



Developing Progressive Academic Physician Compensation Plans for an Emerging “Curve 2” Health Care Market

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Overview and Executive Summary

Organizations with employed and affiliated physician faculty members have accelerated the refinement of their physician faculty compensation plans to prepare themselves to bridge between the current “Curve 1” world (where providers are primarily paid based on fee-for-service reimbursements) to a “Curve 2” world (where providers are primarily paid based on outcomes and/or reduced costs). Organizations have focused mostly on modifying the predominant base-plus-incentive design approaches to include expanded minimum-work-standards (MWS) requirements and to include payments for higher levels of quality, service, efficiency, and other non-throughput activities. As Academic Medical Centers (AMCs) also expand their faculty plans to include geographically dispersed and predominantly clinically focused physicians, they also are utilizing modified “bridge” plan designs with a mixture of base, production, and other Curve 2 performance incentives. As the transition to the Curve 2 world progresses, many AMCs feel enhanced urgency to design and implement more-progressive physician faculty compensation plans.

All health systems face multiple shared clinical delivery reimbursement pressures, such as reduced payment rates for the same or greater levels of historic inpatient and outpatient professional and technical services, reduction and/or elimination of payments for outpatient professional and technical ancillary services, and impending penalties for

readmissions and other adverse clinical outcomes. AMCs and their affiliated physicians face additional challenges to support their missions, including diminished governmental, commercial, and private levels of funding for teaching, research, and other academic activities. More specifically, most AMCs rely even more on revenues from their clinical health care delivery activities, in light of diminished funding for their teaching and research missions, with reduced Graduate Medical Education payments, National Institutes of Health (NIH) grants, and philanthropic contributions. Quite simply, the old business model and financial driver for medical schools and teaching hospitals (i.e., well-reimbursed subspecialty medical care) has eroded—requiring AMCs to re-evaluate their financial models and competitive positions to support their Clinical, Administrative, Research, Teaching, and Strategic (CARTS) missions. These trends have and will continue to escalate, placing increased pressures on clinical integration and enhanced physician leadership for more value-based, efficient delivery of care on a system-wide basis.

This Member Briefing: (1) provides an overview of pertinent market trends and key drivers for revised faculty relationships; (2) discusses the implications of these trends and drivers for faculty compensation goals and design components; (3) identifies key considerations in developing progressive physician compensation plan designs; (4) sets forth a recent Market Example Plan to illustrate a hybrid “bridge design” aiding one large AMC and a faculty plan to accomplish its goals; (5) provides an overview of the legal, regulatory, and valuation considerations relevant to plan design; and (6) concludes with additional considerations for the development of progressive faculty compensation plans.

Pertinent Market Trends and Key Drivers for Revised Faculty Relationships

Shared National Market Pressures for More Clinical Integration

From the outset, AMC leadership should view the physician faculty compensation plan as a strategic tool and not necessarily as an end unto itself. Consequently, the plan must recognize and seek to address means to advance desired physician behaviors to

promote the AMC mission, vision, and values with full recognition of pertinent national and regional market drivers and shared provider pressures. A myriad of key market drivers are forcing the need for expanded clinical integration and consolidation of health care providers in the United States, including hospitals, faculty plans, and others within AMC health systems. As set forth in *Figure 1*, these considerations include multiple macroeconomic factors, as well as science and technology, work force and education, and related health care trends.

Figure 1

INCREASING VOLATILITY AND COMPLEXITY... ACROSS ALL MISSIONS

Macro Economic Factors	<ol style="list-style-type: none"> 1. Impact of demographic and disease burden trends 2. Increasing healthcare as percent of GDP, and highest cost globally 3. Global financial crisis, national debt crisis, state budget crisis 4. Healthcare reform and changing payment models, flat NIH funding, scrutiny on costs and impact of research 5. Growing regulatory burden and increased transparency 6. Natural disasters
Science and Technology Trends	<ol style="list-style-type: none"> 7. Growth in interdisciplinary and team science 8. Growth of comparative effectiveness research and implementation science 9. HIT adoption / proliferation, evolving into database / statistical science, digital revolution 10. Blurring boundaries among academia, industry, government, and funders
Workforce and Education Trends	<ol style="list-style-type: none"> 11. Generational shifts in leadership, faculty, staff, residents, and students 12. Physician / nurse shortages and resident work hours 13. Team-based care and education / training 14. Diversity shifts in patients, trainees, and faculty / staff 15. Evolution of maintenance of licensure and certification
Healthcare Trends	<ol style="list-style-type: none"> 16. Growing payer concentration 17. Increased focus on outcomes, reliability, safety, cost and the patient experience 18. Increasing emphasis on prevention and population health 19. Health system consolidation and physician acquisition 20. Emergence of accountable care organizations to improve quality and reduce waste 21. Migration to lower acuity / cost settings

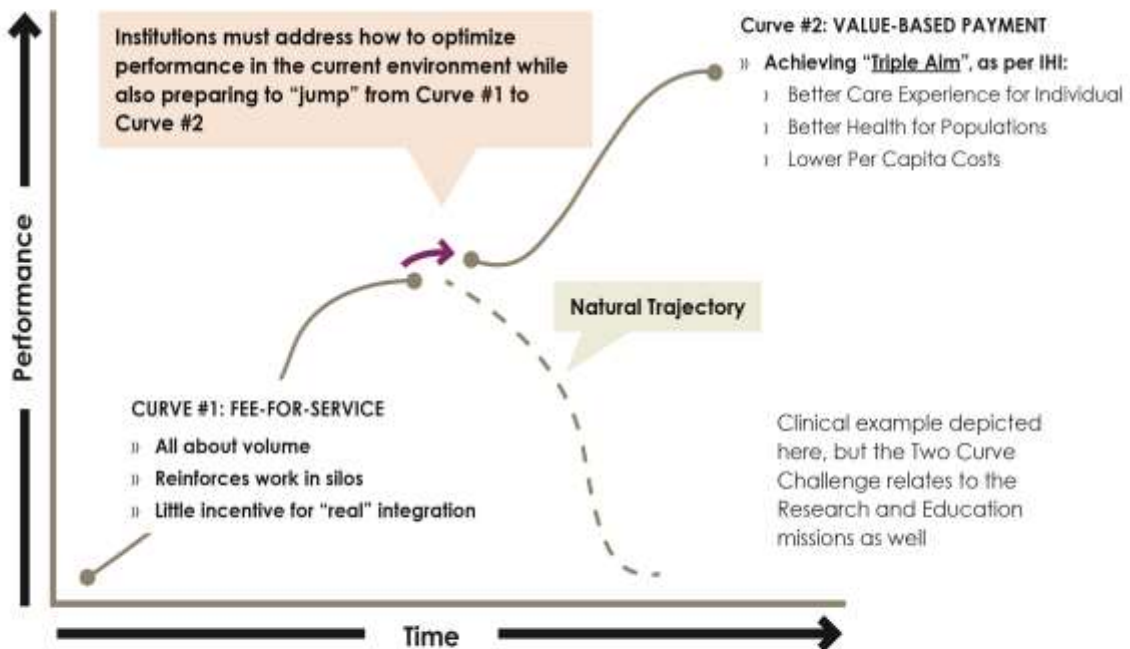
As fully described below, academic medicine is further impeded in its ability to adapt to these factors and trends in part due to its: (1) hierarchical structures that frequently lack flexibility; (2) intricate organizational culture and decision making; (3) slowness to adapt;

and (4) business models that often are less efficient than competing non-academic provider institutions.

All health care providers are concerned about how to better align with their physicians and other care team members to address the increasing levels of accountability for more value as opposed to pure volume of health care services in the transition from Curve 1 to Curve 2, as shown in *Figure 2*.

Figure 2

STATE OF HEALTHCARE NOW AND IN THE FUTURE: "CURVE 2" CHALLENGE ACROSS ALL MISSIONS



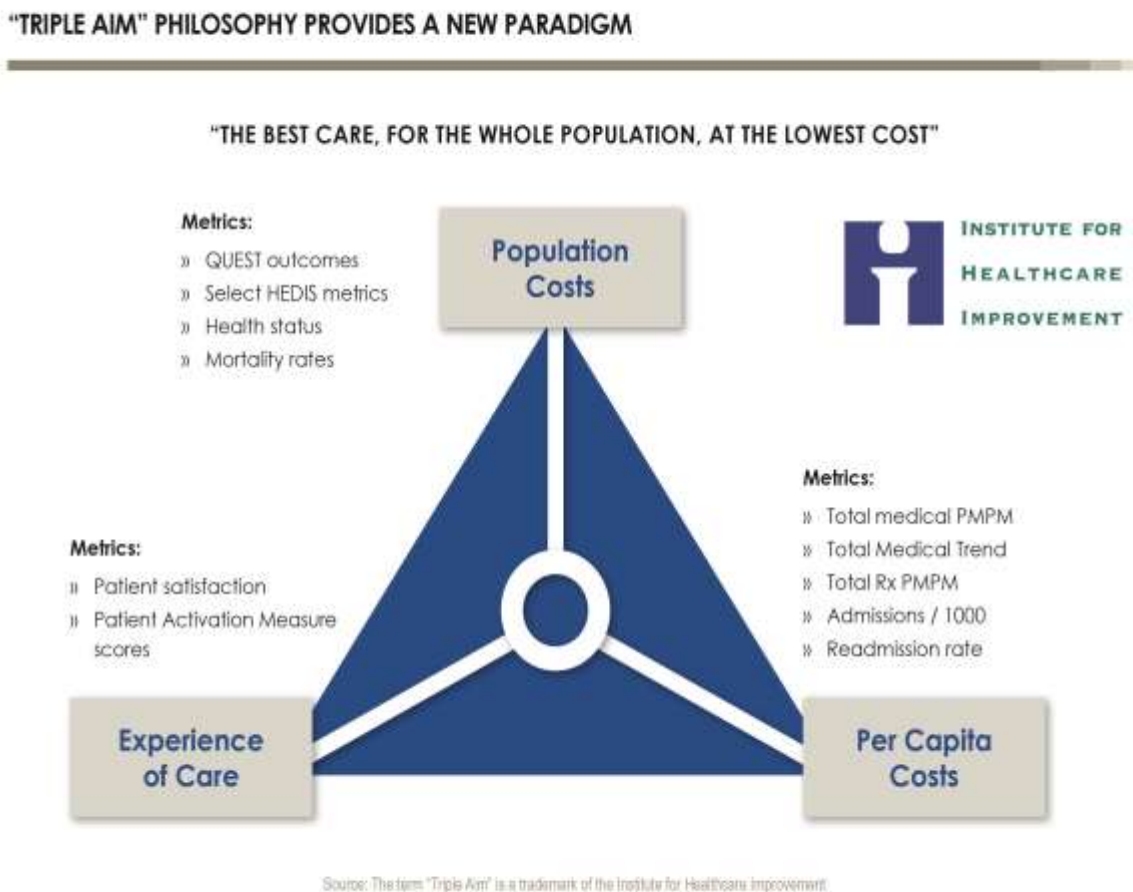
Source: Futurist Ian Morrison, Institute for Health Improvement

Passage and progressing implementation of the Affordable Care Act, as well as other related commercial insurance initiatives, are increasing the need to ensure that the health system is prepared and able to adjust to market reimbursements, such as

bundled payments, capitation, payment-for-performance, and other related “score card” measurements that place higher levels of financial risk on providers.

Both the Centers for Medicare & Medicaid Services (CMS) and commercial payers seek to enhance overall provider accountability for the Triple Aim goals of population health, cost efficiency, and enhanced patient service experience, as outlined in *Figure 3*.

