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SECOND GENERATION COMPENSATION PLANS: IS THIS ALIGNMENT ARMAGEDDON? PART I

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Introduction

Over the past 30 years, physicians and hospitals have explored ways to work together in arrangements that are far different from historical interactions. The concept of *integration* between hospitals and physicians began in the '80s and, since then, has taken on varying roles, structures, and models. In today's vernacular, the term *alignment* is used to describe these working relationships, which means some form of integration between hospitals and physicians. Intrinsically, the word connotes synchronization. Specifically, the two parties function in unison, working toward common goals and objectives and, often, as a fully integrated entity.

More recently, alignment or integration has often resulted in hospitals employing physicians or engaging them through an "employment lite" model, such as a professional services agreement (PSA). With employment, PSAs, or similar arrangements that are designed to achieve "full" integration, the compensation plans are built upon a structure that attempts to align incentives, and, even more, the overall goals and objectives among the physicians and hospitals.

The transactions that were completed during this latest wave of physician-hospital integration/alignment (i.e., those commencing approximately five to seven years ago) are now coming up for renewal. While better planned than they were in the '80s and '90s where minimal incentives or "stretch goals" were required of the physicians, many of the compensation plan structures are proving to be flawed. These "first generation" compensation arrangements fall short in achieving aligned incentives. Many of the transactions will soon be subject to renewal. The question now is how hospitals and physicians will handle the revised compensation and incentive structures.

In Part One of this two-part paper, we will briefly explore the history of the compensation models, then, focus on why many of the existing "first generation" contracts are not succeeding and need modifying. Part Two will focus on the "second generation"

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compensation and incentive structures for physicians, which will be very different from the earlier models, if those contracts are renewed. The question in terms of alignment is whether the renewal terms will create an "Armageddon"—the end of the compensation world as we know it. Will physicians accept different terms, encompassing significant reductions in guaranteed compensation and substantial increases in at-risk compensation, as opposed to their original plans that formed the basis of their current working relationships and contracts? If not, this could create "alignment Armageddon", i.e., the end of the actual affiliation between the physicians and hospital/health system.

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I. Evolution of Physician Compensation

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During the '90s and earlier, compensation entailed few incentives tied to productivity; as a result, guaranteed amounts were high. A stronger focus was put on productivity in the early 21st Century, mostly tied to work relative value units (wRVUs). Still, much of the total compensation package was tied to some form of guaranteed income, and overall, the percentage of incentive compensation was low (i.e., percentage of total of incentives to total compensation). Benefit packages that were in the newer arrangements were good, although they were not as lucrative as those in contracts from earlier years. Figures I-1 and I-2 illustrate the evolution of physician compensation.

Figure I-1 -- Evolution of Physician Compensation

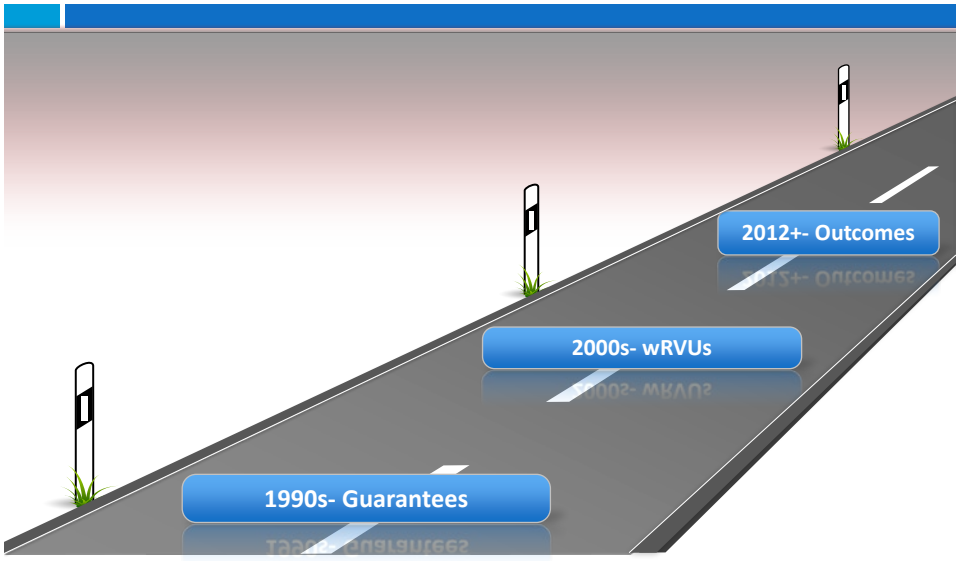

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Figure I-2 -- Evolution of Physician Compensation

