An HR perspective

Nothing but change for healthcare industry stakeholders

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Contents

We're all in this together: Nothing but change for healthcare industry stakeholders

By Hector Mislavsky and Sandra Hunt

Health care organizations today find themselves amid transformation on numerous fronts: everything from merging provider organizations to converging providers and payors to changing compensation models. Many of these changes are starting to reflect an Affordable Care Act America, along with more general shifts in the US healthcare industry—all of which yield implications for stakeholders across the board, including executives, employees, and physicians.

A prescription for mastering today's talent challenges

As organizations grow larger and more complex in a sea of mergers and acquisitions (M&A), entities' ability to attract and retain key executive leadership and other critical talent can be a make-it-or-break it factor in meeting deal objectives. To stay on track, you need to be strategic and proactive and work to encourage and nurture a "We're all in this together" outlook.

Effective compensation models are central to securing the talent you need to succeed, both at the executive and physician level and across all other employees. A thorough evaluation of compensation policies in light of a merger presents opportunities to assess how the payment policy encourages newly desired behaviors to move the entity forward sustainably.

Notably, these models are moving away from volume-based payment approaches as organizations seek to reward behaviors in recognition of the importance of quality care, patient satisfaction, and overall contributions to the organization in determining how to distribute available revenue. These changes can be challenging for AMCs—particularly when they merge with non-AMCs. We also see implications for physician compensation as it goes from a fee-for-service or salary approach to one that's based on the wide array of elements healthcare organizations consider in their attempts to shine in an increasingly competitive marketplace.

Learn more about the many factors that must be taken into account in the bid to craft an effective merged compensation strategy and for insights into the steps organizations can take to tackle related challenges.

In this issue of An HR perspective, we'll take a close look at:

- Resourceful: The people power behind M&A success
- Executive decisions: M&A implications for top talent
- The best medicine: Physician compensation and patient-centric care
- AMC faculty compensation: The challenges of multiple mission priorities and the strategic alignment opportunities they create

Read on for an in-depth view into how organizations in the healthcare industry can get ahead of the trends, target top talent, and achieve their mission-critical goals to pull the potential from their deals—without derailing deals, or losing sight of quality care, long-term goals, and sustainable success.

Resourceful: The people power behind M&A success

By Steven Slutsky and Ashra Jackson

Intense transactional activity in the health-care sector presents newly merged healthcare providers, their stake-holders, and the industry itself with the potential to position themselves for significant cost-savings and strategic advantage.

As organizations strive to seize these opportunities, they often move quickly through pre-transaction due diligence and post-transaction integration processes.

But the pace of change can come with a cost, the short timing precluding human resources issues from getting the thoughtful and thorough consideration they deserve. The environment is rife with examples of transactions that fail to meet their strategic objectives because of human resources-related challenges, including dissimilar cultures, dissimilar compensation (pay philosophies and pay structures), and loss of critical talent.

Given this fact, during the due diligence stage, HR professionals should take the time to:

- Assess the respective organizations' current human resources programs, policies, and practices
- Consider the potential new healthcare provider's human resources policies and practices
- Begin to develop a process for getting to the desired future state

We'll focus on one human resources-related area, broad-based employee compensation, for healthcare providers to consider during the due diligence process and the post-transaction integration phase.

The due diligence process

During this process, the array of pay structures, programs, and practices are collected from the respective healthcare providers and critically assessed. Pay practices analyzed would include:

- Salary structure and ranges/grades
- Pay mix among base salary, annual incentives, and other forms of compensation
- Perquisites and other similar benefits
- The market-competitiveness and cost of the programs

This current state assessment lends insight into the way the healthcare providers differ in compensation philosophies and pay structures, the performance culture, and the competitiveness of similar positions to the market. At the same time, it reveals potential barriers that might arise in the post-transaction environment.

In addition, the plans and programs are typically reviewed for compliance with applicable employment laws and regulations.

Without a thorough assessment of the compensation programs and practices, the buyer risks taking on more liabilities than expected. Understanding all elements of the target's compensation program separately and its total overall value helps the buyer determine how the overall package mix can be adjusted to better align with the post-transaction healthcare provider's program. For example, common compensation elements for the buyer to review include answering these questions:

- Does one healthcare provider provide higher base salaries for similar positions?
- Does one healthcare provider offer extra pay (e.g., shift pay, on-call pay, weekend pay) or

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have different policies and levels regarding the extra pay?

- Does one healthcare provider offer bonuses to a larger employee and clinical population?

The cost implications of potentially modifying, eliminating, or adding an element to the compensation program is analyzed by the buyer. Also, conducting preliminary financial cost modeling during the due diligence process aids the buyer in determining the most appropriate compensation program for the post-transaction healthcare provider. As most compensation elements interconnect, the buyer needs to consider and address how a change in one element of compensation affects other elements.

Base salary review

If salaries vary significantly between comparable positions, the buyer faces the challenge of determining if the healthcare provider with the higher (or lower) salaries should be adjusted. For example, will employees with higher salaries receive lump sum payouts or no increases to their salaries while the healthcare provider with the lower salaries receive merit increases, until the salaries are relatively consistent across comparable positions? When weighing the alternatives, the buyer generally addresses the cost of the options and how a potential change might affect employee trust, retention, and motivation.

Shift pay and special pay review

In light of the various ways nurses and other clinical roles may be compensated, differences in extra pay (e.g., shift work, evening and weekend premium pay, on-call pay) are also examined in the due diligence process. This review is particularly important if the buyer doesn't offer extra pay and the target does, and if the buyer wants to eliminate the extra pay element. Absent appropriate communication, the target's nurses and other clinical roles may view this as a pay decrease.

In these cases, the buyer considers how it will modify, eliminate, or fade away the extra pay. For example, the buyer can develop a special compensation arrangement with the target employees and integrate them into the buyer's salary structure over multiple years. Or the buyer can provide decreasing quarterly or monthly lump sums for up to a certain number of years to replace the extra pay and provide a "soft-landing" for a period of time. Financial cost modeling will help the buyer review the alternatives and their associated costs and implications.

Alternatively, the buyer can include the extra pay as an element of the post-transaction organization's compensation program. Given the potential financial impact, the buyer often first considers its post-transaction operating model and analyzes the size of the financial impact before deciding what changes to make.

Incentive pay review

Other compensation factors evaluated between the healthcare providers include the target incentives, the performance metrics used to determine the annual incentives, and actual payouts compared to target opportunity. The buyer should understand the target's eligible employee population, the culture concerning pay-for-performance and bonuses, and the level of discretion available to managers in determining bonuses for direct reports.

With regard to long-term incentive pay, the eligible employee population may differ significantly between the two entities and employees of the target may not be eligible to receive a long-term incentive award under the buyer's compensation program. Many buyers review the target's historical award values and the form of the award to gain insight into how the target employees may view potential changes.

Another important consideration is the way in which the changes to the annual and long-term incentive plans will be communicated to employees, particularly if significant changes are contemplated. The buyer may want to consider if and how the target employees can or should be compensated for the loss of this element of pay and the most appropriate means of communicating changes to them.

Severance pay

It's critical to understand the providers' severance provisions, given their cost implications. If the organization is thinking about eliminating positions or laying off employees in the transaction, the costs of those actions should be considered and included in the budget.

Cost implications can include:

- Base salary continuation
- Bonus or special payments
- Healthcare and other benefits continuation
- Long-term or other deferred compensation payouts
- Outplacement assistance
- Perquisites continuation

Many severance provisions continue post-transaction, so their terms need to be read carefully. For example, the target's employees may be protected from termination for up to one year following the transaction.

Post-transaction integration

Once the transaction is approved, the organizations enter into the transition and integration phase, where the human resources professionals from the entities develop the compensation philosophy to align with the strategic and business goals of the newly merged healthcare providers.

The due diligence process typically gives the providers a basic idea of the compensation programs and elements of pay (e.g., extra pay, incentives) that need to be modified or eliminated to fit with the newly merged provider's philosophy and programs. Harmonizing multiple salary structures can be challenging and require planning, especially if it's difficult to add new positions or salary grades to the anticipated HRIS system.

If the legacy healthcare provider's human resources professionals have been laid off in advance of or immediately after the transaction, these issues grow greater still. A great deal of institutional knowledge about the compensation programs, especially regarding how they are administered and interpreted, may be lost when those individuals exit. It's therefore critical to collect the information during the due diligence phase. If it can't be collected during due diligence for legal or other reasons, many companies refrain from laying off these individuals until they have the necessary information, sometimes providing retention or stay bonuses to increase the likelihood of talent retention.