Figure 3



In light of the expected pressures for health systems, including AMCs, to effectively provide care and remain viable in both a Curve 1 and Curve 2 world, many AMCs seek to partner with their physicians and pursue effective development and implementation of several initiatives, including: (1) clinical integration strategies (focused not just on the

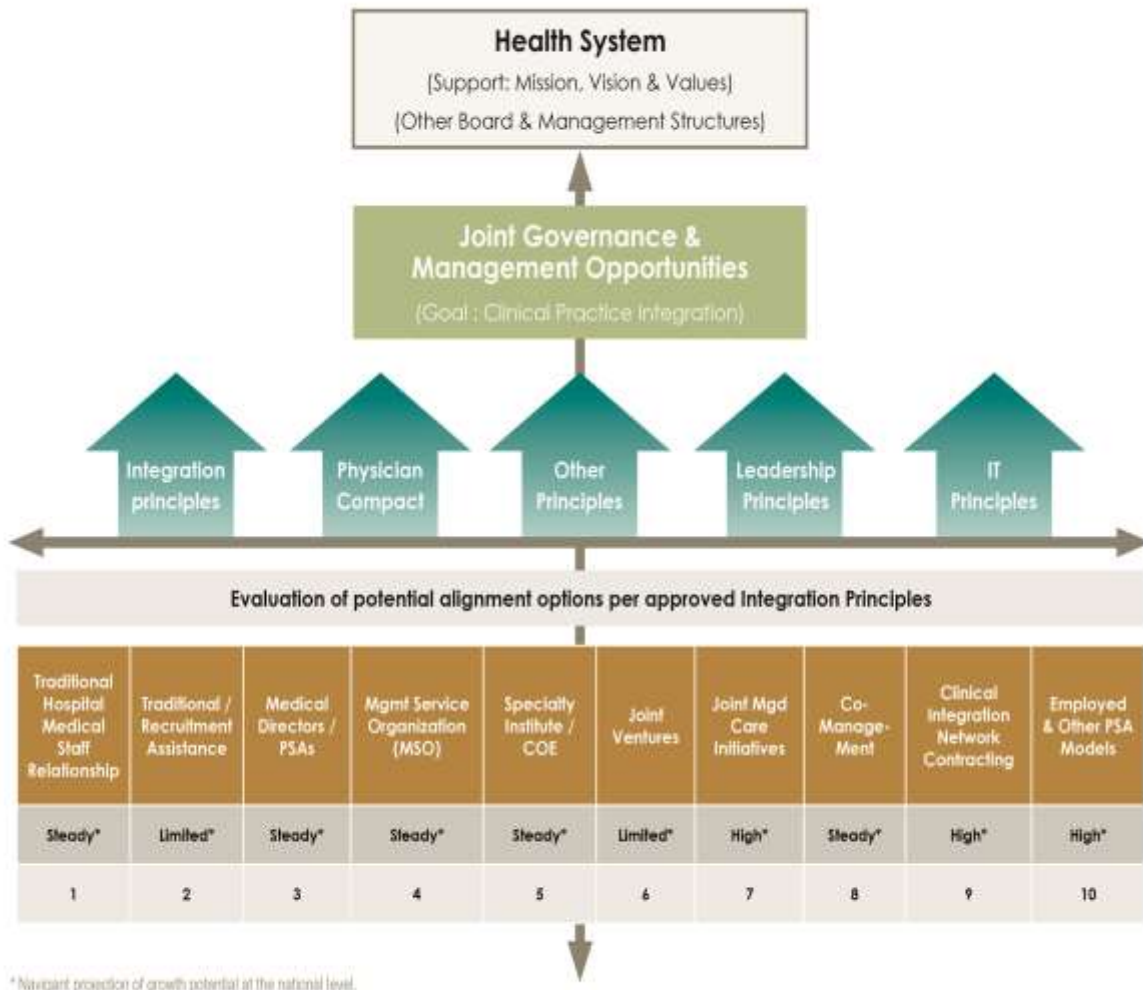
ability to contract through payer networks and Accountable Care Organizations (ACOs), but also on clinical care redesign and reduction of clinical variation to reduce unnecessary expenses and inefficiencies); (2) increased reliance on high-performing medical groups (with employed and other exclusive affiliated physicians to serve as core members of the delivery system); and (3) enhanced physician leadership, culture, and accountable compensation programs.

Just as all hospitals/health systems ramp up their levels of physician employment, many have faced shrinking operating margins to invest in physician-hospital affiliation initiatives and other investments in Curve 2 readiness. Furthermore, according to the 2013 *Cost Survey*, Table 2.4e, from Medical Group Management Association (MGMA), the median net income loss per full-time hospital/health system-employed physician (based on the performance of the ambulatory practice alone) was approximately \$176,000 in 2012. Despite these financial challenges, the competition to employ physicians is increasing among hospitals that recognize the importance of stronger relationships with their physician partners. At the same time, too many hospitals and physicians are reluctant to develop and implement progressive physician compensation plans that provide higher levels of incentives for quality, service, and efficiency (that go beyond current pressures for increased levels of productivity that effectively produce more revenues and require lower subsidies). For the same reasons, AMCs encounter varying degrees of resistance to measuring productivity based on effort generated, regardless of the level of actual collections received per patient.

Increasing Reliance on Employed, Risk-Adverse Physician Partners

As set forth in *Figure 4*, many observers anticipate that most health systems, including AMCs, will utilize a mixture of affiliation models with their physicians; however, the growth and reliance on employed physicians to be reliable and effective partners in clinical integration and Curve 2 development strategies will be paramount.

Figure 4



Aside from the need to respond to other financial and strategic market realities, AMCs and other integrated health systems also must develop their physician compensation plans with an appreciation of the changing nature and profile of their talent pool. Physicians in private practice and those coming out of residency and fellowship training face many of the same market pressures, as well as others, in the evaluation of their practice models. The same pressures of increased practice overhead costs, decreasing market reimbursements for physician services, and other practice uncertainties and complexities will only increase the level of physician employment and other forms of system affiliation for the foreseeable future.

In addition, we note that virtually all physicians, and particularly the newest generation of recent residents and fellows who are evaluating their practice opportunities, are increasingly more risk-adverse and find health system employment far more attractive than their predecessors. *Figure 5* summarizes some of the key generational differences among physicians that will comprise the AMC medical staffs and faculty plans.

Figure 5

PERTINENT MARKET TRENDS: GENERATIONAL IMPLICATIONS

	Millennials 1976+	Xers 1965-1976	Boomers 1946-1964	Matures Before 1946
Outlook	Hopeful	Skeptical	Optimistic	Practical
Work Ethic	Determined	Balanced	Driven	Dedicated
View Of Authority	Polite	Unimpressed with titles	Question to a point	Respectful
Leadership By:	Pulling together	Competence, Show me!	Authority	Chain of command
Relationships	Inclusive	May wait to commit	Like to be in charge	Personal sacrifice

Additional Challenges and Considerations for AMCs and Physician Faculty Practice Plans

As if the shared market pressures for clinical integration, provider consolidation, and other Curve 2 work readiness were not enough, AMCs and their faculty practice plan physicians also face additional challenges beyond those of the typical non-academic hospital/health system. In short, the desire and responsibility to ensure that the

physician faculty compensation plans promote multiple missions is generally greater than those found among non-academic organizations. As set forth in *Figure 6*, AMCs must seek to balance and address multiple CARTS missions and funding considerations for their physician faculty compensation plans.

Figure 6

IDENTIFYING ACADEMIC MEDICINE CARTS CONSIDERATIONS

Clinical	<ul style="list-style-type: none"> Clinical practice income for all professional services The value and method of payment is not a subsidy of transfer, but payment distinct practice of clinical medicine Productivity benchmarking
Administrative	<ul style="list-style-type: none"> Medical administration services essential to the effective operation of a hospital or medical group Signed agreement with clear delineation of duties, expected outcomes, time frame, accountability and reporting relationship, "without cause" termination and fair market value for payment
Research	<ul style="list-style-type: none"> Provided pool of money to departments Includes federal, state, hospital, philanthropy, unrestricted endowments or other grant support
Teaching	<ul style="list-style-type: none"> Instituted compensation methodology for time devoted to teaching and teaching administrative responsibilities according to a formula which considers Residency Review Committee (RRC) requirements Considers RRC defined residency / faculty, salary variances based on specialty, administrative support and delineated roles for Chair, Chief, Medical Director and Program Director
Strategic	<ul style="list-style-type: none"> Identifies a consistent source of funds for mission-critical core support for programs and recruitment that have a multidisciplinary and organization-wide implications, such as seed funds, capital expenditures, for new technology, recruitment packages Business plans must be developed for these expenditures that a project return on investment within a reasonable time period

Evolving physician faculty compensation plans also must address the following additional market pressures and demands on AMCs and their aligned faculty plans:

- Increased transparency of physician performance linked to payments (e.g. Physician Quality Reporting System, et al.);

- Increased reliance on alignment (employment) of community-based physicians that are referral sources to faculty;
- Decreased Medicare funding for Indirect Medical Education funding;
- Decreased funding for basic research (e.g., NIH);
- Decreased state funding for state-sponsored AMCs and in Disproportionate Share Hospital payments;
- Expansion of payments and residency slots for primary care;
- Increased curricular pressure to train in teams, expand scope of practice for mid-level practitioners, et al.;
- Increased competition for faculty from non-traditional employers (e.g., independent research organizations, health plans, and others);
- AMCs' increased dependence on unrestricted gifts and development efforts;
- Increasing levels of dean's taxes on faculty plans, which creates additional potential gaps between their compensation and competitive compensation for other community physicians; and
- Decreased access to capital for technology, wet labs, et al.

One of the most problematic challenges for AMCs is the emerging movement to bundled payments, which poses a significant threat to revenues and margins in AMC acute services. The cost differential for services furnished by most AMCs is significantly higher than those in many standalone acute organizations, which places AMCs and faculty at a disadvantage in bundled payment contracts with third-party payers.

Unfortunately, there are continuing strains and pressures on the availability of other sources of funds for CARTS activities, including high-cost structures that challenge the margins from the clinical enterprise of the AMCs, even beyond reduced external funding

for teaching and research activities. *Figure 7* and *Figure 8* summarize some of these additional challenges.

Furthermore, additional restrictions of federal expenditures due to sequestration mandates also have reduced funding for these academic missions.

Figure 7

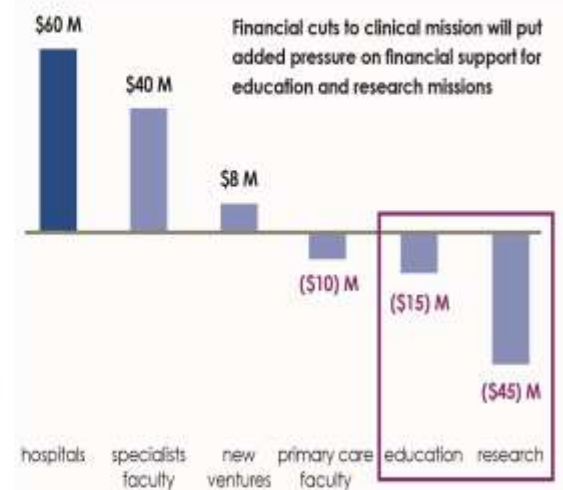
PRESERVING BOTH MISSION AND MARGIN POSES A DISPROPORTIONATE CHALLENGE IN THE REFORM ERA

EDUCATION, RESEARCH, AND PATIENT CARE

AMCs have fundamentally different cost structures than other types of hospitals due to the added complexities of high acuity services and mission related costs

Estimated Cost Per Case	Academic Medical Center	Other Teaching Hospitals	Urban Community Hospitals
Base costs	\$3,974	\$3,984	\$3,993
Wages and case-mix costs	\$2,214	\$1,389	\$985
IME and other mission related costs	\$2,360	\$674	\$260
Total	\$8,548	\$6,047	\$5,238

Negative margins in research and education missions are subsidized by positive margins in clinical services.