1990s	• High guarantees • No productivity expectations • Significant benefit packages
2000s	• Strong focus on productivity (mainly wRVUs) • Guarantee treatment largely depends on locale • Limited performance incentives (outside of productivity) • Reasonable benefit package (no more pensions)
2010s	• Continued focus on productivity, although changing • Significant focus on inclusion of performance incentives (outside of productivity) • Decreasing guarantees • Reasonable benefit package (no more pensions) • Questions of what the future looks like

The contracts that are being structured today have a greater focus on productivity and incentives. However, the deals that were consummated three or four years ago are largely tied to significant amounts of base compensation and even the incentives that are relatively easy to attain. Compensation has improved for the physicians on a comparative basis post-transaction. Thus, many such deals have been completed, and physicians are relatively happy with their compensation under the new employment or employment lite arrangements.

So, why would the industry want to change the current structures? The answer is that the flaws in the compensation plans are becoming evident, and, while physicians may be reasonably happy with their pay, their hospital employers are not because they are unsustainable. Reimbursement models of the past will not apply in the future. There is a major shift from volume to value, from individual reimbursement to bundled payments that must be spread across a group of providers. Further, many of the details of how this will play out in the

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marketplace are still unknown. Therefore, compensation structures of the past three decades are unaffordable, so they must come to an end. They must be replaced with models that are based on a shift from volume to value, and they must be flexible to allow for adaptation as the changes unfold.

The following section addresses the flaws in "first generation" contracts and why they will not work in the unknown reimbursement models that are on the horizon. By looking at the past, we can learn what must occur to avoid mistakes in the future in an era of accountable care.

Reasons for Flawed Compensation Plans

The transactions that have occurred over the past approximately five years have been flawed, largely due to the *structure of the compensation and incentives* placed with the physicians at the outset of those agreements. Most of those contract's incentives are based upon a work RVU (wRVU) productivity plan. While wRVUs are a valid and useful tool to measure productivity and derive compensation, they do not relate directly to the "real world" of actual dollars reimbursed. Furthermore, many physicians have been able to manipulate the system by knowing RVU values (one relative to the other) and maximizing their assigned CPT codes and converting to higher RVU rates. This is not an assertion that physicians overtly abuse the system and commit violations of Medicare and other regulations. It is a natural human tendency to be aggressive in both coding and the overall accumulation of productivity units (i.e., wRVUs) when incentivized to do so. The result is that, as the compensation plans with a high guaranteed wage (at least in the early years of the contract) are expiring, hospitals are reconsidering whether it is best to renew the contracts under similar basis (i.e., wRVU productivity criteria).

Another reason the flawed compensation plans were generated is that *many health systems had expected to take market share away from their competitors*, enabling them to justify losses from their newly employed (or fully aligned via contracts) physicians. Again, not to

suggest any improprieties, it is not difficult to justify higher levels of compensation through "easy" incentives when market share is the opportunity that has been afforded. While this may well have been justified from a business standpoint in the original transaction, this is more difficult to accept five or seven years later as that transaction's second generation approaches. Boards of directors and other leaders of health system are increasingly insistent upon a significant reduction in the direct losses from employed or fully-aligned via contracted physicians. The best way to effectuate financial improvements is through reductions in physician compensation. Conversely, financial improvement can occur by increasing productivity without commensurately increasing compensation.

The compensation models that were established approximately five plus years ago under the new era of physician alignment/integration rarely included any significant incentives tied to costs and the control of overhead.