Base salary structure integration

Base salaries result in a significant increase in fixed costs to the new healthcare provider. Therefore, many providers assess the target's salary structure administration, including salary grades, ranges, and midpoints. During this review, it's determined whether the newly-combined organization will adopt one of the existing healthcare providers' structures and integrate employees into that structure, or if a new salary structure will be developed. The considerations about whether to create a new structure or integrate employees into an existing structure include:

- Whether one legacy organization is substantially larger than the other, so that fitting employees from the smaller organization into that structure creates less disruption
- The relative market-competitiveness of the existing structures and whether they need major changes to remain relevant
- The flexibility of the existing salary structures and administrative ease of using one of the existing structures
- Consistency of the existing structures with the compensation philosophy going forward

In addition to salary structure administration, the post-transaction healthcare provider typically analyses how salaries vary between similar positions within the organizations. The post-transaction

healthcare provider performs a job "cross-walk," in which one healthcare provider's positions are matched to the other provider's positions, based on job title and duties and responsibilities.

This "cross-walk" analysis aligns similar positions between the healthcare providers and shows which positions can be mapped easily to one of the salary structures, assuming an existing salary structure from the buyer or target will be used after the transaction. The positions that can't be matched to the salary structure because of job coding are noted during this review and a new job code can be developed.

The post-transaction healthcare provider also identifies which positions and employees are above or below the post-transaction healthcare provider's salary ranges and can analyze what to do in these situations.

In addition to determining the degree to which it will be challenging to recruit new employees for positions, the post-transaction healthcare provider can determine whether:

- All positions are going to remain in their present form over the longer-term
- The individuals in certain positions are expected to stay with the post-transaction healthcare provider for the foreseeable future
- It's critical to the post-transaction healthcare provider to retain certain individuals

The "cross-walk" can provide key information regarding potential unanticipated costs that need to be managed over the long term. It will further provide early warning about potential employee dissatisfaction developing when people who are working side-by-side in the same job are being paid quite differently.

Shift pay and special pay modifications

The post-transaction healthcare provider faces special challenges in handling extra pay elements that only one legacy organization provided. These can include:

- Shift differentials or premiums
- Degree or certification pay
- On-call pay
- Holiday pay
- Reporting pay
- Charge or supervisory pay
- Training pay

The post-transaction healthcare provider needs to consider the potential cost impact of providing the premium pay, as well as the impact of eliminating the pay on the employees' relative competitive pay positioning. Many organizations provide below-market base salaries, but make it up with premium pay items. These additional pay elements were popular over the last decade; however, current changes in the healthcare

The "cross-walk" can provide key information regarding potential unanticipated costs that need to be managed over the long term.

industry are leading providers to revisit these premium pay elements and whether the compensation programs can be simplified to reduce overall costs.

If these pay elements are to be eliminated, they generally are phased out over time. Employees typically see the removal of premium pay as a "takeaway," since it reduces their pay. In addition, these employees may fall below the minimum of the salary range without the additional pay, potentially requiring an increase in base pay. Some organizations will immediately move such employees to the salary range minimum, or at least phase it in with above-market pay increases over a multi-year period. Before deciding to move an employee to the salary grade minimum, a comparison of the target healthcare provider's positions, skills, abilities, and actual duties should be conducted.

Alternatively, if the post-transaction healthcare provider makes use of a greater flexible or contingent workforce, these premium pay elements may be appropriate, so that all appropriate employees may not be eligible for them. In this case, the healthcare provider must perform a detailed analysis of the cost impact on the organization and the individuals when including this premium pay based on the new workforce work schedule. Many employees, especially those who did not previously receive premium pay, may need to have their base salaries "red circled," meaning that they no longer receive regular pay increases. These individuals may receive a lump sum that does not increase their salary each year until the pay market catches up to their base salaries, or may be told that there will be no further annual pay amounts.

Communication

A key step and challenge in the transition and integration phase is communicating to employees the new compensation philosophy and program, especially if employees view the changes to elements of

compensation as takeaways. This can be done through town hall meetings, personal meetings, emails, and newsletters. The ability of managers and supervisors to disseminate information cannot be overlooked, as they are natural purveyors of information to employees and can use the organization's preferred messaging. Communications should focus on the reasons for the transaction and the potential benefits and opportunities it can provide to the employee. It's also vital that employees have a forum through which they can voice concerns and questions.

Consider HR in due diligence or risk losing talent and downing the deal

Ensuring that compensation plans, programs, and policies are included in the due diligence process will identify potential issues and barriers that may negatively affect the post-transaction environment.

By examining the differences in compensation plans and programs, human resources professionals can begin to strategize what the newly merged healthcare provider's compensation plans, programs, and policies should be and how the compensation philosophy and program can be tailored to meet the business and strategic needs of the post-transaction entity.

Post-transaction, the newly merged healthcare provider faces challenges in integrating or developing new compensation programs and structures and communicating effectively with employees. Taking smaller proactive steps, rather than giant steps, the buyer and the target can better position themselves to strike the right balance for deal success.

Taking smaller proactive steps, rather than giant steps, the buyer and the target can better position themselves to strike the right balance for deal success.

Executive decisions: M&A implications for top talent

By Steven Slutsky

As healthcare providers grapple with the ongoing increase in industry mergers and acquisitions, we see escalating executive-level focus on what might happen to their jobs and compensation in the face of a change in ownership. Concomitantly, healthcare provider organizations have a stake in motivating executives who survive the transaction and driving the right behaviors through the challenging transition process and beyond.

Boards of directors and executive teams now face two vastly different sets of challenges as they consider entering into a transaction and overseeing the operationalization of the newly combined entity. Prior to the transaction, executives may expect that the organization will guarantee them a "soft landing" economically to compensate them for their years of service, as well as to motivate them to make the transaction successful. After the transaction, the board and management team are challenged to integrate the organizations while moving performance forward—often a daunting task.

Before the transaction: Why should executives receive change-in-control protections?

Executives often have competing priorities when the possibility of a transaction arises. As those ultimately responsible for ensuring that the organization provides the best healthcare to patients and achieving the rest of the mission, executives are obligated to act in the best interests of the healthcare provider and other stakeholders, including patients, employees, admitting physicians, the community, bondholders, and others with a vested interest in seeing the healthcare provider successfully achieve its mission.

Executives' reward opportunities, especially those delivered through incentive plans and deferred compensation arrangements, are typically aligned with successfully achieving the mission and meeting stakeholders' expectations. This may include entering into a merger or sale of the healthcare provider, if it's in the best interests of the organization's mission, including goals such as such as continued high-quality patient care.

The uncomfortable truth, however, is that a transaction that's in the best interests of stakeholders may create a negative economic impact on executives. Quite simply, a transaction can result in the cessation of an executive's employment—and consequent loss of income. Executives may lose anticipated compensation even if their employment is not terminated, since multi-year cash bonus plans and deferred compensation programs may be eliminated. This underlying uncertainty can distract executives from their duties and lead them to consider searching for a new job "just in case."

Change-in-control protections are designed to eliminate these distractions so that executives can continue performing their normal job duties while helping the healthcare provider move toward a transaction while reducing personal livelihood concerns. These protections, also known as "golden parachutes," typically take the form of pay and healthcare benefits continuation while also protecting retirement and other deferred compensation programs.

Written protections are often found in employment agreements, special change-in-control agreements, or the terms and conditions of the

Contrary to the perception among some external stakeholders, executives don't typically receive large sums of cash as soon as the transaction closes.

compensation and benefits plans themselves. Assured of a financial soft landing, even in the event of employment termination, the executive can work on moving the healthcare provider toward the transaction in an objective manner. These protections also have the benefit of retaining key executives in the period before and immediately after the transaction, an arrangement that may be critical to making the transaction a success going forward.

Common change-in-control protections

Contrary to the perception among some external stakeholders, executives don't typically receive large sums of cash as soon as the transaction closes. Rather, most change-in-control protections today provide payouts only if an executive's employment is terminated in connection with the transaction; even then, the payouts are generally structured over time.

This is consistent with the intent behind most change-in-control programs, namely, to provide the executive with a soft landing in exchange for help in making the transaction a reality; they are not intended to provide executives with windfalls.

"Double trigger" change-in-control provisions

The most common such arrangement today, these directly assuage executives' concerns that if they do the right thing in bringing the transaction to fruition, they will not be left without a salary. Not surprisingly, therefore, these agreements require that there be a transaction—and that the executive's employment be terminated as part of the transaction.

The requisite job loss is often protected for a time running from shortly before the transaction up to one year (occasionally two years) after it. This is to keep both the legacy and the new healthcare provider from terminating the executive's employment a little before or after the transaction in an attempt to avoid making any payments.