Why focus on the clinical mission? Although the **education and research missions are what differentiate and define** academic medicine, the **clinical mission drives the margin**, and therefore, when discussing financial viability and strategic planning, the clinical mission is at the forefront of the conversation, especially during a time of acute fiscal pressures.

Source: Koenig L, et al., "Estimating the Mission-Related Costs of Teaching Hospitals," *Health Affairs*, 22: 1112-1122; Wietecha M, et al., "Governance of the AMC: Striking the Balance Between Service and Scholarship," *Academic Medicine*, 84: 170-176

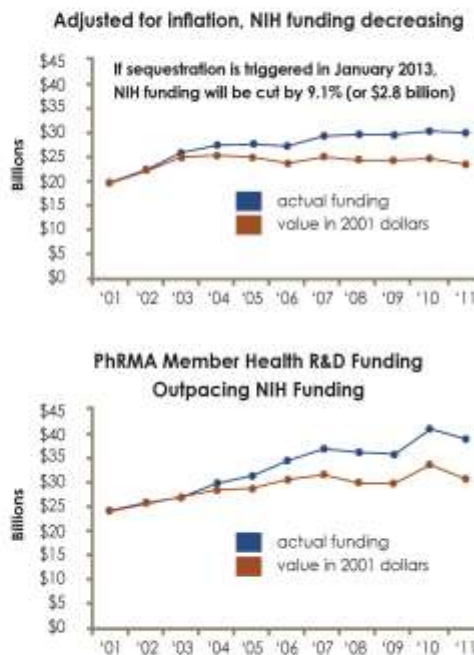
Figure 8

GROWING PRESSURES AND COMPETITION MAY DEFINE THE RESEARCH ENTERPRISE IN THE FORESEEABLE FUTURE

Research Operations Include Internal and External Pressures and Competition

- » Securing grants and funding from government and industry
- » Managing the Institutional Research Board (both efficiency and cost structure)
- » Publishing articles (increasing quantity and improving quality by publishing in the most "prestigious journals")
- » Competing for institutional capital expenditures to expand and improve facilities and technology
- » Increased burden of administrative duties over scientific work
- » Growing need for expertise in new fields, such as informatics

An increasing percentage of total research funding may come from private funding from industry



Source: NIH: http://www.phrma.org/site/default/files/159/phrma_industry_profile.pdf; <http://blogs.sciencemag.org/sciencecareers/2012/04/the-budget-cut.html>

The 2014 Advisory Panel Report on *Advancing the Academic Health System for the Future* from the American Association of Medical Colleges (AAMC) recently outlined some of the additional current and emerging strategic challenges for AMCs, including the following:

- (1) The AMC of the future will be system-based, with a broad regional presence and clinical services aligned across the continuum of care;

- (2) Academic health systems require strong and aligned governance, organization, and management systems committed to a unified direction, transparency, and internal and external accountability for performance;
- (3) University relationships will be challenged to evolve as academic health systems grow and develop, requiring leadership and structure to support clinical expansion, community engagement, alignment on financial requirements, and implementation of productive industry relationships;
- (4) Growth and complexity of academic health systems require an enhanced profile and responsibilities for department chairs, new roles for physician leaders, and evolution of practice structures to focus on organizational leadership designed to lead clinicians into a new era;
- (5) Transparency in quality outcomes and financial performance across the academic health system is central to high achievement that is demonstrable to patients and purchasers;
- (6) Competitive viability and long-term mission sustainability will require radically restructuring the operating model for cost and quality performance;
- (7) Academic health systems must begin the movement to population health now, as purchasers look to reward organizations that can demonstrate improved outcomes for attributed populations of patients, and as community leaders address the social determinants of health; and
- (8) Academic health systems must conduct candid assessments of strengths and weaknesses essential to achieve change, and must revamp organizational culture, if necessary.

Other competitive threats, as well as potential increased raiding and attrition of current faculty and/or future candidates, can emerge as a result of intensified physician integration and recruitment initiatives by other health systems. Many of these competitors to AMCs frequently offer higher compensation levels and are developing

their own expanded and prioritized institutes and Centers of Excellence (COE) tied to core service lines that include significant research and teaching opportunities.

Related Implications for AMC Physician Faculty Practice Plans

Given the dependency of AMCs on faculty physicians to advance their full CARTS missions, AMCs must view their faculty practice plans as critical strategic partners in the advancement of these missions through the evolution of Curve 1 and Curve 2 environments. AMCs will need well-aligned and supportive faculty practice plan relationships (ideally, reinforced and promoted by more progressive physician faculty compensation plans) to:

- Serve as attractive platforms for the ongoing recruitment and retention of needed physician leaders, faculty plan members, and other care team providers;
- Serve as key “anchor” tenants of Clinically Integrated Networks (CIN) and ACO networks;
- Require enhanced peer accountability for expanded Curve 2 individual and team behaviors;
- Expand their scope of subspecialties and likely expand opportunities for more non-tenure track full- and part-time physicians to become part of the system through current or hybrid faculty plan relationships;
- Further assist in the development and execution of prioritized clinical service lines and COE strategies; and
- Lead the expanded focus on interdisciplinary care and enterprise-focused CARTS initiatives.

Related Implications for Faculty Compensation Goals and Design Components

Refinements to Formal and Informal Compensation Plan Goals

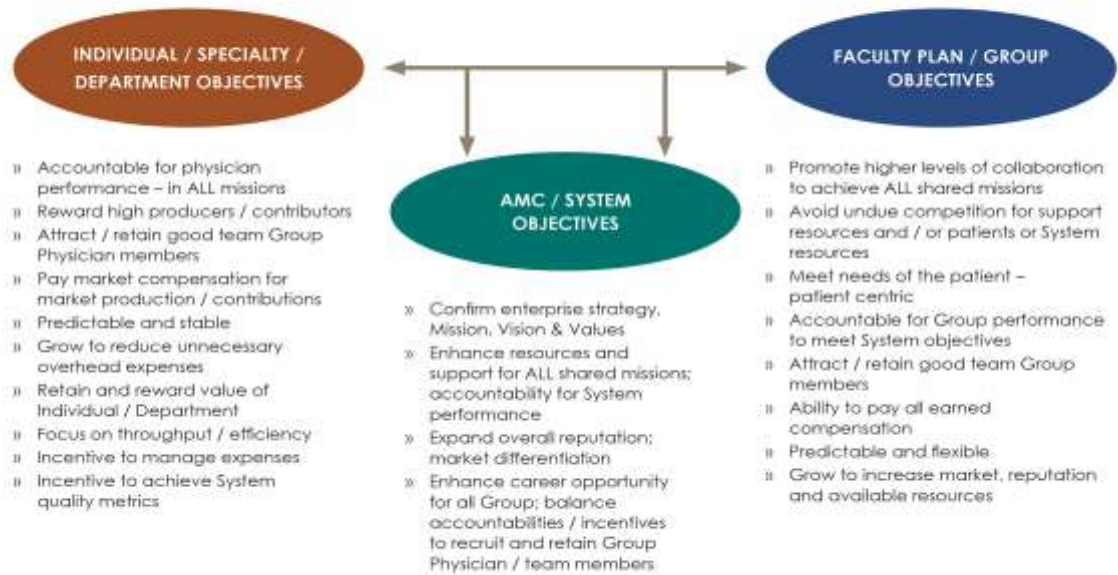
The ultimate purpose of physician compensation plans is to promote desired behaviors and to reinforce the desired culture that aligns with the organization's strategic direction. The compensation plan also should provide a platform to recruit and retain desired physician partners and team members. The plan should formally recognize these key goals to foster alignment. Moreover, the faculty compensation plans will need to be:

- (1) Internally equitable;
- (2) Externally competitive; and
- (3) Aligned with the system's mission, vision, and values.

Many existing physician compensation plans have failed to clearly articulate a detailed and balanced set of guiding principles and to align the key constituents' interests. Consequently, the revised physician faculty plan should identify multiple shared objectives between the individual physician member, the faculty plan, and the AMC, similar to the objectives set forth in *Figure 9* on page 16.

Figure 9

EXAMPLES OF SHARED PHYSICIAN COMPENSATION OBJECTIVES



Key Design Components to Support AMC and Physician Faculty CARTS Missions

Most employed physician compensation plans include some levels of secure base salary (even beyond a “draw” against potential production-only based clinical compensation formulas), as well as other incentives for other work or production. Many of the plans include clinical compensation incentives for production (most frequently measured by CMS-defined Work Relative Value Units (wRVUs) and/or professional collections) above a threshold level required to earn the base salary amount.

Additionally, to help enhance Curve 2 behaviors, many of the plans include 10% or more of the physician’s base salary as a potential incentive for achieving further quality, service, and/or programmatic development incentives.

The physician faculty compensation plan development should include the following principles:

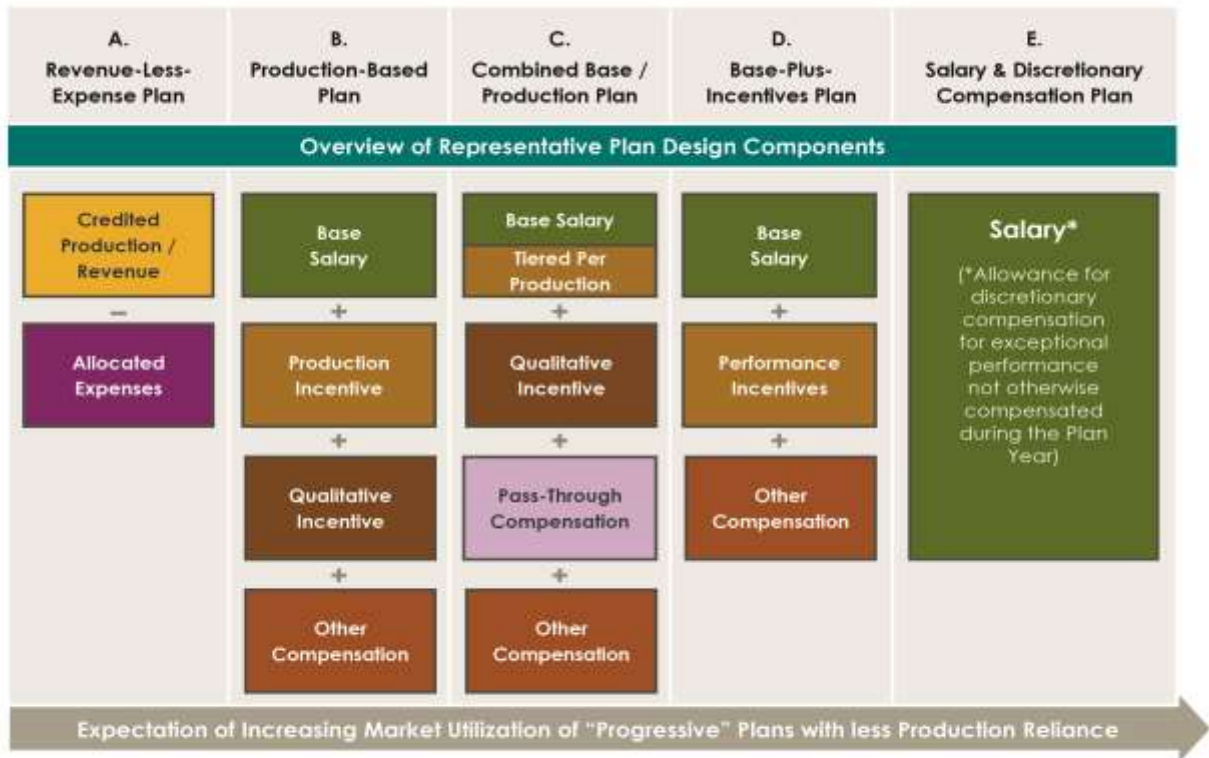
- Both secure base salary and other performance incentives;
- Enhanced definitions of CARTS funding and performance expectations to earn the base salary;
- Both production and non-production performance incentives for faculty physicians with significant clinical practice responsibilities;
- Primary reliance on personal (individual faculty member) performance targets, with defined and usually capped levels of performance incentive amounts, generally tied to a fixed level or percentage of the physician's base salary; and
- Secondary reliance on department, division, or faculty plan practice-wide level of performance targets, generally set at a much lower percentage of the potential non-production performance incentive amounts. (From the authors' experience, group-wide and/or system performance targets are not as well received, and higher levels of buy-in occur when the incentives focus on behaviors that the physicians believe they can most influence).