Models have been flawed because they also did not provide any significant incentives tied to *cost controls*. Overhead approximates 50 percent of the total costs or more; the remaining 50 percent or more is dedicated to provider compensation and benefits. The compensation models that were established approximately five plus years ago under the new era of physician alignment/integration rarely included any significant incentives tied to costs and the control of overhead. Thus, because the employed/contracted physicians had no incentive to control expenses, they have not done so. Further, in a highly-productivity-based incentive compensation model structure, there is a disincentive for the physician to control costs. Thus, as the new contracts are being consummated, health systems are offering updated versions that encompass significant amounts of incentives tied to cost containment and control. Physicians find this concerning, for many believe that they have very little to do with controlling overhead of a practice, particularly under an employed setting.[1] Under updated models, the physicians maintain the responsibility of controlling

[1] This is also a reason why PSA models have become popular, especially the model that does not entail the health system employing the staff but leaves this responsibility with the practice. (We call this the "global payment PSA.")

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costs and, in many instances, those who do a good job can realize a slight profit from the reimbursement for those expenses they receive from the health system. This factor makes PSA models very interesting and favorable, indicating they will continue to be so in the near- and longer-term future.

Earlier compensation models that are now expiring were also flawed because of a lack of non-productivity-based incentives. Not just those that are tied to cost and expense containment, but other areas that have become increasingly important relative to accountable care era structures and impending changes in the overall reimbursement paradigm. Factors such as patient satisfaction, attaining quality metrics, and other non-productivity-based incentives are more relevant as the second generation compensation plan structures are being formulated. Physicians view these factors as somewhat onerous because measurements of metrics for patient satisfaction, quality, and similar type performance indicators are difficult, if not somewhat nebulous to quantify. Physicians prefer to produce wRVUs and to be paid more as a result of greater production rather than being measured by these indicators. Nonetheless, as reimbursement structures start to change and with the move to bundled payments and other similar types of reimbursement, it is essential to implement incentives that are tied to something other than productivity (e.g., wRVUs, or some other measure).

A final reason for the flawed compensation structures is that, globally, both the hospital leaders and the physicians lacked partnering mentalities. Neither party seemed to appreciate the need for a partnering attitude. Previously, minimal discussion occurred about governance, and minor attention was given to working together in a joint "partnership" structure. With lessons learned from the lack of unity, in some of the more recent transactions, the parties have recognized the importance of working as partners and have spent

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considerable time vetting the issues of governance, day-to-day management, and oversight. Providing compensation to the physicians for this work, while not seeming to have a direct relationship with "dollars in the door", has proven to be a very useful tool for stimulating a successful working relationship. The contracts up for renewal, therefore, are including compensation structures that provide and address in detail units of governance and true partnering efforts. These also are realized through clinical co-management agreements (CCMA) wherein hospitals and physicians work closely together to help manage and oversee the applicable service line within the hospital facility.

Contracts Coming Into Second Generation Structures

Many contracts that are expiring call for automatic extensions, but often those extensions are only for one year. Moreover, most employment contracts call for either party to terminate without cause after a certain period (usually three years or longer). So, the premise that a contract cannot be changed or terminated until it expires is incorrect. Most health systems will honor a physician's contract until it officially comes to its full term. Regardless of the contract's renewal status, hospitals/health systems and employed and/or contracted physicians are confronted with added challenges as they continue to work in alignment. It is challenging to construct a new employment contract that provides overall compensation, including incentive components that are acceptable to both parties. This is especially true when moving away from straight (almost 100 percent) productivity-based compensation incentive models.

In the next section, we will explore why compensation models have not succeeded in relations to the structures we have outlined above. These discussions will focus on the specific reasons for failure of the existing compensation models and explain why they are unacceptable for renewal. Finally, we will consider the ramifications of these new contract terms and provide go-forward solutions.

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II. Why Compensation Models Have Not Succeeded

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There are specific economic reasons that first generation compensation models were unsuccessful, which we will address in this section. In many instances, these matters are being rectified in the second generation compensation structures that are now coming into play. With renewal terms that address today's expectations driven by the accountable care era, hospitals and health systems are attempting to cure the overcompensation that resulted from the earlier arrangements. Physicians are not accepting these changes without challenges and opposition, as would be expected. For this reason, it is important to be able to articulate the reasons why former compensation models cannot be continued under the emerging reimbursement paradigm.