Significantly, executives are often protected not only from actual termination, but also from "constructive" termination. Constructive termination, often called termination for "good reason," occurs when the healthcare provider makes a substantive change in the executive's terms and conditions of employment, so that the executive feels compelled to leave. If this were to occur, most change-in-control programs permit the executive to quit and still receive the change-in-control payments. Employment changes that can trigger "good reason" for quitting, and the resulting obligation to make change-in-control payouts include:

1. A substantive reduction in job duties or the executive's reporting relationship. Often, CEO agreements state that if the individual is no longer CEO, or no longer reports to the board of directors, this change constitutes good reason. This can be important, since legacy

provider CEOs typically no longer have the title or reporting relationship they had before, so that the healthcare provider needs to recognize that the legacy CEO may be automatically entitled to payouts. Similarly, if the legacy provider's CEO will become head of the new healthcare provider, the existing CEO also may be entitled to quit and receive payouts. This dynamic makes it critical for healthcare providers to understand the change-in-control agreements in the context of the expected future organizational structure.

2. Any reduction in compensation (e.g., base salary, incentive opportunity, perquisites) or benefits (whether healthcare or retirement). This can be an important nuance, since many organizations look to harmonize compensation and benefits programs, a move that may result in a natural decrease in some forms of rewards.
3. Requirement to move office locations outside of a reasonable commuting distance, usually expressed in miles.
4. Violation of any other provisions of existing employment agreements. Since employment agreements often provide for unusual arrangements, these need to be understood carefully. For example, we are aware of employment agreements that provide the executive with time off to attend college athletic events where their children are members of the team.

Double trigger arrangements balance the healthcare provider's objective of not making payouts to an executive it wishes to retain and keeping the executive from quitting just to get the payouts. Conversely, the double trigger motivates the executive to stay with the organization through the transaction, knowing that he or she will be protected financially if the organization decides not to retain his or her services.

Finally, the financial costs of the double trigger provisions also encourage healthcare providers to do a good job of determining in advance which executives it wants to retain, so that they do not unduly terminate employment relationships that they later determine they should have maintained.

"Modified trigger"

The modified trigger provision is still used on occasion where there is a concern that a transaction might result in an organization that does not have a mission or culture the executive believes in, or an environment where the executive does not enjoy working. As with the double trigger, under a modified trigger provision, there must be a transaction, but in this case, the healthcare provider does not terminate the executive's employment. Of course, if the executive's employment is terminated, he or she receives the change-in-control payouts.

The modified trigger provides an additional protection for the executive. The executive is given the opportunity to resign voluntarily for any reason after the transaction is completed and still receive the

payments. Although the executive can quit for any reason (or no reason; there is no requirement that the executive needs "good reason" to quit), the executive must work for the new organization for a defined period of time, typically six months-to-twelve months, before making the decision to resign, and then must make that decision within a specific period of time.

The advantages of the modified trigger arrangement include:

1. The assured financial stability helps retain and motivate executives during the uncertain period leading up to and immediately after the transaction. The incentive for the executive to provide his or her best efforts can be especially important to an acquirer wishing to obtain maximum value from the transaction once completed.
2. The organization must decide relatively quickly whether the executive is part of its plans going forward and, if so, act in a manner that persuades the executive not to resign and trigger the payments. Similarly, the executive must decide whether he or she wishes to continue a career with the organization.

Even if the organization doesn't wish to retain the executive long term, it still gets the benefit of the executive's services during the critical transition period; likewise, the executive receives sufficient financial protection to willingly assist in that transition.

"Single trigger" provisions

Single trigger change-in-control provisions provide the broadest protection to executives, but are very rarely used in today's governance environment, since they are considered a "giveaway" to management. A typical single trigger provides that an executive automatically receives payouts as soon as a change-in-control occurs. A related type of agreement allows the executive to resign at the time of the transaction, be re-employed by the healthcare provider the next day, and still receive payouts. Sometimes called a "golden bungee," this type of provision essentially permits executives to obtain the change-in-control payments without losing their job.

These single trigger arrangements can be highly disruptive if the healthcare provider wants to retain the legacy organization's executives. This forces the healthcare provider to choose between losing legacy executives and providing what are often extremely lucrative special compensation packages to convince them to stay.

Forms of change-in-control payouts

Once it's determined that executives should be protected in a change-in-control, focus shifts to the amount and form of payouts. The amount of payouts usually varies by organizational level. CEOs for example, typically receive change-in-control payouts that represent one year of compensation. (Some organizations

still provide up to two years of compensation, based on prior long-term employment agreements, but they have become less prevalent over time.)

Direct reports to the CEO and other executives usually receive lower payouts, cascading down based on the CEO's arrangement. These usually range from six-to-one year of compensation. These payout levels have been trending downward over the last few years, from a time when CEO benefits typically were at least three times existing compensation, and most of the management team received payouts of one-to-three years of compensation.

These reductions in change-in-control benefits were driven by two main factors. First, Internal Revenue Code (IRC) Section 4958, known as the "Intermediate Sanctions" legislation, requires compensation levels, including change-in-control payouts, to be "reasonable" based on market-competitive practice. Second, the economic downturn and changes in industry financials made it difficult for healthcare providers to afford these higher payout levels.

Payouts tend to be in four forms:

1. Salary (and sometimes bonus) continuation
2. Accelerated vesting of long-term incentive and deferred compensation arrangements
3. Benefits continuation
4. Outplacement and similar items

Let's take a closer look at these.

Salary and bonus continuation: Many healthcare providers provide only base salary continuation, and not bonuses, on the theory that only base salaries are "guaranteed," and since bonuses should be performance-based, they should not be paid, as future bonuses cannot be "earned." Most organizations, however, include some form of bonus continuation, based on the theory that bonuses are part of an executive's "expected" compensation, and therefore should be included. (If the transaction occurs mid-year, most organizations pay out the entire bonus either at target, or based on performance up to the date of the transaction.)

Long-term/deferred compensation acceleration: Transactions rarely close in congruence with the close of a multi-year performance plan period, requiring healthcare providers to determine how to handle payouts under those programs. Using the theory that the transaction is in the best interests of stakeholders, healthcare providers typically determine that executives should not be penalized because the transaction occurred partway through the performance cycle.

Most organizations decide to accelerate the vesting of the long-term incentive plan and pay out the full amount in a lump sum at the time of the transaction. If performance goals must be met, organizations determine relative goal achievement at the time of the transaction and adjust the payouts to account for that achievement. Where relative performance

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cannot be determined, organizations typically assume target performance.

Deferred compensation arrangements such as Supplemental Executive Retirement Programs (SERPs) often require an executive to remain employed for a set number of years or until a certain age (typically retirement age) to receive the accumulated amounts.

Healthcare providers normally accelerate vesting and pay out the pro rata account accrual, under the theory that the executives should be rewarded for having stayed with the organization through the time of the transaction.

Benefits continuation:
Healthcare providers provide executives with the same health and welfare benefits that they were receiving before the transaction, under the same terms and conditions. The continuation period is the same as the base salary continuation period.

Outplacement and other items:
Healthcare providers make outplacement assistance available to executives who have lost their positions in a transaction on a fairly routine basis. Other perquisites, such as autos and allowances, are not typically provided once employment is terminated.

After the transaction

Once the transaction has closed, the healthcare provider faces the challenge of integrating executives and other employees, operations, patient care processes, and systems, all while retaining key employees and motivating the right behaviors. Setting the right tone with the executive team is critical to achieving the goals of the transaction while meeting the patient care mission and satisfying stakeholders. If the executive team supports the goals of the organization, the chances of success are greatly enhanced.

Three key compensation elements will engage the executive team and motivate them to achieve the organization's goals: annual incentives, long-term incentives/retention plans, and retirement/deferred compensation. In addition to these behavior-based programs, it's critical to get the base salary right for the new organization. Complicating the challenge is that all of these must stay within the requirements of the IRC Section 4958 reasonable compensation regulations.

Compensation philosophy

The first step is to determine the healthcare provider's compensation philosophy going forward. The new organization should not merely engraft the compensation philosophy from one of the pre-transaction healthcare providers onto the new organization.

For example, one healthcare provider may believe in a greater risk/reward profile and thus have lower base salaries and a greater incentive opportunity. Note that it may be difficult to introduce pay-for-performance

programs, including the relative reliance on merit pay and incentives, to executives who are not used to a performance culture and may in fact have been hired for skill sets that are not aligned with such a culture.

The compensation philosophy must be decided early on, since it forms the guiding principles for compensation program design. It also must be communicated to all executives, so that they know where the organization is going and can make reasoned decisions about their ability to fit in with the healthcare provider's culture into the future.

Base salary

It's often tempting for healthcare providers to default to keeping the same base salaries that the incumbents were receiving before the transaction. However, this strategy often backfires, mainly because executive compensation levels tend to be positively correlated with the size of the organization. This is because increased size often brings with it additional complexity and scope of business needs, requiring healthcare provider executives to demonstrate more advanced and new skills to handle the increased responsibility.

