC should be influenced by a bonus plan when deciding whether to refer a patient to a physician.

4. The design doesn’t violate regulatory requirements. The following is according to legal guidance provided to SullivanCotter:

   a. There can be private inurement from an Internal Revenue Service (IRS) perspective if APC compensation is above fair market value (FMV).
b. Because APCs order items or services that can be reimbursed by Medicare or Medicaid, the financial arrangements with APCs do implicate the Anti-Kickback Statute.

c. Although Stark does not apply to APCs directly, as Stark is targeted only to physicians, if a hospital has an agreement with a physician organization and some of the contracted services are to be performed by an APC, Stark can be implicated.

Of course, there can be another regulatory issue if an APC’s productivity is “added” to that of a physician’s in order to calculate the physician’s productivity bonus.

**WHAT ABOUT THE WORK ENVIRONMENT?**

The level of physician support for APCs in an organization, as well as the level of independence APCs are allowed, can be a source of satisfaction or dissatisfaction for an APC. The physicians need to view APCs as partners and not competitors or an added burden.

Stipends for APC oversight and team-based reward systems can go a long way in addressing this issue, but ultimately it’s a matter of an organization's culture whether APCs will feel they are valued.

**Of course, state practice laws will also determine the level of APC independence and it appears the trend is toward more APC independence. The following are examples:**

Nurse practitioners in Virginia have been lobbying for autonomy in practice for more than two years. Currently the law requires that doctors supervise and direct NPs and until very recently physicians in Virginia had resisted any changes to the law.

The proposed changes would require NPs to work in teams led by physicians, which would provide more flexibility in coordinating patient care and the bill being written would allow for electronic collaboration.

On April 4, 2012, Nebraska’s unicameral legislature cast the final vote to approve changes to the law that will allow PAs to order respiratory therapy when delegated by the supervising physician.

Finally, what other factors will APCs consider in assessing the rewards an organization offers? Pay for evening, night and weekend shifts, being on-call, working extra shifts - these “extra” pay offerings cut two ways. They may be perceived as valuable to the APC, but can also reduce the value proposition for the organization. It is not uncommon for
SullivanCotter to find, in helping a Client catalogue all their special pay practices for APCs, situations where pay for these “extras” has driven take home pay up more than 25 percent above the base salary.

WHAT’S NEXT AND HOW TO PREPARE?

The growth in demand for APCs will fuel competition and thus salary increases. The need to balance salary costs against reimbursement will (for forward thinking organizations) provide opportunities to reward the best performing APCs and health care teams.

The best strategy is to have a strategy. That may require assessing what you are doing now in terms of base pay, extra pay, the work environment and in comparison to market practices and trends; getting the key stakeholders together to identify what’s good, what’s working and what is not so good about what you’re doing; establishing a total compensation strategy; and articulating and implementing that strategy in a way that provides a true competitive advantage.