Key Elements and Trends to Develop Progressive Physician Compensation Plan Designs

An Overview of Commonly Employed Physician Compensation Plan Designs

A wide range of employed physician compensation plans, including related physician faculty compensation plans, are in use throughout the United States. The five plan designs set forth in *Figure 10* are among the most frequently utilized. These designs range from revenue-less-expenses (Option A) to salary-plus-discretionary bonus (Option E), as well as multiple base salary plus incentive options in between.

Figure 10



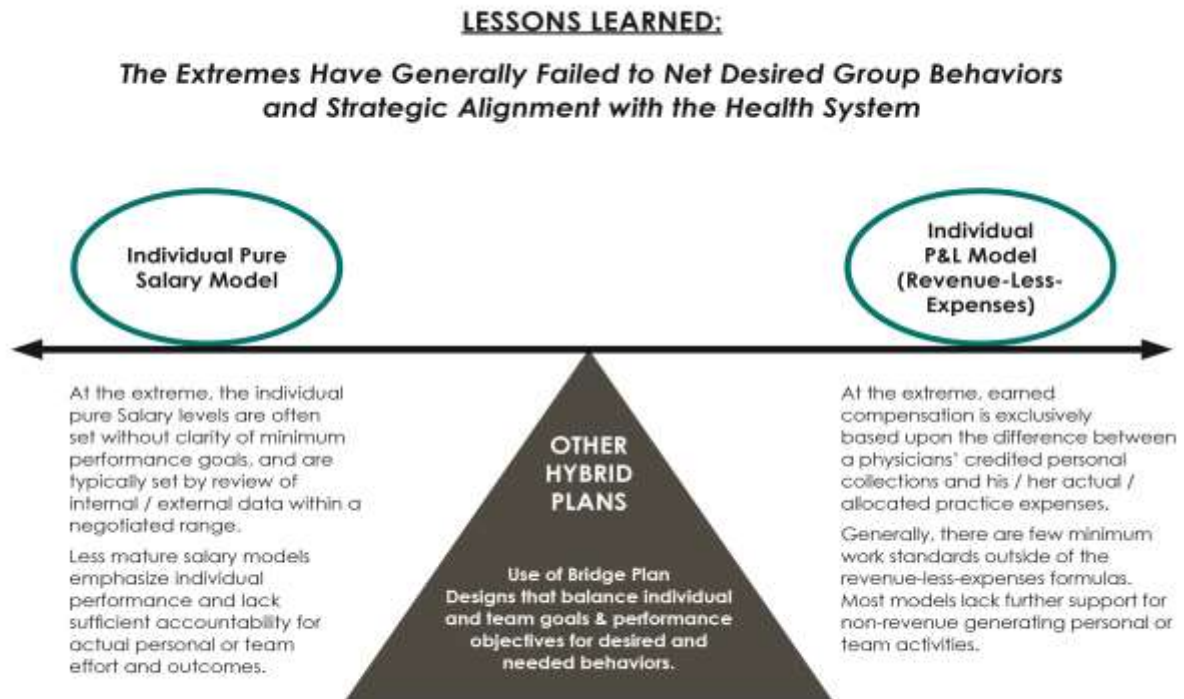
For all employed physicians, one can expect an increasing utilization of base-plus-incentives options that include a range of MWS and stretch goals for further Curve 2-focused behaviors to be utilized to establish more-progressive “bridge strategy” plan design approaches for the next three to five years. While exceptions exist for the most mature AMC and integrated health systems that employ physicians, there has been a move from the more pure salary-based plans (Option E) utilized by some faculty practice plans and AMC organizations to those with more-defined performance incentives (e.g., Options B–D), as set forth below.

Comparative Advantages and Challenges to the Sample Plan Design Options

Both within the still predominant fee-for-service compensation plans and the (future) shared risks of CINs/ACOs, it is best to avoid the more extreme pure base salary and

pure individual productivity physician compensation plan designs, as set forth in *Figure 11*.

Figure 11



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Pure base salary plans generally lack sufficient accountability for MWS and do not provide motivation for above-MWS performance in more dynamic practice settings. Pure productivity plans provide significant accountability for actual financial performance for individual physicians, but often fail to promote teamwork or include sufficient motivation for quality, service, and other balanced-performance behaviors. Pure productivity plans also tend to promote or sustain more of a transactional mindset and culture among both physicians and administrators at the expense of higher levels of buy-in for broader levels of service, quality, efficiency, and program development not always as easily measured.

Figure 12 summarizes additional key benefits and challenges of the employed physician compensation plan designs set forth above.

Figure 12

A. Revenue-Less-Expense Plan	B. Production-Based Plan	C. Combined Base / Production Plan	D. Base-Plus-Incentives Plan	E. Salary & Discretionary Compensation Plan
Comparative Benefits				
<ul style="list-style-type: none"> » Highest level of individual accountability for actual P&L performance. » Uses actual, not projected, accounting for allocated physician revenues and expenses. » Reflects similar approach among private practice groups. 	<ul style="list-style-type: none"> » Payment is often based upon a nationally recognized payor-neutral production metric (wRVU) that is externally competitive. » The comp / wRVU benchmarks include market overhead, ancillary services, and allied health provider usage. » Provides metric for further proxy wRVUs for other non-CPT generating work. » Provides better internal equity re: pay rates. 	<ul style="list-style-type: none"> » Similar advantages as Option B; however, further seeks to de-emphasize transactional approach to payment for incremental wRVUs. » Provides further emphasis upon bands or tiers of expected behaviors (which may be adjusted annually or every other year) that support the rolling Base Salary, but also recognized differentiated levels of physician work. 	<ul style="list-style-type: none"> » Provides significant security for annual compensation for hospital-based and / or other subspecialties that have less control over their own production and / or should not be incentivized to increase production. » Still includes team-based performance incentives for alignment of goals and minimum work standards to ensure accountability. 	<ul style="list-style-type: none"> » Similar advantages as Option D; however, further promotes predictable, secure levels of compensation during the Plan Year. » Further de-emphasizes production and transactional mindset for compensation, with expected higher minimum work standards to earn higher Salary levels. » May reduce further barriers to teamwork and work flow distributions.
Comparative Challenges				
<ul style="list-style-type: none"> » Promotes individual and less team culture; internal inequity. » Vulnerable to market volatility. » Enhances demands for control over basic operations, revenue allocations, etc. 	<ul style="list-style-type: none"> » Continued focus on production as a priority. » Requires further expense control to reduce churning. » Shifts significant risk to health system re: affordability of pay rate. » Stability of pay rates are subject to FMV ratio tests. 	<ul style="list-style-type: none"> » Similar challenges as Option B, including continued focus on production as the primary method to adjust Base Salary levels. » May provide further buffer for physicians that produce lower levels of wRVUs within the tiers. 	<ul style="list-style-type: none"> » May limit individual accountability and / or reward for production. » Requires higher trust for non-production performance metrics. » Effectively caps / limits the total compensation that may be earned annually. 	<ul style="list-style-type: none"> » Similar challenges as Option D; however, requires even further maturity of team culture and MWS behaviors. » Requires higher levels of trust and leadership oversight of work flows / performance to ensure internal equity.

There is no simple one-size-fits-all approach for AMCs. Most organizations will find it advisable to use more than one plan design to recognize that some physicians may and others may not have an ability to affect their own base of work.

The feasibility to implement more-progressive models will highly depend on the nature of the current and impending market, including the subspecialty practice setting, and other contributing factors regarding physician willingness to rely on higher levels of individual MWS and team accountability for stretch goals.

To effectively move from Curve 1-based to Curve 2-based plan designs, multiple criteria and conditions will likely need to exist. Some of the key indicators to assess the viability of implementing more-progressive physician compensation designs include:

- Higher levels of consistency in provider performance and practice stability;
- Enhanced understanding of required interdisciplinary teamwork;
- Enhanced understanding and ability to achieve more-mature Curve 2 MWS;
- Enhanced capabilities to measure and report Curve 2 behaviors;
- Support for sub-specialization among the care team members and willingness for shared team performance incentives;
- Enhanced support for team-based work flow assignments—tied to tailored MWS, and quality, service, and efficiency goals;
- Significant levels of shared provider/administrative trust and buy-in to shared mission, vision, and values; and
- Market stability and reward for advanced Curve 2 behaviors.

Without these conditions, most organizations employing physicians, including physician faculty plans, will likely find it advantageous to utilize Options B through D to promote more progressive Curve 2 behaviors.

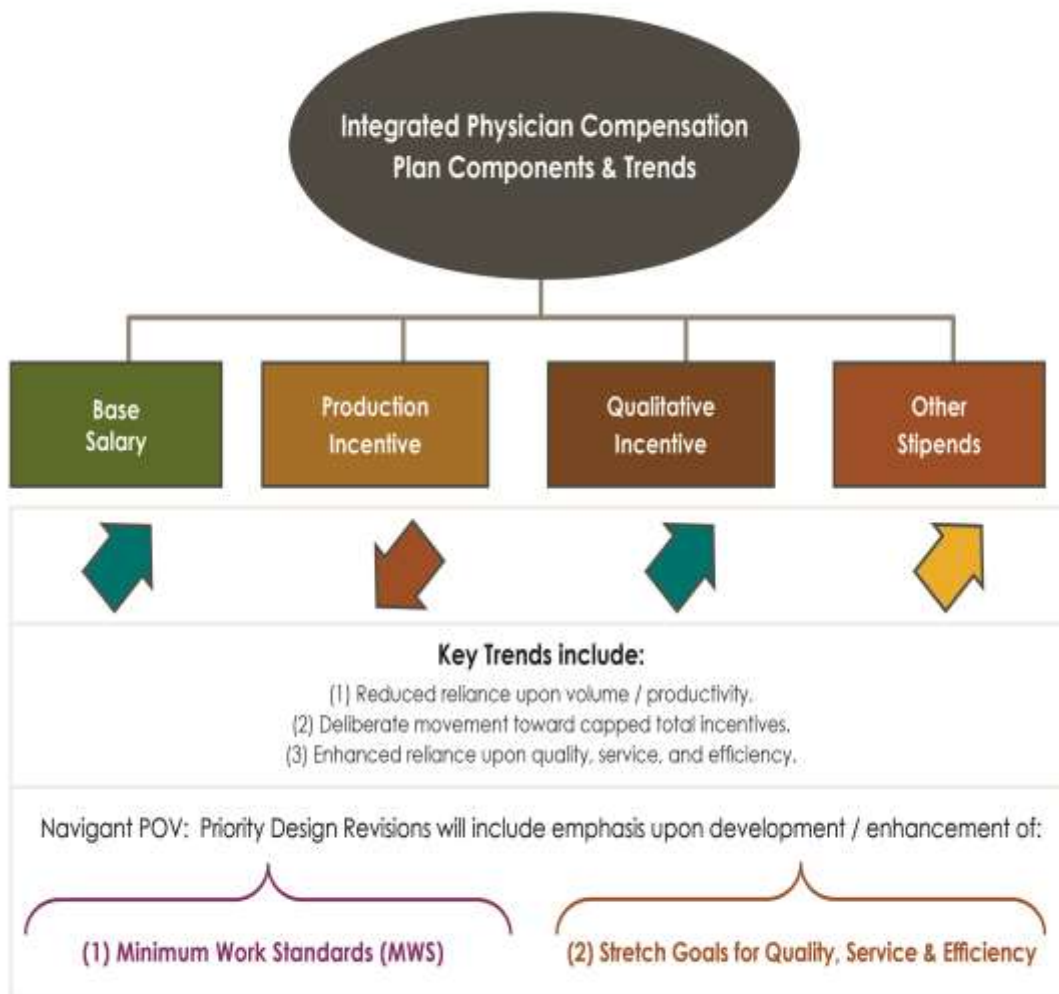
In addition to the other comparative benefits and challenges noted above, two key reasons for these movements include: (1) challenges to account for allocated revenues and expenses within the Option A approach (beyond the physician's control) may not fully recognize physician effort and required practice expenses, and may incentivize extensive competition for the best-paying patients at the expense of ensuring access for all types of patients; and (2) incentives that over rely on production (professional collections, wRVUs, or other similar volume-based metrics) frequently promote more activity rather than focus on value in terms of quality, service, efficiency, and overall outcome of physician-directed work.