Healthcare providers that maintain base salary levels can find themselves with the following issues:

- Other healthcare providers of a similar size recruit away executives by paying them more money consistent with their market/size-based salary programs
- Executives leave because they are unhappy with being forced to take on more responsibility without a commensurate increase in pay
- Dissatisfaction and internal equity issues arise when the healthcare provider pays market-competitive base salaries to attract new executives from outside the organization

To avoid these pitfalls, healthcare providers need to analyze market-competitive levels for organizations similar in size to the post-transaction

organization. This analysis should take into account potential changes to the duties and responsibilities of the executive positions due to the transaction. The organization also needs to recognize that new positions may have to be created and that these need to be carefully slotted in the interest of internal equity.

Annual incentives

The most impactful—and trickiest to handle—compensation element is the annual incentive or bonus plan. Most healthcare providers have some form of executive incentive plan; however, even plans that sound the same often are administered differently. The form of the incentive plan, and the performance objectives used, will drive the healthcare provider's culture and its ability to meet its mission and stakeholders' expectations.

All annual incentive plans share the same underpinnings: executives receive compensation in addition to their base salary based on some definition of performance. In the case of an acquisition, it's fairly common to see the acquirer's incentive plan extended to include any executives who are being retained. In a merger of equals, healthcare providers often create a new incentive plan to reduce the friction of merely adopting one legacy organization's plan over the other.

Regardless of whether a provider decides to use an existing plan or create a new one, there are some key considerations to making the incentive plan as effective as possible. We'll look at these next.

The incentive plan should be consistent with the pay-for-performance culture

When combining multiple organizations, a healthcare provider should be aware that the legacy organizations and their executives may have different perspectives on the appropriate pay-for-performance culture and the role of the incentive plan in supporting that culture. The critical first step is to develop the philosophy that will guide pay-for-performance. The greater the desired pay-for-performance culture, the stronger the annual incentive opportunities and the more challenging the goals.

Executives who are used to a less performance-based culture may not recognize the need to focus on the stated objectives. More frequent communications about relative performance and the need to meet the stated objectives should be provided to those executives.

Similarly, executives may not be used to balancing the need to meet individual/functional goals with the need to meet the overall organization's goals and the mission. Executives with more experience with pay-for-performance plans should have objectives that include working more collaboratively with their colleagues, so the organization as a whole can be successful.

The incentive plan should focus executives on the desired behaviors

It's critical that the incentive plan motivates executives to demonstrate the desired behaviors. Combining executives from the different legacy organizations is guaranteed to result in a clash of behaviors and focus. The incentive goals, therefore, need to be carefully focused on how executives will achieve the combined organization's goals.

For example, where financial considerations are critical to the new organization's success, financial goals should be a key part of the incentive plan to help overcome executives' perspectives regarding the mission to the exclusion of financial stability. Similarly, where certain patient outcomes might have been lacking in one of the legacy organizations, patient care goals might take precedence in the incentive plan to demonstrate the importance of those objectives. Regardless of the desired behaviors, at all times the organization must not lose sight of the ultimate mission, and must ensure that the performance objectives support that mission.

Integration of the legacy organizations must be part of the incentive plan

Whenever one or more organizations are combined to form a new healthcare provider, there will be employees throughout the organization who are more focused on protecting their turf or on a "We never did things this way at the old place" mentality. Sending the message throughout the organization that there was a good reason for the transaction and that things must be done differently going forward is critical to the success of the transaction. This messaging starts with the executive team fully supporting the integration. One way to drive such support is to include integration milestones in the incentive plan, so that executives see the tangible rewards for their integration activities.

Long-term incentive programs

In any transaction, there are immediate integration needs and longer-term objectives. To the extent that the organization can define those longer-term objectives, a cash-based, multi-year long-term incentive plan may be appropriate. This has the dual effect of focusing executives on both short-term and long-term milestones, as well as providing a compensation-based retention tool so that executives are reluctant to leave knowing that there is a payout down the road.

Deferred compensation/ retirement programs

In addition to a long-term incentive plan, putting in place a deferred compensation or retirement program also may assist in retaining executives over time. These programs, which usually have vesting periods running from as little as five years to as long as through retirement age, result in a "golden handcuff," which

ties executives to the organization for many years.

However, if the healthcare provider's post-transaction perspective is that the executive team will be in flux as the organization assesses the executive talent, these programs can prove costly as executives are asked to leave the organization.

Therefore, the healthcare provider should balance the cash cost of payouts against the cost of losing executives that the organization wants to retain.

Reasonable compensation

Complicating a healthcare provider's compensation program design is IRC Section 4958, which requires that not-for-profit healthcare providers refrain from providing excess compensation to their executives. There is no specific dollar amount under Section 4958; rather, healthcare providers must analyze market-competitive practices at similar organizations and stay within those practices.

This becomes especially nuanced in a transactional situation, where special retention and other compensation programs may be required to create and motivate the right executive team. Healthcare providers should be careful to use the right comparator organizations for benchmarking market-competitive practices, and fully understand the impact of the the executive compensation programs to stay within these requirements.

Top talent in transitional times: Final thoughts

Numerous executive compensation issues arise in any transactional event. Executives are expected to take actions that provide the most value to stakeholders and are otherwise in their best interests. At the same time, executives need to know that they will be protected if they make decisions that are in stakeholders' best interests even when uncertain how those decisions may impact the executives own pecuniary interests.

When an organization decides to enter into a transaction, whether it's the target or the acquirer, it must analyze the executive protections to determine the effect on the transaction. Any potential impact from change-in-control or other similar programs should be identified and handled as early in the transaction as possible to reduce the impact.

Similarly, thoughtful development of the post-transaction compensation philosophy and programs should be developed and communicated as far in advance of the transaction closing as possible to boost their effectiveness. Transactions by nature tend to speed ahead at a breakneck pace. A little strategic thought and planning in advance, followed by careful follow-up early in the transaction process, can resolve most issues and keep the circle of stakeholders serene and the entity sustainable.

The best medicine: Physician compensation and patient-centric care

By George Batalis

As healthcare in the United States has moved toward providing care on a broader scale, compensation models, which have been in a state of flux over the past few decades, continue to shift, changing the focus from volume to patient outcomes. No longer is the goal to push through as many patients as one can per day. Physicians need to be rewarded for high-quality, patient-centric care.

A medical history

In the past, physician compensation was relatively straightforward, focusing on either:

- Straight salary guarantees
- Purely productivity based (encounters or relative value units [RVUws]) models

These models were simple and inexpensive to implement and made a lot of sense for small physician practices. But as convergence continues across the industry and cost reduction pressures increase, they no longer drive the correct behaviors among physicians. While this effort started with hospital providers, payors and providers alike are witnessing the need for physician involvement and buy-in for forging close ties between quality, efficiency, efficacy, and citizenship.

More recently, we've seen the development of physician compensation models that move to the other extreme:

- Models that focus purely on the hot topics of the day
- Models that attempt to take all behaviors into account, but result, instead, in diminishing returns

Such models can be challenging to manage and explain, not only to physicians, but also to CFOs and administrative staff. This can create a disconnect between physicians and the administration, an outcome that may have negative tangential impacts on many aspects of the practice.

Compensation model incentives need to be relative. As more and more incentives are added, given the same initial dollars to work with, the return on each of those incentives begins to dwindle. As values go down, physicians have more of a choice regarding where to focus their efforts to drive their compensation.

A new model for a new agenda

While many factors need to be considered in the development of a compensation model, most current models are designed to promote desired behaviors, including:

- Provide high-quality patient management and efficiency
- Increase participation in Patient Centered Medical Homes (PCMHs) and adaptation of the Advanced Care Model (ACM)
- Improve overall cost of care for the populations served
- Promote accountability for financial and operational metrics directly attributable to the physician or the center in which they practice
- Promote an environment of group communication and effectiveness
- Reduce reliance on a traditional 100% productivity-driven model while rewarding effective, hard work
- Build transparency and physician buy-in
- Develop a culture of citizenship

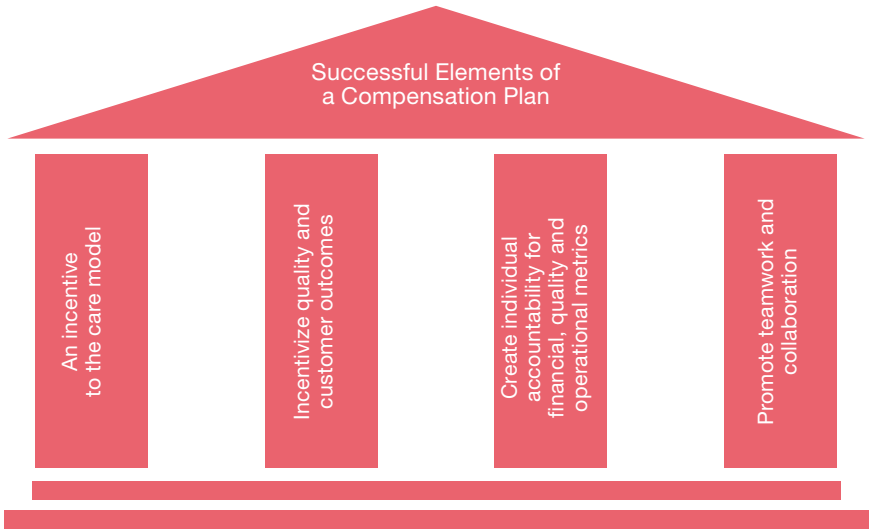
No longer is the goal to push through as many patients as one can per day. Physicians need to be rewarded for high-quality, patient-centric care.