The primary reasons why compensation models have not succeeded are as follows:

- ***Too much guaranteed pay.*** When physicians were handed contracts that gave them significant amounts of guaranteed base pay, the lack of incentives (no matter what they were based upon) became apparent. This component affected behavior as well as outcomes. The results of too much guaranteed pay are evidenced by lack of productivity, lack of consciousness of controlling expenses, and lack of accountability for patient satisfaction, efficiency, and throughput, etc.
- ***"Easy" incentives.*** Incentives are delicate matters that have to be dealt with carefully in developing compensation structures. If they are too easy to attain (which has contributed to the problem), then not only is the compensation "earned," it can easily become excessive in an economic modeling sense. By the same token, incentives cannot be unattainable. If they are too difficult to reach, then they become disincentives. On the other hand, the models that are included in contracts up for renewal have entailed incentives that are much too easy to reach. As corrections are made going forward, they are not being received positively, as to be expected.

- ***Formulate the pay structure now—worry about its effects later.*** This mentality has been extremely prevalent and as a result, "later" is "now." Lack of thought, planning, and failure to tackle the tough issues were the norm when many of the earlier transactions were completed. Typically, this occurred because the hospital/health system was interested in completing the transaction, particularly if it meant some stabilization of provider base and/or increased market share. Now, these transactions have to be more closely scrutinized. Some believe that because the physicians are entrenched in the working relationship and to maintain the alignment, they will accept tougher terms. Others are not so sure and, in fact, they may not renew these contracts, even at the risk of subjecting the physicians to one- or two-year non-compete terms.
- ***Lack of education.*** Physicians were not fully apprised of the expectations of their employment and the overall performance measures. Because the incentives were "easy", performance and overall expectations within the employment or professional services contracts were not fully clarified. As a result, many lapses have occurred, which have to be corrected going forward.
- ***Lack of collaboration in the development.*** Although physicians were involved in the way the compensation structures were developed (i.e., few and "easy" incentives), there was a lack of collaboration in thinking through the various ramifications and expectations. Moreover, many hospitals/health systems were not thinking ahead through the whole process; they did not realize the necessity of education on expectations, as noted, as well as collaboration in working together and explaining the expectations. Though the renewal contracts that are now being formulated are more collaborative, they are still being met negatively and with reticence, due to the tougher terms hospitals/health systems are requiring.

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- ***Few checks and balances.*** The worth and overall effectiveness of an employment incentive contract between a hospital/health system and physician ultimately is determined by its checks and balances. This means that because of the thorough job of education and collaboration, both parties understand that their relationship is like a partnership, which requires checks and balances of behavior and overall performance. As a result and more specifically related to compensation model structures, there are many more requirements in order to attain additional compensation. Checks and balances are essential to stand the test of time.
- ***Little discussion about governance.*** While some of the early-on transactions addressed governance and decision-making within the "Newco" practice structure, many gave only lip service to this important component. Although the governance discussion may seem unrelated to compensation and incentive plans, it has a lot to do with this matter. Governance is more than just deciding how the practice runs day-to-day. Governance is structured best in an arrangement where physicians and hospitals/health systems work collaboratively (i.e., as a partnership) in all areas, including physicians' productivity, overall performance, and compensation.

Epitome of a "Bad" Compensation Model

Unsuccessful compensation incentive model plans encompass several key elements that doom them to failure. While "unsuccessful" is in the eyes of the beholder, in most instances, both the employer and the employee physician are disappointed and dissatisfied when these components are a part of the arrangements. These negative factors are cumulative, meaning that standing alone, each component is not necessarily a negative factor, but collectively, when a compensation model comprises most (or all) of these elements, the arrangement is apt to fail. As a result, new or

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second generation compensation models must be more than "tweaked"; they must be redesigned rather than merely modified. Following are components that have proven to be unsuccessful.