Within the base-plus-incentive (Option D) approach, many faculty compensation plans essentially combine the production and quality/service incentives identified separately within Option B. Furthermore, while most non-academic employed physician compensation plans still emphasize open-ended production incentives and most rely on wRVUs as the primary “production” metric, observers expect that the market will increasingly cap individual performance incentives and rely even further on other compensation incentives for team-based quality, service, and efficiency performance targets.

Key Trends and Opportunities to Develop More-Progressive Plan Designs

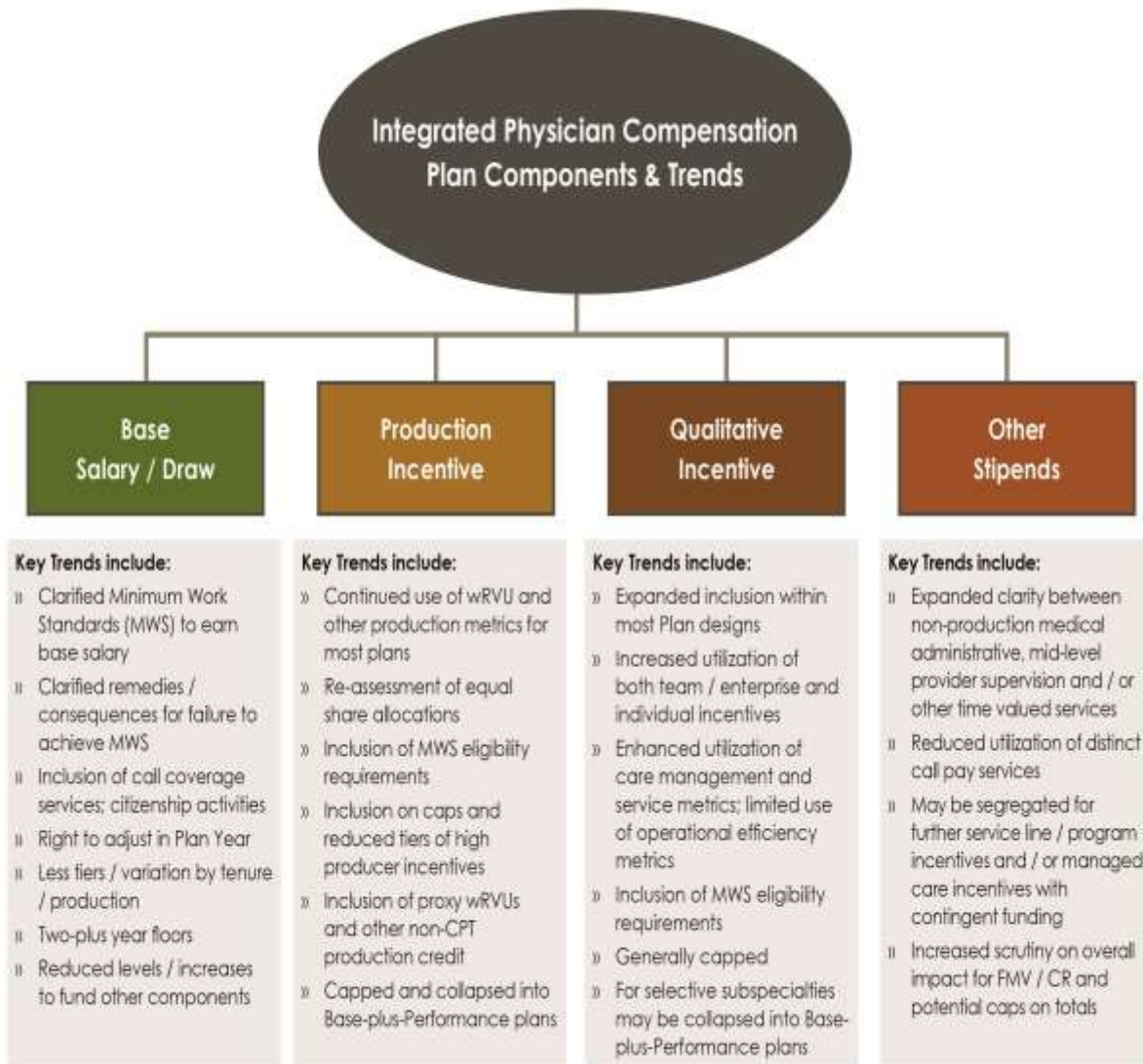
Most non-academic employed physician compensation plans include elements of the four components in the Option B design above, including an “open-ended” production incentive (typically based on physician wRVUs), and with growing percentages of total compensation available for value-based performance incentives. On page 23, *Figure 13* illustrates the trend to further reduce the emphasis on pure wRVU or other production accountability and to significantly expand the overall percentage of total compensation at risk for qualitative performance behaviors.

Figure 13



On page 24, *Figure 14* sets forth further refinements to these types of design components, with enhanced inclusion of more-balanced MWS and stretch goals for production and non-production based performance incentives.

Figure 14



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These additional components and features include more-progressive physician faculty compensation plan designs. As described in the next section, additional considerations also must be made to account for the expanded desired CARTS supportive behaviors.

Applying Shared Market “Lessons Learned” to Faculty Compensation Plan Development

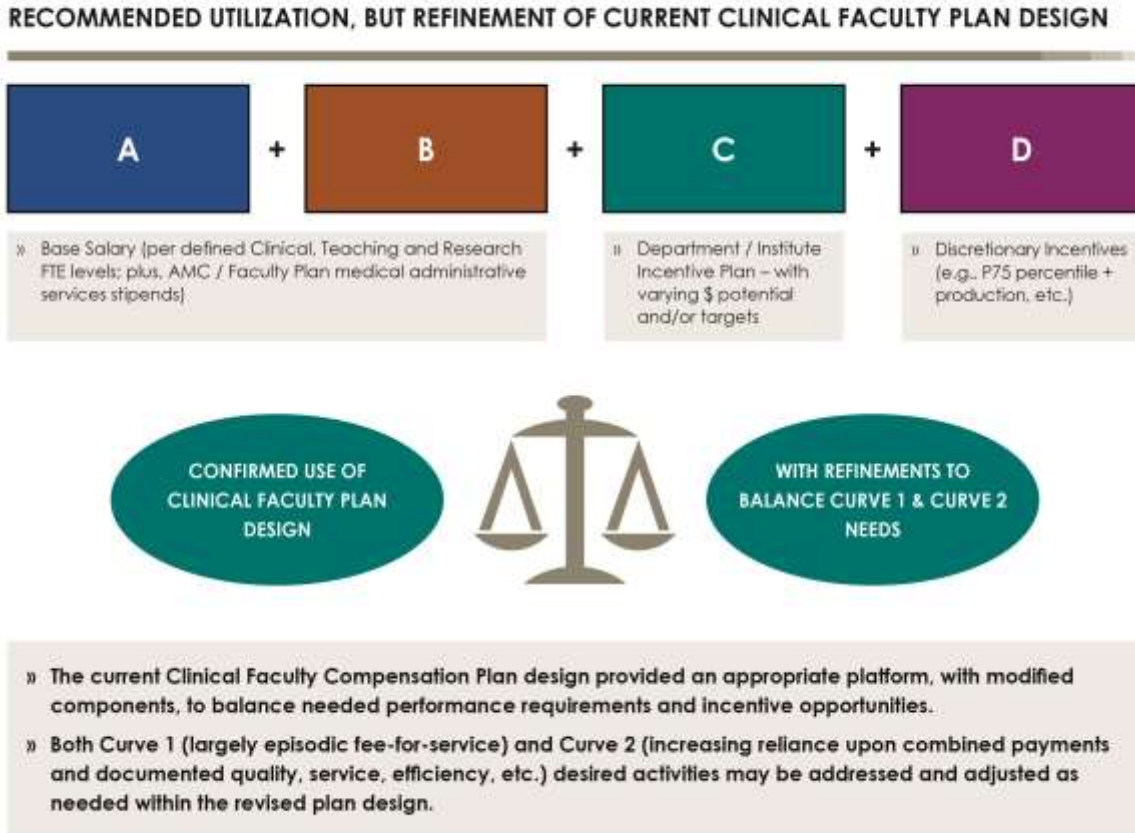
The market pressures and design enhancement opportunities listed above for other health systems and their employed physicians are equally, if not more, applicable to AMCs and their faculty practice plan physicians’ performance needs. Therefore, most, if not all of the “lessons learned” and recommended employed physician compensation plan design enhancements above should be considered and applied to better enable AMCs to align their faculty plan physicians in bridge designs for an emerging Curve 2 world. However, there are additional unique considerations for AMC physician faculty plan compensation development to address regarding the expanded CARTS missions and culture for tenure track and non-tenure track faculty. AMCs should consider relying mainly on Option C or Option D approaches to migrate a faculty plan with relatively modest to unclear performance expectations to one with balanced accountabilities and opportunities for Curve 2 behaviors.

For the most mature faculty plans with significant market stability, potential refinements of the Option E approach may be warranted. However, reliance on this approach can be expected to occur only within a minority of AMC/faculty plan relationships over the next three to five years. Rather, most faculty plans would benefit from refocusing on inclusion of the expanded MWS (with clearer definitions for all funded CARTS behaviors) and Curve 2 stretch goals that enhance alignment between the faculty performance and key CARTS priorities of the AMC and the related school of medicine.

Review of a Recent Market Example Progressive Physician Faculty Compensation Plan

To illustrate some of these considerations, this Member Briefing summarizes the key components and additional design considerations of a more-progressive Market Example Plan in the process of implementing a 1,000-plus physician member faculty plan. This Market Example Plan was developed as a hybrid between Option C and Option D designs. *Figure 15* sets forth a graphic illustration of the plan components.

Figure 15



Components A and B of the plan included combined payments for basic expected CARTS behaviors within a base salary. Component C of the plan included potential funded payments for additional stretch goals for further CARTS behaviors, with the emphasis on quality, service, efficiency, and programmatic development goals. Component D of the plan included discretionary payments for exceptional, non-budgeted individual and/or team CARTS performance.