Our experience suggests that these are positive components of a successful plan; however, there is a delicate balance between selecting a sufficient number of drivers to further strategic goals and diluting the pool to a point where individual drivers become marginalized or obscured.

Elements of a successful model

As illustrated here, four critical elements can underpin a successful compensation model in today's competitive environment:

1. **Align incentives to the care model.** Gone are the days of strictly rewarding physicians for pure productivity or by salary. Today's models should be base and incentive-based, with more compensation being put "at-risk" over time; as more goes "at-risk," the opportunity for additional reward also must exist.
2. **Reward for quality and customer outcomes.** The number one incentive driver in today's environment needs to be quality and outcomes. Many payors now go "at-risk" with hospital providers and large networks with respect to patient quality and outcomes reporting, hence the growth in alignment models between physicians and hospitals. At the same time, physician compensation models now need to be designed with quality and outcomes in mind.
3. **Create individual accountability.** Physician models will work by developing a baseline for selected criteria (quality, outcomes, access, and the like) for the group. Depending on where the baseline is set, some physicians will receive incentive payments while others may not. It's important to note that the incentives must be attainable for the vast majority of the group. If physicians don't believe they have a chance to earn the incentive payment, they will not put in the effort to change their behaviors. Experience has shown that while not everyone is immediately in the incentive bonus pool, 30%-to-35% are extremely close. By changing their behaviors slightly, they can be in a position to quickly receive the incentive payment.
4. **Promote teamwork and collaboration.** As these models evolve, they quickly become increasingly transparent. Physicians have access not only to their scores, but also to those of the group; by setting up dollars that are "at-risk" from an individual perspective and from a site or group perspective, the group can work more collaboratively and lift each other's performances. Similarly, citizenship is meant to encourage physician involvement, for example, by attending meetings and lectures, hosting community events, publishing, and appearing being in the news.



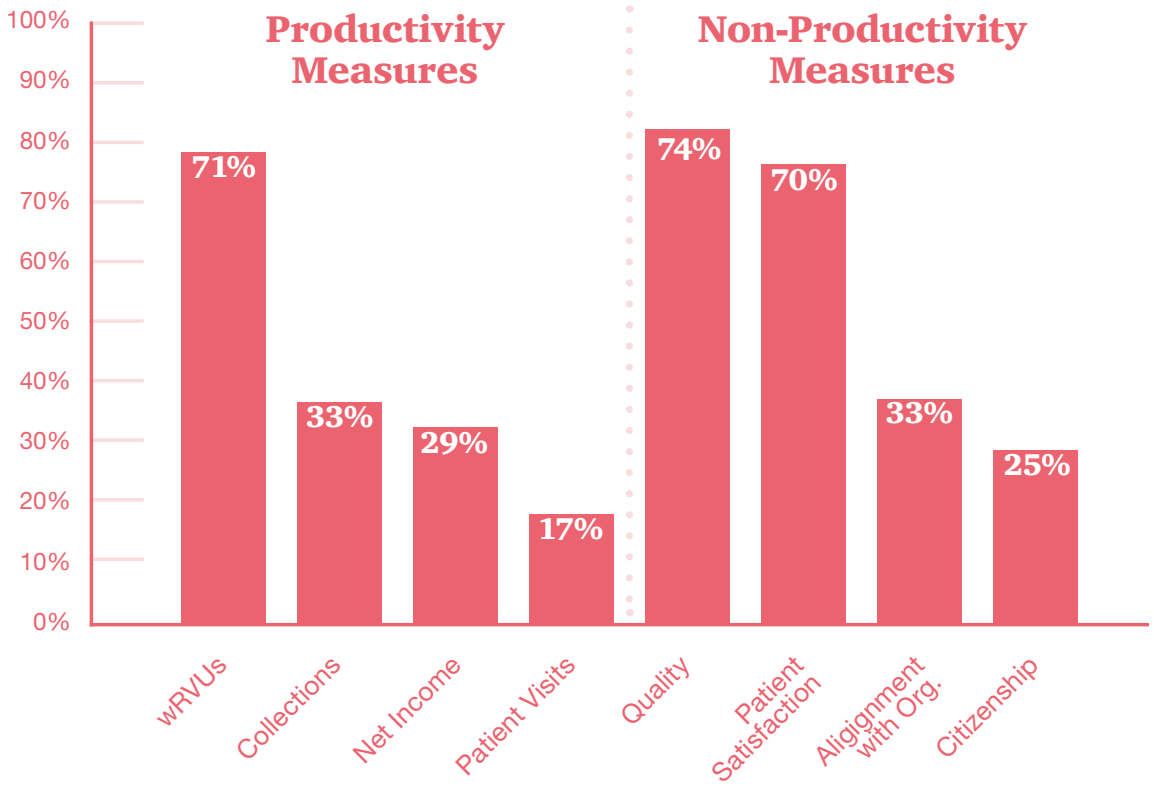
Changing sources of revenue

Current physician compensation models will have to evolve their incentives for medical groups to succeed, basing more of their incentives on medical management metrics and transitioning away from strictly salary or productivity.

We have identified three phases that health care providers tend to move through. One aspect of these phases is the idea of taking on risk-based contracting. As care providers move into the population health phase and risk-based contracts account for a substantial portion of practice revenue, physicians and administrators must work to change their culture to shift away from a focus only on productivity.

	Introductory Phase (less than 25% risk-based contracting)	Transitional Phase (25–50% risk-based contracting)	Population Health Phase (more than 50% risk-based contracting)
Current characteristics	• Majority of revenue coming from fee-for-service billing • Little need to address utilization and control inssues • Low productivity from one provider does not adversely affect other in the group • No risk for physicians with high utilizations.	• Organization begins to supplement fee-for-service revenues with prepaid revenues • Activities that were once profitable have the potential to negatively impact risk-based bonus payments	• Revenues are paid on a PMPM basis regardless of the services provided to the population • Tighter controls on expenses are necessary • Focus on care management is necessary
Challenges to Comp model	• Per procedure compensation models become problematic as organizations take on increasing amounts of risk • Transitional plans may be implemented as prepaid revenues increase and behavioral changes are necessary	• Physicians must be motivated to embrace the shift towards a risk-based environment to remain financially viable • Appropriate motivators have to be in place to reward desired behaviors under both a FFS and risk-based contracting environment	• Physicians must be motivated to operate in a 50% + risk-based environment • Productivity models need to be redesigned to align with the objectives of a population health management organization operating in a risk-based environment

Current versus future-state incentives	Current State Volume-Based Reimbursement (Fee-for-Service)	Future State Risk-Based Reimbursement (ACO / Shared Savings / Capitation and Quality-Oriented)
	Low financial accountability for cost of care	High financial accountability for cost of care
	Defines population as patients who present at doctor's office	Defines population as every patient in the provider organization panel, regardless of whether they present at the doctor's office
	Minimal infrastructure (technology, staff, data, etc.) to maintain more than the sickest / most complex cases	Must have infrastructure to manage the entire population
	Culture rewards volume and operational efficiency	Culture rewards optimization of cost and quality



Incentives commonly measured today

- Most physician organizations (84%) use incentive-based pay with an allocation of 80%-to-85% of salary and 15%-to-20% performance-based pay; Advisory Board suggests that at least 20% of total compensation is necessary to drive behavioral change
- Note that the majority of these groups are not in the population health phase
- Physician organizations need an advanced compensation model to derive value for patients and physicians in the future

It's important to note that these models exist on a sliding scale. As practices begin to make the shift between phases, it's common to see hybrid models that incorporate varying levels of productivity and outcome-based compensation.

Designing a model for the future

The future physician compensation model should draw upon past learning and experience and encourage and reward for the future behaviors the group is attempting to promote. Incorporating the correct blend of base and incentive compensation can make or break a model.