- ***Guaranteed pay at or near historical levels.*** A lesson learned early on as hospitals began employing physicians in the '80s and '90s is that when guaranteed pay is excessive, it does not work. When a physician (or likely, any other individual in such a setting) is guaranteed as much or more than they have made historically--particularly, just prior to employment or contracted), their performance likely will —suffer. This applies to productivity, attitude, or overall commitment to the position and is due to human nature. An acceptable exception to this is a guaranteed floor of compensation during the initial one or two years of the contract. An acceptable exception to this is a guaranteed floor of compensation during the initial one or two years of the contract. In referring to guaranteed compensation, we are denoting second generation contracts and, specifically, situations where upon renewal, that initial term is extended with guaranteed pay at or beyond historic levels and for much longer period.
- ***All productivity-based incentives.*** This topic is somewhat prickly because most of the early contracts were centered largely on production-based incentives. However, over time, a need has arisen for incentivizing physicians in other areas, including expense controls, patient satisfaction, and quality and performance metrics. Compensation incentive plans that are 100 percent productivity-based, therefore, are now viewed as rather detrimental. Many employers, for example, have become somewhat negative toward productivity incentives tied to the production of relative value units (RVUs), and usually work-only RVUs (wRVUs). This is because wRVUs, although a very useful and important methodology for determining productivity, particularly on a comparative basis from one provider to another, do not represent "real money." Nonetheless, productivity-based models are being revisited,

particularly during the second generation, when many other elements are just as important, especially in the era of accountable care era.

- ***No expense control incentives.*** Generally, physicians respond to what incentivizes them. When productivity-only models (without expense controls) are the only incentives in place, physicians tend to react by maximizing their productivity, with little regard for controlling costs. In the era of accountable care, the ability to demonstrate true cost savings ultimately will translate into improved reimbursement. Therefore, those compensation plans that lack incentives for controlling expenses must be revisited and revised to incorporate such incentives. Based on the absence of history of requirements for cost consciousness, this change could present a difficult adjustment to the physicians.
- ***No accountable care-based incentives.*** Similar to the previous point yet broader are other areas of importance, such as the potential reimbursement measurement for patient satisfaction, and overall efficiency, and quality outcomes. These matters will become significant in second generation contracts. Those models without accountable-care-based incentives will be challenged in the second-generation arrangements.[2]
- ***Little ability to adjust to changing trends; no flexibility in the existing model.*** Regardless of whether the existing model for those expiring contracts are tied to guaranteed pay that is too high or all the incentives are productivity-based, if the wording of that contract does not allow for adjustments to changing trends, it becomes a challenging situation, especially in this changing reimbursement environment. Now, most contracts are being written with the stipulation that if the reimbursement paradigm changes (i.e., moving away from fee-for-service/fee-for-volume to something akin to fee-for-value), this would trigger a revisiting of the compensation incentive plan. Plans that are coming due without this stipulation for flexibility should be modified for this adjustment and documented in the second

[2] To be fair, the first generation models that are more than three years old and now expiring probably would not have considered these types of incentives as they were not that prevalent at that time.

generation contract. Many hospitals that engaged or employed physicians in the past may have wished they had been able to effect these adjustments without invoking a without-cause termination clause.

- ***Extended terms and easy renewals.*** Some may view simple terms for contract extensions and easy renewals as beneficial to the parties. However, automatic extensions and renewals (perhaps with minimal without-cause termination rights) may have been detriments to the overall success of the first generation compensation models. It is best for both the employer and the employee to have the flexibility to make at least some changes without having the contract continue indefinitely or being renewed with minimal changes.
- ***No non-compete.*** While most contracts, first generation and beyond, do have non-compete clauses, those that do not often engender a measure of disappointment, especially for the employer. Many non-competes are written so that the restrictive covenant is not applicable if the physician chooses to return to private practice. This is a reasonable caveat; however, the lack a restrictive covenant presents considerable challenges going forward.

While most contracts, first generation and beyond, do have non-compete clauses, those that do not often engender a measure of disappointment, especially for the employer.

SUMMARY

This section has considered compensation models from a negative perspective, especially those that have been in existence for several years and are now nearing expiration. Reality is that the compensation models that were constructed three, five, even seven years ago often have flaws that now must be corrected. It is easy to know the right thing to do after something has happened, for hind sight is 20/20. That is the intent in the retrospective review. More importantly, looking back and learning from mistakes helps in organizing the necessary strategies to improve the terms of upcoming contracts. The goal is to avert "alignment Armageddon" or the end of the compensation world as we know it. Further, the

goal is to develop working partnerships that are viable and acceptable for the accountable care era—a period where all providers will need to work for bundled payments based on pay for value—not volume.

Part Two of this paper takes a positive approach to ways to improve upon compensation plan models during and beyond their second generation. In addition, the next section will identify the benefits of the new approach.

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