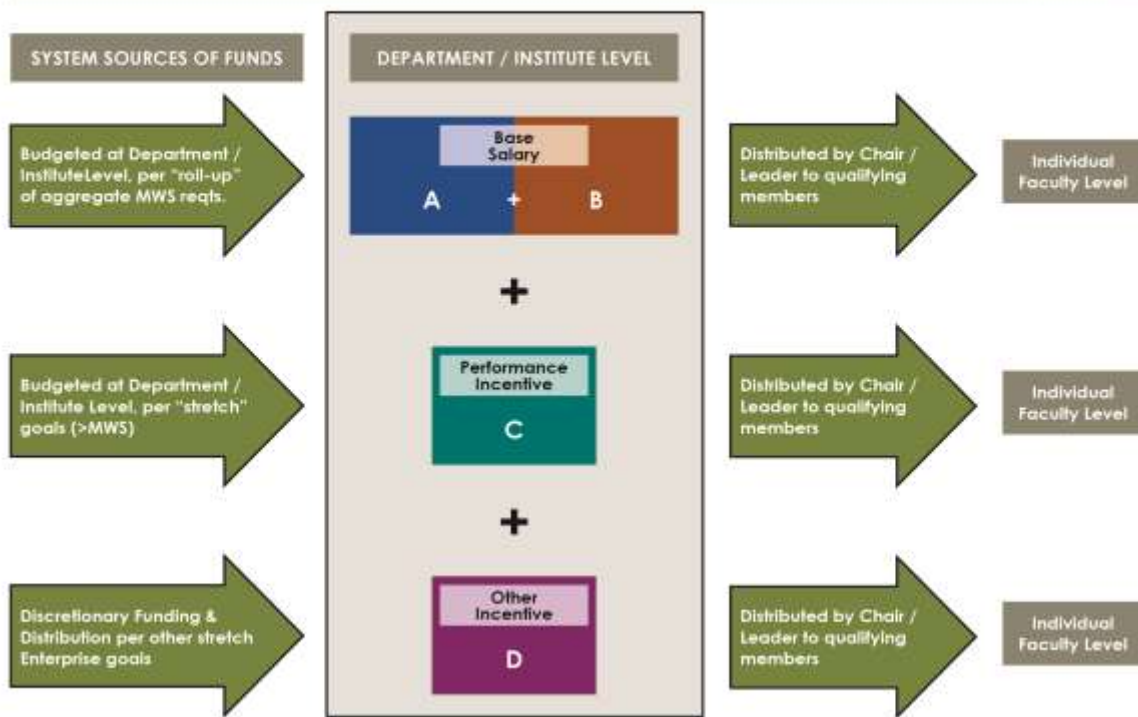
Distinguishing Funding Versus Distribution with the Market Example Plan

In this example, the AMC was the ultimate source of funding for the balance of compensation plan needs versus actual faculty plan financial performance and/or other

school of medicine contributions for CARTS activities. Consequently, the annual system budget for the plans included department and institute/COE performance targets for the respective base salary and potential incentive components. Actual distribution of the funded components to individual physician faculty members was contingent on the department chair's or institute leader's review of physician performance and other defined discretion to allocate funds within the department/institute compensation pool to qualifying physicians. *Figure 16* sets forth an illustration of the funding and distribution distinctions.

Figure 16

FUNDS BASED UPON TARGETED DEPARTMENT / INSTITUTE PERFORMANCE - WITH CHAIR / DIRECTOR DISCRETION FOR INDIVIDUAL, DIVISION DISTRIBUTIONS PER MORE UNIFIED STANDARDS

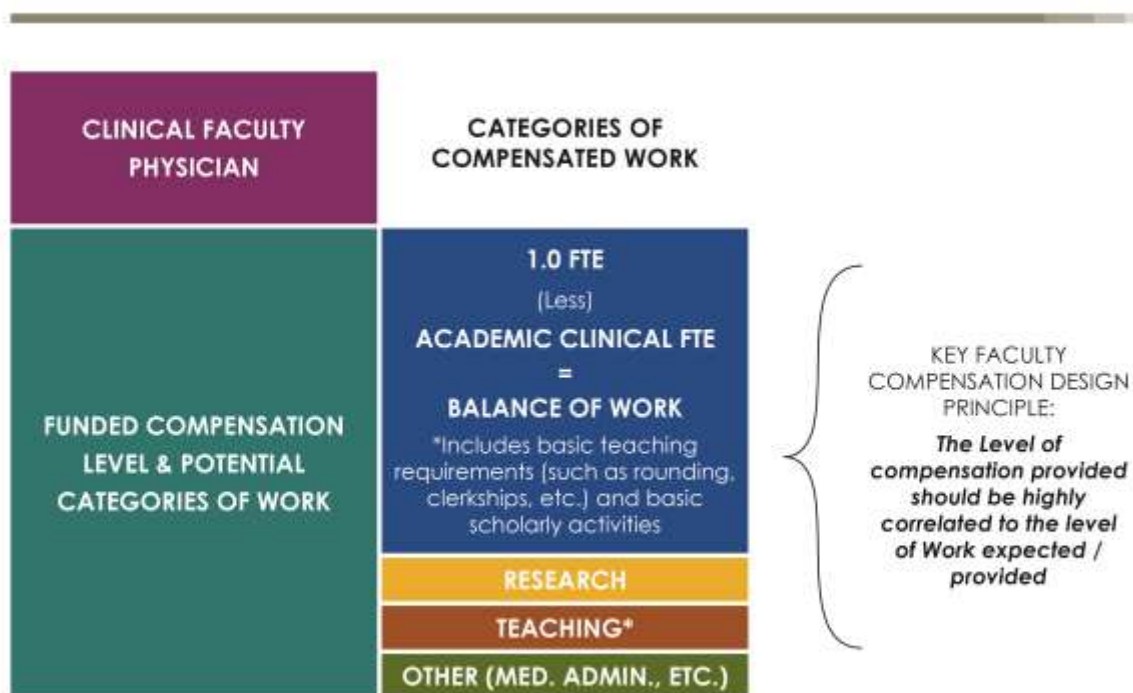


Enhancing Consistency in the Development of Base Salaries

As shown in *Figure 17*, the Market Example Plan approached the definition of a faculty member's full-time equivalency (FTE) with the initial assumption that the physician is a

1.0 academic clinical FTE. That level may only be reduced to the extent that a defined source of funding exists for other budgeted research, teaching, and/or medical administrative roles. Payment for strategic work is generally included within medical administrative roles, or provided as “proxy” production credit within one of the other CARTS categories.

Figure 17

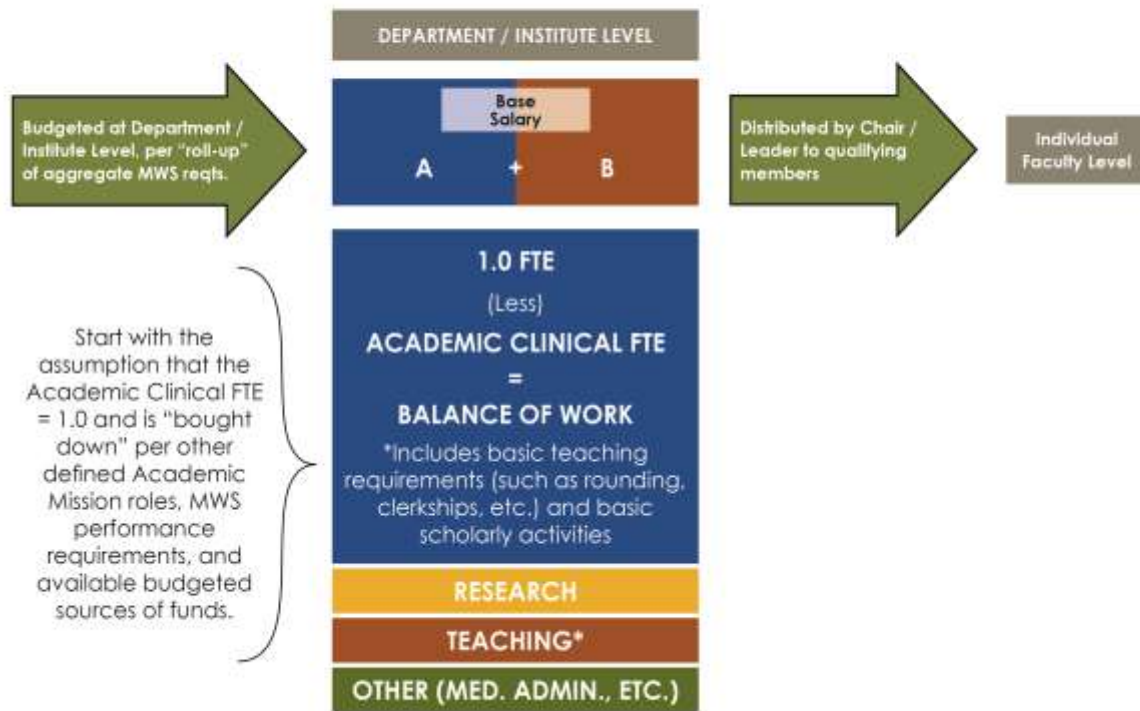


* Note: Standard levels of teaching activity are expected as part of the Faculty role. However, additional discrete teaching activities may merit distinct payments. This requires a higher level of funding accountability for the funding of these additional teaching payments (e.g., CARTS).

As set forth in *Figure 18*, the department/institute will have budgeted levels of base salaries and potential incentives based on the budgeted levels of potential performance; however, actual payouts to the faculty members will depend on achieving the MWS associated with those budgeted base salary amounts.

Figure 18

RECOMMENDED INCLUSION OF MINIMUM WORK STANDARDS (MWS) FOR FUNDING & PERFORMANCE



Enhancing Accountability to Earn Base Salaries Through Clarified MWS

The inclusion of consistent categories of MWS and performance levels to earn the physician’s base salary help advance both internal equity, as well as more-consistent accountability for the Curve 1 and Curve 2 behaviors needed by the AMC. While the categories for MWS should be similar, the actual performance target and metrics may be tailored to account for differences in the department/institute’s history and nature of the subspecialty practice setting. *Figure 19* shows a number of standard MWS that can be utilized for the clinical salary. *Figure 20* sets forth some MWS parameters to earn compensation for teaching, research, and other medical administrative activities.