The base compensation component usually follows a more traditional route such as straight salary or wRVUs. The incentive component is intended to drive positive behaviors related to cost, quality outcomes, operational efficiency, patient satisfaction, access, and citizenship. These incentives may be based on individual results or the performance of the group as a whole. We have found that a mixture of group and individual metrics helps to build culture and accountability for the practice as a whole while continuing to emphasize the activities of the individual.

The following example of this compensation model illustrates how an organization can integrate large physician groups and arrive at a compensation model that's fair, provides an upside to the many, drives the desired behaviors, and can be foundational in the development of a new culture.

Additional issues for consideration

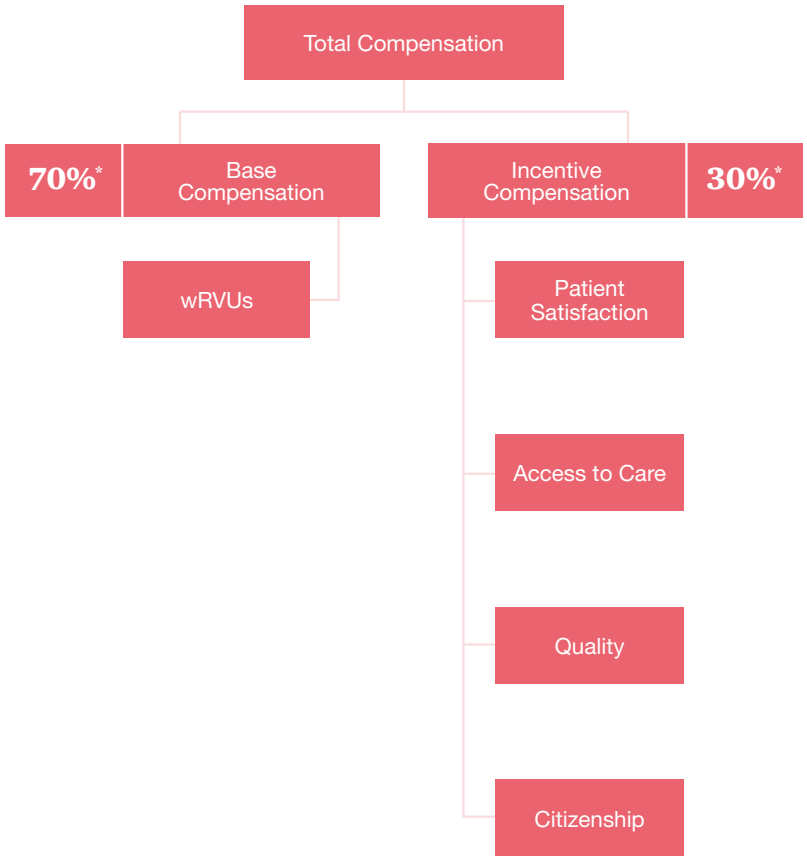
As with every model and situation, each group's needs and circumstances will help determine the final model. As physicians and groups make annual headway toward specific goals, those goals achieved can remain as part of the model or be traded out for new areas of focus for the group on an ongoing basis. Similarly, as healthcare reform and other practices come into effect, this model enables the group and physicians to achieve meaningful change and a more sustainable future.

While the subsequent model typically works for 80%-to-85% of physicians in a multi-specialty group, some specialties require their own models:

Hospitalists: As they are hospital based, they will initially tend to be salary based because they work mandatory hours and the number of patients they see on a daily basis tends to fluctuate. Their model should include incentives based on quality, outcomes, and readmissions

Radiologists: Their compensation remains largely productivity-prone. Finding ways to include them in the continuum of care and allowing for final outcomes will help drive final value.

Newly-hired physicians: Physicians just entering the group can range in experience and expectations and will have varying quality and outcome profiles, all of which should be taken into account.



* This is an illustrative example as the 70% and 30% weighting is an example but certainly not required.

Education is vitally important. All physicians will need to be fully educated on how the model will affect them and how they can alter their performance and up their game. Physician buy-in is another must-have. Without the support of physicians who have assisted in the development and direction of the compensation model, the model has a lesser likelihood of success. In our experience, when physicians sell this to other physicians, chances of the model's overall success increase.

Prescribing the right model

When designing a compensation model, it's important to take the time to adequately identify the areas of focus:

- What does the group want to accomplish?
- What are we aiming to build?
- How will this invest in our future culture and define our brand?

Answering these questions will create a target for measuring progress and provide a framework for selecting metrics and drivers. Working collaboratively, administration, physician champions, and communication is critical in the creation of a new model, bringing all parties into the process and keeping them involved.

Once the components of the model have been finalized, it's critical that physicians are fully educated about it. Understanding the model's components and what activities drive each element will help practices achieve their goals and succeed in today's increasingly complex healthcare economy.

Working collaboratively, administration, physician champions, and communication is critical in the creation of a new model, bringing all parties into the process and keeping them involved.

AMC faculty compensation: The challenges of multiple mission priorities and the strategic alignment opportunities they create

By David Church

Academic medical centers (AMCs), like the health-care industry overall, face a time of unprecedented change. Healthcare reform, reimbursement pressures, intensifying competition, rising capital and operating expenses, patient volume pressures, and the resulting financial challenges are forcing organizations to evaluate how they are strategically positioned in their market.

Questions that must be addressed include:

- How prepared is the organization to thrive in an environment where quality of care will increasingly drive more value than simply quantity of care?
- How will the organization maintain and grow market share, whether in a population-based, fee-for-service, or hybrid market environment?
- How is the organization competitively differentiating itself when it comes to market share, quality, and patient satisfaction?

Non-academic health systems look to AMCs to help answer these questions. AMCs strengthen critical elements of a non-AMC through the integration of large, multi-specialty practices at the leading edge of evidenced based medicine that augment or complement their existing medical staffs. This helps ensure the specialty/sub-specialty expertise and patient volume needed to excel in a consolidating, vertically integrating, consumer-driven, and population-based health environment.

In addition to the clinical challenges AMCs must address, the tri-partite mission priorities of research and education further influence the fiscal challenges they face, including:

- Competing research and education mission priorities influencing faculty effort devoted to patient care and potentially limiting clinical revenue
- Federal research funding in support of the science behind evidence-based medicine; this continues to stagnate and decrease in certain areas
- Increases in the number of graduating medical students to address the projected physician shortage without incremental GME funding to offset the residency training costs
- The rising cost of medical education, leaving the average graduating medical student with approximately $170,000 of indebtedness, potentially influencing subsequent specialty decisions based on future compensation and lifestyle, instead of community needs and interest

Determining the strategic path through this time of fiscal challenge and uncertainty has created an environment where AMCs actively engage in M&A discussions with other AMC and non-AMC health systems in attempts to better position themselves collectively for future success.

In the last several years, we've seen examples of prominent AMC faculty practice plans being acquired, employed by, or merged into a hospital's or health system's organization.

When mergers and acquisitions have occurred, ensuring an actively engaged and aligned faculty is critical to effectively addressing current fiscal and healthcare reform challenges. As with all M&A discussions, the determination of future revenues is central to whether a deal goes forward. In an AMC, this means faculty productivity and the resulting

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In an effort to maximize those future revenues by aligning the faculties' interests with those of the parent organization, compensation and incentives are seen as an important means of helping to build this alignment.

patient volumes and revenues they generate become a key determinant in the ultimate success of the venture.

In an effort to maximize those future revenues by aligning the faculties' interests with those of the parent organization, compensation and incentives are seen as an important means of helping to build this alignment.

AMC compensation challenges

Whereas private practice and community-based physicians focus exclusively on delivering patient care, clinical faculty within an AMC are committed to fulfilling a tri-partite mission of patient care, research, and education. Faculty effort in support of each of these missions varies considerably, depending on institutional priorities, interests, and financial resources, as well as the demands placed on faculty to perform the various administrative duties inherent to a school of medicine (service on the admissions committee, IRB, and the like).