Figure 19

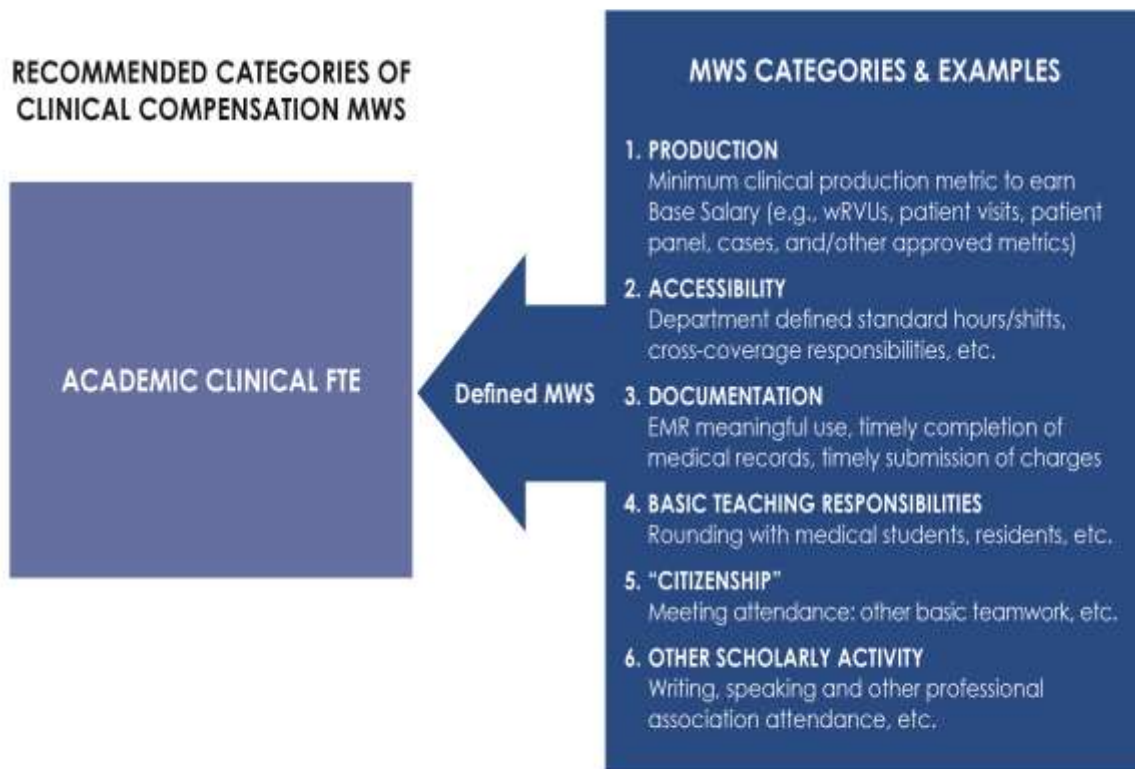
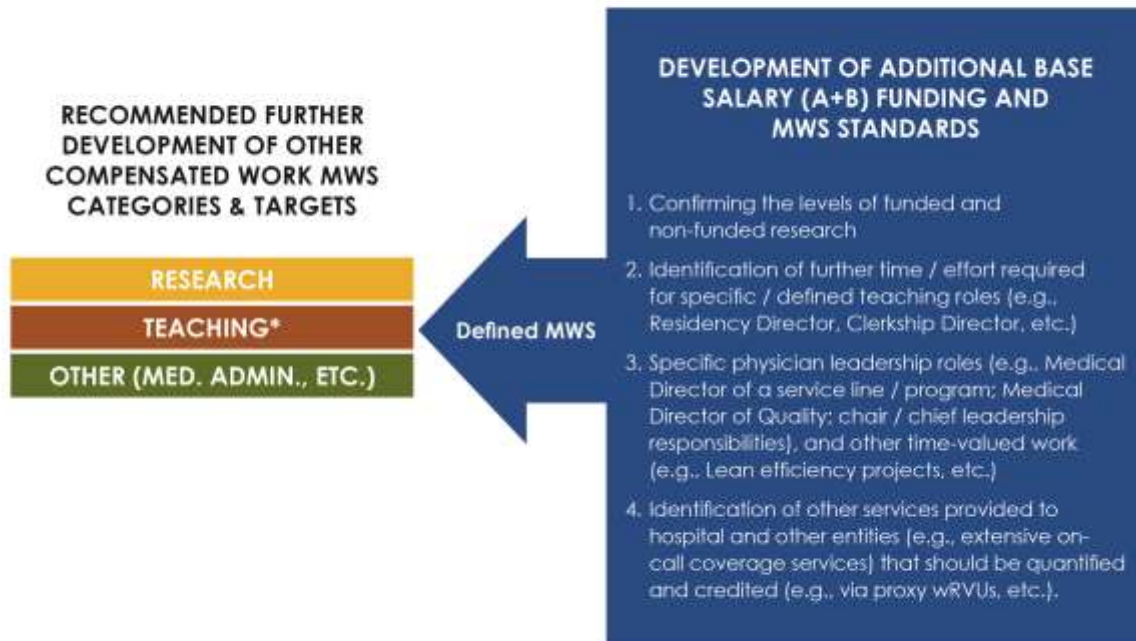


Figure 20



Remedies for Failure to Meet MWS Requirements

If a physician receives notice and fails to meet the MWS, a series of remedies are available. The first recommended remedy is a disqualification from any other plan design incentives until the standard is met. For continued violations of the MWS requirements, a physician may receive a base salary reduction during the plan year, up to a specified pre-approved percentage, or within leadership discretion. For ongoing violations, termination for cause is the most extreme remedy; this approach allows enhanced accountability in the compensation plan and reinforcement of even the most basic behaviors required to establish and maintain a well-aligned faculty plan group.

Allowances for Bands of Performance to Earn Base Salaries

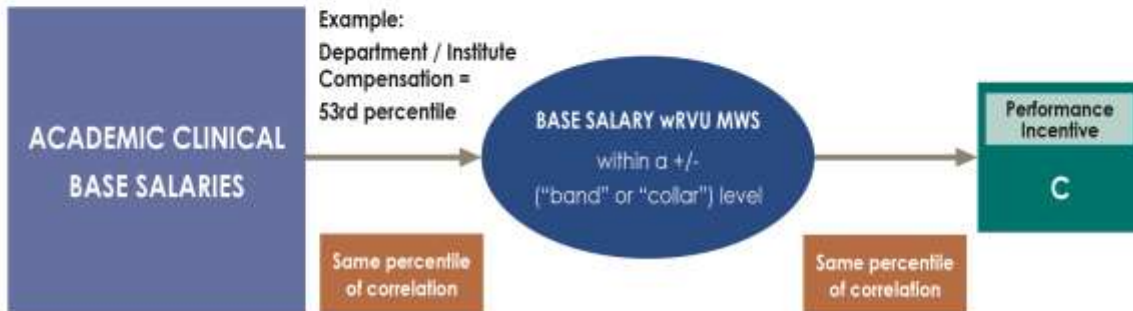
Similar to the tiers to establish base salaries within Option C in *Figure 10*, the Market Example Plan includes bands of clinical performance to earn a subspecialty-specific level of compensation (tied to the physician's academic rank or assigned equivalent). Rather than expecting an exact level of personally produced wRVUs to earn their base salary, physicians would be allowed to be plus or minus a defined "band" of percentile points to their base salary compensation level.

As shown in *Figure 21*, a ten percentile-point variance (up or down) was allowed, for example, for a physician with a 53rd percentile base salary level. Therefore, if produced wRVUs are within the 43rd to 63rd percentile levels corresponding to the physician's specialty and rank-specific academic benchmark, then the base salary is earned. Modest exceptions to this approach may be allowed at the leader's discretion for continued payment of the budgeted base salaries to individual faculty members in a department/institute; however, for continued funding of base salary levels at the department/institute level, the actual wRVU production must be within the "collar" of those selected percentile bands.

The allowance for such bands also helped assuage some concerns of the respective physician and administrative leaders that the reported academic compensation and production benchmarks included comparable practice environments for the respective AMCs and their faculty. (In this instance, the AAMC Faculty Compensation Survey and University Health Consortium (UHC) production data were utilized for full-time faculty members.)

Figure 21

RECOMMENDED INCLUSION OF "CORRELATION COLLAR" FOR MWS & INCENTIVE TARGETS



- » **DOWNSIDE TARGET:** If required correlation is 10%, then wRVU production must be no less than 43rd percentile (e.g., 53rd percentile less 10 percentile points).
- » **UPSIDE TARGET:** If required correlation is 10%, then no new \$ for wRVU production until 63rd percentile (e.g., 53rd plus 10 percentile points).

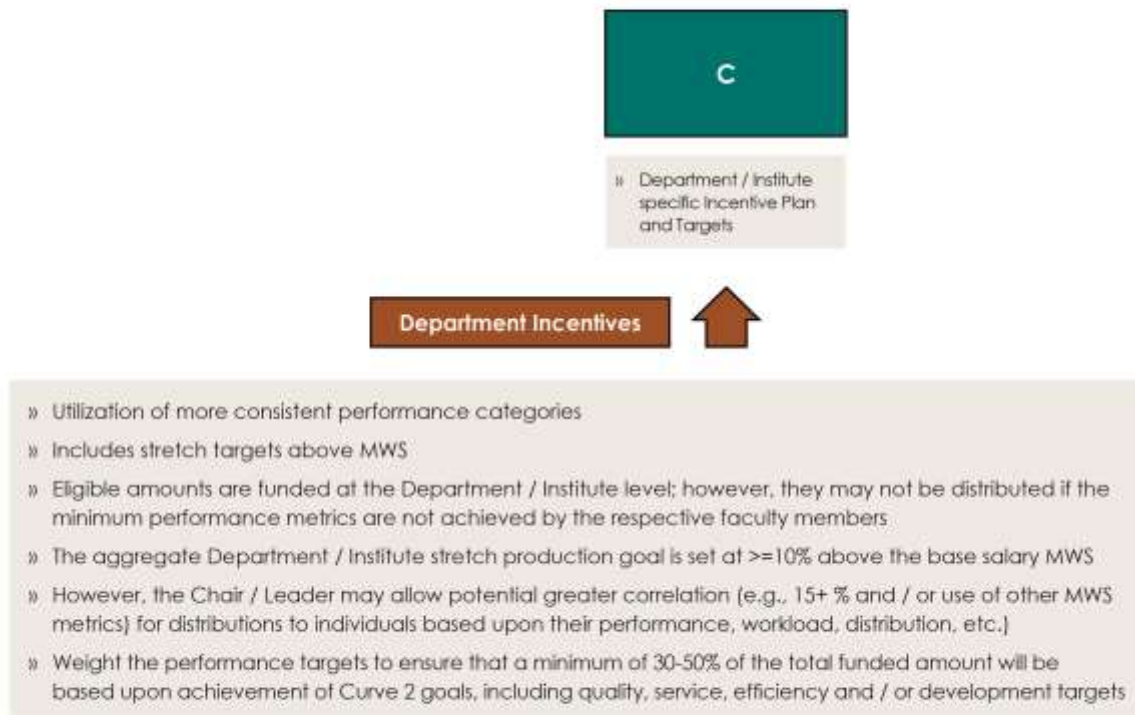
- » To set a stretch goal for the budgeted portion of Category C Performance Incentives at the Department / Institute levels, the same percentage of the "band" or "collar" of percentile correlation should be utilized for both the upside and downside targets.
- » However, the Chairs / Directors may utilize other metrics and/or correlation targets for distribution of the earned incentives to their respective individual faculty members.

Inclusion of Additional Funded Potential Performance Incentives for Stretch Goals

Similar to the inclusion of additional Curve 2 performance incentives in Option D, set forth in *Figure 10*, the Market Example Plan includes performance incentives, as illustrated in *Figure 22*.

Figure 22

RECOMMENDED INCLUSION OF BALANCED PRODUCTION AND NON-PRODUCTION INCENTIVES



Inclusion of Discretionary Incentives for Other Exceptional Performance

Similar to the inclusion of an allowance for other performance incentives in Option D, as set forth in *Figure 10*, the Market Example Plan includes an opportunity for contingent funded additional performance incentives for exceptional individual or team performance, as illustrated in *Figure 23*.

Figure 23

RECOMMENDED INCLUSION OF FURTHER "ENTERPRISE-BASED" & OTHER INCENTIVES



Additional Lessons Learned from the Market Example Plan Development Experience

Additional lessons learned from AMCs' increased use of the base-plus-incentive approach include:

- Acknowledging that the pressures and reliance on clinical revenue to support all academic missions continues to require higher levels of accountability for wRVUs, professional collections, and/or other clinical volume within better defined MWS to "earn" the budgeted base salaries;

- Willingness to fund base salaries at the department or division level, to the extent the aggregate participants' production and qualitative performance meets budgeted levels of MWS targets;
- Willingness to allow chairs and division leaders discretion to set varying clinical production MWS targets at the individual faculty member level and allocate work to maximize team-based performance;
- Acknowledging that AMCs must require better defined sources of funding for all missions, including otherwise non-funded additional teaching and research activities. For example, requiring that there be MWS for all forms of funded base salary activities, and potentially reduced salaries for non-funded activities or unmet MWS;
- Clarifying that the initial academic clinical FTE is set at a 1.0 level and that the sources of funding for buy downs in other activities above and beyond teaching, research, and medical administrative activities must be clearly identified;
- Increasing budgeting for performance incentives (as a percentage of base salary levels) based on a combination of production and non-production metrics, for achieving stretch goals that exceed base salary MWS levels. Examples could include incentives for excess wRVUs above the MWS level required to earn the clinical base salary level, or achieving a high level of defined core measures for clinical protocols or actual outcomes;
- Recognizing that open-ended incentives for higher volumes of wRVUs or similar metrics (rather than balanced Curve 1 and Curve 2 incentives) will continue to promote volume-based behaviors. Placing a cap on the potential incentive for incremental wRVUs or other volume-based production metrics will better strike an appropriate balance, as well as better limit the organization's subsidization for incentives without a funding source;
- Providing that up to 25–50% of the potential (beyond base salary) performance incentives is based on non-production metrics, to heighten focus and reliance on documented quality, service, and efficiency behaviors. Examples could include high

levels of patient satisfaction, clinical outcomes, and achieving expense/wRVU targets;

- Including increased “other incentives” for supportive physician co-management activities of key service lines and programs that result in higher levels of efficiency, reduced costs, and expanded service offerings. Examples could include payments to aligned faculty members for adhering to protocols that reduce readmissions, improve operating room turnaround times, and standardize surgical device implants; and
- Increasing emphasis on team-based work and decreasing emphasis on individual performance.