The multiple mission priorities of clinical faculty need to be understood when entities merge and are establishing future financial projections and performance expectations. Several of these AMC characteristics include:

- **Clinical FTE (CFTE):** Whereas a community-based physician is considered a fulltime clinician (CFTE = 1.0), an AMC's clinical faculty will frequently spend less than 100% of their time focused on delivering patient care. Consequently, establishing productivity targets (e.g., wRVUs, revenues) must proportionately reflect accurate clinical effort.
- **Clinical teaching:** By definition, AMCs engage in the training of medical students, residents, and fellows. The opportunity to teach future generations of physicians can be a key factor in attracting clinical faculty to an AMC. The education, training, and mentoring of learners requires greater time and effort by the faculty—effort that could otherwise be devoted to patient care. While the amount of effort required will vary (e.g., the difference in effort required in supervising a first- or third-year resident is significant) recognizing and accounting for the effort required to fulfill this core mission is critical.
- **Translational and clinical research:** AMCs are at the leading edge of medicine precisely because of the translational efforts of research discovery from bench to bedside. Whether clinical faculty are the principal investigators (PI), actively engaged with their basic science research colleagues, and/or supporting patient enrollment in clinical trials, productivity expectations should reflect the value of these activities and make appropriate accommodations.
- **Large multidisciplinary practice demands:** Faculty practice plans that act as one large

multidisciplinary practice plan in support of an AMC's missions will, at times, need to invest in specialties that may not generate sufficient revenues to support themselves but that are critical to fulfilling their core missions. Examples of this may include ensuring sufficient pediatric or surgical subspecialties to provide adequate training opportunities; or requiring two trauma surgeons to satisfy the coverage needs of a level I trauma center, even if there is not sufficient volume to support their market based salaries. In a merged entity, greater scale may reduce some of the financial investments in these types of specialties, but fundamentally they would need to be supported consistent with AMC mission commitments.

- **Organizational Structure:** In an AMC, compensation plan design may reside with departmental chairs and not centrally with the Dean or practice plan leadership. While this may work well within some institutions, variability of compensation plans can lead to:
  - » Mission priorities being valued and compensated differently
  - » Questions of fairness, consistency, and transparency among faculty
  - » Faculty switching departments for higher compensation but unchanged productivity
  - » Poorly designed plans not aligned with institutional goals and objectives
  - » Faculty confusion, frustration, and anxiety about what is valued
  - » Uncertainty and delays in incentive payments that diminish effectiveness in the bid to reward desired behavior

Furthermore, a more centralized and uniform approach to compensation, often an M&A consequence, can represent reduced chair discretion and autonomy, resulting in disenfranchisement and dissatisfaction.

A compensation continuum

Another difference between an AMC and non-AMC environment is their historical approach to compensation. Typically, within traditional non-AMC clinical practices, compensation is a function of patient volume. More patients generate more patient revenue and thus, more income once practice expenses were covered.

However, several factors inherent to many AMCs do not support this traditional income generation model. Disproportionately high uncompensated care can mean more patient volume but lower or no revenue. Scholarly efforts in education and research are mission critical, but divert attention away from patient care activities and the generally higher revenues they generate. Offering a guaranteed salary within an AMC, protected by tenure or historical precedent, has traditionally been seen as a means to recruit and retain accomplished faculty who forgo a more lucrative private practice model for the ability to

Private Practice Approach	Guaranteed Salary
Faculty compensation directly correlated to revenues generated minus practice expenses	Faculty compensation established based on organizational, specialty, and market characteristics subject to periodic review and adjustment

Pros

Private Practice Approach	Guaranteed Salary
Higher productivity increases revenue/ income and thus faculty compensation	All patient payer classes viewed similarly from an access to care perspective
Incentive exists to minimize expenses in order to maximize income	Faculty supported in pursuit of research, education, and training missions regardless of revenue generation
Health systems benefit from increased downstream referral volume	Adequately compensates specialties that cannot generate sufficient revenue on their own due to volume and/or reimbursement, but that are necessary to an AMC's education, training, and service missions
Allows opportunity to offer competitive compensation relative to community-based physicians	Removes detrimental income opportunity costs of collaboration
Quality may be assumed for high producers even if it may not necessarily be directly correlated	

Cons

Private Practice Approach	Guaranteed Salary
Compensation directly correlated to payer mix creating disincentives to treat unfavorable or unsponsored payer classes	Removes monetary incentive to be highly productive
Dis-incentivizes cross-mission subsidy or non-clinical efforts that create AMC differentiation in the market	Potential competitive disadvantage relative to private practice income generation ability
Dis-incentivizes time consuming and lower reimbursed cross-specialty collaboration at the expense of improved quality, outcomes, and patient satisfaction	Quality and outcomes not a factor in determining compensation
Hospital-based specialties dependent on referring physicians with limited ability to increase volume on own	Typically a hierarchical environment that may prove discouraging to junior faculty

pursue academic goals with financial security.

The table to the left outlines the ends of this compensation continuum, from highly variable (e.g., traditional private practice) to guaranteed (e.g., traditional AMC environment)—and the corresponding pros and cons of each approach.

Despite these many challenges and approaches to compensation, successful practice plans have been able to offer competitive salaries because of faculty who are willing to collaborate and cross-subsidize across practices and missions with constant attention toward mission and revenue aligned productivity. Examples of mission priorities that align with revenue sources include:

- Clinical productivity that generates patient or contract revenue
- Research productivity that results in extramural grant revenue
- Education productivity that efficiently allocates tuition/training funding

Alignment and collaboration support overall high-quality patient care, subsequent market distinction, patient demand, and resulting reimbursement premiums that collectively benefit the AMC and its faculty. Funds flowing from the affiliated hospital/health system benefiting from alignment with a successful practice plan (e.g., for medical directorship, program administration, call coverage, charity care) can further support the faculty practice. By successfully aligning faculty compensation with AMC mission priorities valued in the market, AMCs have been able to generate sufficient revenue to reward performance.

As AMCs and non-AMCs consider merging, a clash of cultures and productivity expectations can arise when the multi-disciplinary nature of faculty group practices and their competing but complementary mission priorities are not well understood.

Establishing guiding principles

Establishing a common set of goals and objectives or guiding principles with respect to faculty and physician compensation is critical in order to articulate the rationale behind an acquisition, as well as to create the foundation upon which performance will be measured and compensated. While some AMCs still ascribe to a fixed or guaranteed salary, we see a national trend toward more performance-based compensation plans.

In contemplating a merger and creating the desired organizational and faculty alignment, it's important to consider not only those traditional factors driving clinical reimbursement (e.g., visits, procedures) and new factors of increasing importance (e.g., quality), but also factors consistent with the AMC's other mission priorities (e.g., research funding, education/training efforts).

The evolving economic environment demands a thoughtful approach that reflects the complexity of faculty practice and is guided by a set of principles providing the foundation upon which more specific compensation policies can be established. Examples of guiding principles to incorporate into a faculty compensation plan include:

- Strive to be uncomplicated, understandable, fair, and transparent to participants
- Provide incentives to encourage not only clinical productivity but also teaching and research productivity
- Provide incentives to improve quality and efficiency
- Make funds available to support programmatic priorities and faculty development
- Offer adequate compensation to attract and retain outstanding faculty
- Be responsive to changes in the market

Once compensation principles consistent with the goals and objectives of the acquisition are established,

specific compensation goals and policies can follow. Depending on the merged parties' expectations (e.g., maintain, grow), their existing compensation plans (e.g., guaranteed, incentive based), their approach to management (e.g., centralized, decentralized), and their willingness to implement and manage change, a compensation plan can be developed that aligns with the guiding principles.

Targeting desired compensation

Determining an overall level of desired compensation is a necessary first step in establishing a faculty compensation plan. Most AMCs have a stated goal of compensating their clinical faculty consistent with specialty and market demands. The AAMC Faculty Salary Survey is a commonly used source for benchmarking faculty compensation, given the AAMC's targeted focus on surveying only faculty associated with the nation's medical schools.

Other benchmarking sources are sometimes used for comparison purposes (e.g., Sullivan & Cotter, MGMA) along with certain specialty associations (e.g., AAAP) that conduct their own surveys. On a cautionary note, using disparate sources within one institution can become operationally challenging to monitor and adjust year after year.

Targeting faculty compensation to a specific benchmark will be specific to the market and AMC circumstances. While many AMCs do not want to pay at the lower end of the scale in order to be able to recruit the caliber of physician desired, nor do they aim to pay at the highest end of the compensation scale, given financial, academic, cultural, and competitive demands. Targeting total compensation at or above the median is common depending on the market, an organization's financial performance, and organizational aspirations. Achieving higher compensation is increasingly linked to productivity-based incentives.

Productivity expectations

In designing new faculty compensation plans, traditional productivity measures of patient volume, reimbursement, and operating expense are still prominent, as many AMCs still face challenges with their clinical faculty generating even modest clinical volumes and revenue.

Work RVUs (wRVUs) are the industry standard used to determine faculty productivity, since they are viewed as a fair measure of faculty effort, unbiased by the payer mix and practice expenses, which challenge many AMC practice environments. Various industry sources including FPSC, MGMA, and Sullivan & Cotter collect wRVU data by specialty and by region to generate productivity percentiles for benchmarking purposes. Productivity expectations frequently are set at the 50th percentile or higher depending on the AMC and the degree of financial pressure each faces.

In a merger or acquisition, future revenue projections and the

associated wRVUs are common metrics (e.g., $/wRVU) used to model future financial performance for the faculty and practice plan and thus are a critical measure.

Increasingly, other measures are emerging as AMCs and market forces look to compensate and reward clinical faculty for more than just maximizing patient volume and wRVUs. These emerging measures emphasize quality, value, and outcomes versus simply volume and activity. Examples include:

- Quality metrics (e.g., readmissions, aspirin/beta blocker prescription, patient satisfaction)
- Group performance that recognizes shared or collaborative faculty contributions within and/or across specialties (e.g., metabolic disease, cancer, OB)
- Health system performance (e.g., operating margin, meaningful use)
- Academic performance (e.g., sponsored research funding, clinical trial enrollment, publications)
- Good citizenship (e.g., timely chart submission, administrative efforts)

These additional productivity metrics provide further incentives to steer faculty toward those activities that affect overall reimbursement in a population-health focused healthcare environment (e.g., ACO), but also support those priorities that differentiate AMCs in their markets because of their research and education missions.

While financial incentives paid to faculty are the most direct form of compensation, faculty also appreciate other types of AMC incentives that reflect institutional support of their efforts. These include:

- **Protected time:** A percentage of faculty effort (e.g., 10%) for a set duration of time, carved out or "protected" from standard clinical duties to pursue academic initiatives
- **Development fund:** A certain amount of non-compensation

Work RVU limitations

A key challenge associated with wRVU compensation models is when revenue per wRVU does not generate sufficient returns to support the expense base (including salaries) of the practice or is based on a benchmark source not consistent with specific AMC experience. AMCs can address this by ensuring that the $/wRVU calculations are based on the organization's actual revenues as opposed to using an external benchmark. In response to this, some AMCs will take a more private practice approach to faculty compensation creating faculty level P&Ls that account for all revenues and expenses by faculty that results in a net income used for compensation and incentive purposes. The challenges of this latter "private practice" model were outlined previously.

In addition, wRVUs do not apply to some specialties (e.g., anesthesia), nor are they always captured under contracted revenue arrangements. However, specialty specific alternatives to wRVUs exist (e.g., ASA units) and contracted revenues can be translated into an equivalent number of wRVUs based on an established $/wRVU ratio.

Cancer center incentive example:

A leading NCI-designated comprehensive cancer institute sought to change the ratio of its clinical trials from reliance on industry sponsorship to more investigator initiated clinical trials. This was viewed as more aligned with their own and the NCI's research goals. While not a direct compensation benefit, faculty with their own investigator initiated clinical trials were supplied with a research coordinator paid for by the health system. This relieved the clinical investigator of a direct practice expense that would cut into practice revenue/income while relieving them of an administrative burden allowing them to be more efficient and able to focus their efforts either clinically or on research. The health system benefitted from an increase in investigator initiated trials, an improved research reputation, higher patient satisfaction because of cutting-edge trials, and happier, more productive faculty.

funding set aside for use by the faculty in support of programmatic initiatives (e.g., research coordinator, equipment)

- **Clinical research support:** Funding or resources provided by the health system in support of mutually beneficial translational or clinical research initiatives
- **Formal recognition:** A variety of forms such as appointment to an institution's "Academy of Scholars" or formal awards

Many organizations are not using a single metric or approach to measuring productivity and creating incentives, but rather employing a combination of volume, quality, and other measures of achievement in their compensation and incentive plans.

Incentives and at-risk compensation

Financial incentives matter when it comes to faculty performance. This is not a universal truth, since there are prominent examples of AMCs that are very productive but operate under a guaranteed salary structure. In principle though, when higher productivity is rewarded with higher compensation through the use of incentives, faculty are more likely to commit the additional effort required to attain those incentives.

Conversely, if faculty have an at-risk component to their compensation subject to achieving a minimal level of productivity, faculty are more likely to commit the necessary effort required to avoid reductions in their base level of compensation.

Incentive structures and calculation vary considerably across institutions and can be variable, fixed, or both.

Variable incentives

Examples of variable incentives include:

- Dollar amount/wRVU for every wRVU generated or for wRVUs above a benchmark level of performance (e.g., FPSC 50th percentile)

- Percent of net income based on the faculty member's revenues minus salary and expenses, including overhead
- Percentage of research salary coverage above baseline expectation (e.g., 60% research salary coverage)
- Incremental dollar amount shared with faculty when the health system exceeds a target level of financial performance (e.g., when operating margin exceeds budget)

In some instances, the value of the incentive can vary depending on the level of performance above the minimum expectation. For example, a physician who receives $25/wRVU for every wRVU above the median benchmark may receive$30/wRVU for every wRVU above the 60th percentile, and $40/wRVU above the 70th percentile. Thus, the more productive faculty members are, the more incentive payments they receive. As incremental revenues are also accruing to the parent health system at lower marginal cost, this is a win-win for all involved.

Fixed incentives

Some institutions also have established fixed incentives that are not always tied to revenue-generating activities, but reward achievement and behavior consistent with the mission and goals of the institution. These fixed incentives can help diminish perceived disparities between faculty of different specialties (or health science schools such as nursing or allied health) with vastly different earning potentials.

These fixed incentives, though often a lesser amount than could be earned by maximizing clinical activity, should be substantive enough to actually incentivize faculty. The amounts can range from hundreds to several thousand dollars and reflect achievement of such things as:

- Quality (e.g., overall and/or specialty specific)
- Academic achievement (e.g., papers, publications)
- Reputation (e.g., top 10 ranking)
- Operational performance (e.g., timely charting)
- Good citizenship (e.g., to be defined by Chair/Chief)

Incentive requirements and timing

Minimum clinical effort requirement: The payout of an incentive, whether variable or fixed, often requires a minimum level of performance (e.g., 25th percentile productivity) and mission effort to qualify (e.g., CFTE greater than 0.6) to further reinforce a baseline level of effort and performance. This has the added benefit of boosting overall clinical FTEs without having to recruit new faculty.

Timing: The timing of incentives is an important consideration. The more immediate and timely the rewards (or loss) relative to performance, the greater impact it will have on faculty and increase the likelihood of influencing future behavior. There is the potential to offer clinical incentive payouts more

frequently throughout the year given the greater influence physicians have on near-term performance and the revenues that are directly generated, in contrast to research and education incentives that rely on longer revenue-generating timeframes. Careful consideration must be given to ensure that adequate reporting systems are in place to dispense incentives accurately and in a timely manner.

Design and implementation considerations

Whereas traditional clinical metrics of productivity are being questioned as the sole criteria for determining compensation, resulting in new approaches to rewarding performance consistent with market and mission priorities, several principles should be taken into account when including additional quality or academically driven criteria or metrics.

- **Focus on fewer metrics that correlate to overall performance:** While some measures are well-defined, many others may be specialty-specific, not apply to the majority of faculty, not correlate to desired performance, or be highly correlated to other similar metrics. In determining what to measure, consider the following axiom and choose wisely: "If everything is valued, then organizations will be expected to value everything."
- **Include only what is measurable:** While quality and outcomes are increasingly important, not all organizations have the data systems in place to capture this information in a timely, accurate, and transparent way, particularly at the individual faculty level.
- **Consider group performance and goals:** With increasing emphasis on multi-disciplinary collaborative patient-centered care, outcome measurement becomes a function of a team's effectiveness in delivering patient care and not of individual faculty.
- **Determine degrees of freedom:** Chair discretion in compensation and incentive decision-making can reflect specialty-specific criteria and program priorities, but also can lead to questions of bias and favoritism. Balancing what criteria can be monitored and managed centrally versus that which is left to Chair discretion will be an institutional determination, but all criteria should be subject to independent verification and justification.
- **Champion change:** In some AMCs, a performance-based approach to faculty compensation will cause anxiety and potentially pose a threat to historical ways of being compensated, the latter often articulated by those vocal faculty with the most to lose under revised expectations. Consider identifying faculty champions, the ones who represent the qualities you are looking to reward and who will fare well under the plan, and enlist them in helping to champion the change.

Creating strategic alignment through compensation

When an AMC merges with another health system, any change in performance expectations, particularly when it affects compensation, will cause concern throughout a faculty practice.

As the organizations go through a merger or acquisition and establish compensation plans, it's important to take the necessary time to determine how the compensation plan can align with the goals of the transaction, what performance metrics align with those goals, how to engage the faculty in the process to help support adoption and avoid unintended consequences. Communicating in a transparent and consistent manner about the rationale for change while highlighting opportunities to reward performance with higher compensation will create those win-wins the deawl needs to meet its potential.

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Health care organizations today find themselves amid transformation on numerous fronts: everything from merging provider organizations to converging providers and payors to changing compensation models. Many of these changes are starting to reflect an Affordable Care Act America, along with more general shifts in the US healthcare industry—all of which yield implications for stakeholders across the board, including executives, employees, and physicians.

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