Physician Services Compensation Regulatory and Valuation Considerations

Overview of Legal and Regulatory Requirements

AMCs are not immune from the myriad federal and state laws that impact financial relationships between physicians and other participants in the health care payment and delivery system. Indeed, applying these laws to AMCs can be difficult because AMCs are typically complex, multi-faceted organizations, and each AMC is structured and operated in a unique way based on its marketplace, historical evolution, and other factors. Moreover, given that some of these laws were developed to combat fraud and abuse in the Curve 1 fee-for-service world, application of these laws during the transition to the Curve 2 world can be particularly challenging and frustrating. Although a full exploration of the application of these laws is beyond the scope of this Member Briefing, this Member Briefing does provide an overview of two of these laws—the federal Physician Self-Referral Law (Stark Law) and the federal Anti-Kickback Statute (Anti-Kickback Statute)—that should be taken into account when designing and implementing academic physician compensation plans.

Introduction to Application of the Stark Law to AMC Compensation Arrangements

The Stark Law generally prohibits a physician from making a referral to an entity for the provision of designated health services (DHS) reimbursable under Medicare or Medicaid if the physician or an immediate family member has a financial relationship with the entity. Notwithstanding this general rule, referrals are not prohibited under the Stark Law if the requirements of an applicable exception are satisfied.

The Stark Law's key terms are broadly defined resulting in its far-reaching application. Of particular note for AMCs, which by definition include teaching hospitals, is that all inpatient and outpatient hospital services (as well as certain other services that various other components of an AMC may provide) are included in the definition of "designated health services." In addition, the term "financial relationship" includes not only *direct*, but also *indirect*, ownership or investment interests and compensation arrangements. Thus, AMCs must consider the application of the Stark Law to their academic physicians' referrals to each AMC component with which the physician has a direct financial relationship, and to each AMC component with which the physician has an indirect financial relationship. Academic physicians would typically have a direct compensation arrangement with their faculty practice plan employer (to which they may refer for some DHS, such as diagnostic imaging or laboratory testing services). They also may have an indirect compensation arrangement with other AMC components, such as the AMC's teaching hospitals.

With respect to an academic physician's potential financial relationship with each AMC component to which the physician makes a referral, there may be various alternative ways to analyze Stark Law application, depending on the facts involved. This Member Briefing focuses on four concepts central to many AMCs' Stark Law compliance: (1) the AMC exception; (2) the bona fide employment relationships exception; (3) the definition of an "indirect compensation arrangement"; and (4) the related indirect compensation arrangements exception. This Member Briefing also highlights the most relevant elements of those concepts regarding the design of a physician compensation plan for academic physicians.

The Stark Law's AMC Exception

In its 2001 “Phase One” final Stark Law regulations, CMS (then called the Health Care Financing Administration) developed a regulatory exception for services provided by an AMC. CMS explained that other exceptions under the Stark Law do not easily apply to AMCs, which can involve “multiple affiliated entities that jointly deliver health care services to patients (for example, a faculty practice plan, medical school, teaching hospital, outpatient clinics)” where there are “frequent referrals and monetary transfers between these various entities and these relationships raise the possibility of indirect remuneration for referrals.”¹ Put more directly, teaching hospitals within AMCs often subsidize, in one way or another, the professional clinical practices of academic physicians, who may spend some time on non-revenue producing activities, such as research and teaching, and who also may refer patients to the teaching hospitals. The Stark Law’s AMC exception reflects the government’s view that the Stark Law should not disrupt these financial relationships if certain protections are in place.

The Stark Law’s AMC exception includes four sets of requirements: (1) requirements concerning the referring physician; (2) conditions applicable to the compensation paid to the referring physician; (3) conditions relating to the AMC; and (4) a condition involving compliance with other laws. The exception also defines the term “academic medical center.” If all these requirements are met, the Stark Law’s prohibition on referrals does not apply to the services provided by an AMC.² Although the AMC exception is especially technical and specific, interestingly, in the first case to apply the Stark Law’s AMC exception, a federal district court took a very flexible, rather than “hyper-technical,” approach in applying the exception.³ Later cases in other contexts suggest that one cannot count on such a lenient application in the face of alleged Stark Law violations.⁴

The exception’s definition of the term “academic medical center” is critical, of course, since the exception applies only to services furnished by an AMC. The definition states that an AMC consists of the following three elements: (1) an accredited medical school

¹ See 66 Fed. Reg. 916 (2001).

² See 42 C.F.R. § 411.355(e).

³ See *United States ex rel. Villafane v. Solinger*, 543 F. Supp. 2d 678 (W.D. Ky., 2008).

⁴ See, e.g., *United States ex rel. Kosenske v. Carlisle HMA, Inc.*, 554 F.3d 88 (3d Cir. 2009).

or an accredited academic hospital (i.e., a hospital or a health system that sponsors four or more approved medical education programs); (2) one or more faculty practice plans affiliated with the medical school, the affiliated hospital(s), or the accredited academic hospital; and (3) one or more affiliated hospitals in which a majority of the physicians on the medical staff consists of physicians who are faculty members, and a majority of all hospital admissions is made by physicians who are faculty members. An AMC may include other components as well; elsewhere the exception specifies that a component of an AMC “means an affiliated medical school, faculty practice plan, hospital, teaching facility, institution of higher education, departmental professional corporation, or nonprofit support organization whose primary purpose is supporting the teaching mission of the academic medical center.”⁵

The four sets of requirements contained in the AMC exception are as follows:

- The requirements pertaining to the referring physician mandate that the referring physician must be a bona fide employee of a component of the AMC on a full-time or substantial part-time basis, must be licensed in the states in which the referring physician practices, must have a bona fide faculty appointment at the affiliated medical school or accredited academic hospital, and must provide substantial academic and/or clinical teaching services for which the faculty member receives compensation as part of the faculty member’s employment. (Physicians who spend at least 20% of their professional time or eight hours per week providing academic and/or clinical teaching services are deemed to have met the “substantial” requirement.);
- The conditions applicable to the compensation paid to the referring physician include the requirements that the total compensation paid by each AMC component must be set in advance, the aggregate compensation paid by all AMC components to the referring physician cannot exceed fair market value (FMV), and the total compensation paid by each AMC component may not be determined in a manner that takes into account the volume or value of any

⁵ 42 C.F.R. § 411.355(e)(1)(i).

referrals or other business generated by the referring physician within the AMC;

- The conditions relating to the AMC require that all transfers of money between components of the AMC must directly or indirectly support the missions of teaching, indigent care, research, or community service; the relationship among the components of the AMC must be set forth in written documents adopted by the governing body of each component; and all money paid to a referring physician for research must be used solely to support bona fide research or teaching and must be consistent with the terms and conditions of the grant; and
- The condition related to compliance with other laws states that the referring physician's compensation arrangement cannot violate the Anti-Kickback Statute or any federal or state law or regulation governing billing or claims submission.

This second set of requirements is central to an AMC's design of a physician compensation plan. Specifically, an AMC relying on the AMC exception should ensure that its compensation plan design will enable it to satisfy the "set in advance," "fair market value," and "volume or value" limitations. These requirements resemble requirements contained in other Stark Law exceptions discussed later in this Member Briefing.

Stark Law Compliance Alternatives to the AMC Exception

In one sense, the AMC exception is very broad and provides expansive protection from the Stark Law for AMCs. As indicated above, the exception applies to *all* services furnished by an AMC, regardless of the array of direct and indirect compensation arrangements that a referring academic physician may have with various AMC components. Thus, if the requirements of the exception are satisfied, there would be no need to comply with any other exception with respect to the academic physician's referrals to AMC components.

Yet, many AMCs find that they may be disqualified from relying on the AMC exception because the exception contains numerous and very specific conditions. The utility of the AMC exception is even more limited for AMCs that have sought to create regional integrated delivery networks that include community hospitals and community physicians. Specifically, for example, the AMC exception may not apply to referrals for services furnished by community hospitals whose medical staffs do not comprise mainly faculty members and do not sponsor at least four residency training programs, or to referrals from employed community physicians who do not devote a “substantial” portion of their time to academic and/or clinical teaching services.

CMS has acknowledged that, if an AMC cannot meet the requirements of the AMC exception, it can comply with the Stark Law in other ways. For example, CMS has said that the exception for bona fide employment relationships, the definition of “indirect compensation arrangement,” and the exception for indirect compensation arrangements (among others) are potentially applicable to arrangements involving AMCs and physicians.⁶ Indeed, many AMCs analyze their Stark Law compliance in these alternative ways. Those AMCs should be aware of the requirements under these alternatives that may impact their physician compensation plan design.

Typically, academic physicians are not owners of the faculty practice plan through which they practice, but rather are employed by a faculty practice plan or other practice entity, distinct from the teaching hospital and other AMC components. *Figure 24* depicts a typical structure showing the relationships among the academic physician, the faculty practice plan, and the affiliated teaching hospital. In such a case, for Stark Law purposes, each employed academic physician would be regarded as having a *direct* compensation arrangement with the faculty practice plan. As a result, under the Stark Law, each such physician’s referrals to the faculty practice plan for the furnishing of any Medicare or Medicaid reimbursable DHS (such as diagnostic imaging or clinical laboratory services that the faculty practice plan may furnish) would be prohibited unless an exception is satisfied. One potentially applicable exception is the Stark Law’s exception for bona fide employment relationships, discussed below.

⁶ See 72 Fed. Reg. 51037-51038 (2007).

Figure 24

POTENTIAL INDIRECT COMPENSATION ARRANGEMENT BETWEEN REFERRING ACADEMIC PHYSICIAN AND TEACHING HOSPITAL



In addition, where the teaching hospital or other AMC components provide mission support payments to the faculty practice plan, each employed academic physician has a potential *indirect* compensation arrangement with those AMC components. Where the AMC exception is not available, for an academic physician’s referrals to such AMC components to be permitted under the Stark Law, there must be either no actual indirect compensation arrangement under the Stark Law definition of that term, or, if there is an actual indirect compensation arrangement, the requirements of the indirect compensation exception must be satisfied. The indirect compensation arrangements definition and exception are discussed below.

The Stark Law’s Exception for Bona Fide Employment Relationships

The Stark Law includes an exception for any amount paid by an employer to a physician who has a bona fide employment relationship with the employer for the provision of

services. The exception includes three conditions: (1) the employment must be for identifiable services; (2) the amount of the remuneration under the employment must be consistent with the FMV of the services and may not be determined in a manner that takes into account (directly or indirectly) the volume or value of any referrals by the referring physician (although a productivity bonus based on services performed personally by the physician is explicitly permitted); and (3) the remuneration must be provided under an agreement that would be commercially reasonable even if the physician did not make referrals the employer.

Thus, AMCs relying on this exception where academic physicians refer DHS to the employer faculty practice plan should ensure that the physician compensation plan is designed to satisfy the “fair market value,” “volume or value,” and “commercial reasonableness” standards—each of which is discussed below.

The Stark Law’s Indirect Compensation Definition

As noted above, academic physicians employed by a faculty practice plan may be regarded as having an indirect compensation arrangement with the AMC’s affiliated teaching hospital and other AMC components that furnish DHS. The Stark Law establishes a three-part test to determine whether a physician, in fact, has an indirect compensation arrangement with an entity to which the physician refers. The first part of the test requires a finding that the referring physician and the entity furnishing DHS are connected by an unbroken chain of any number (but not fewer than one) of persons or entities that have financial relationships between them. If there are “fewer than one” persons or entities in the chain between the referring physician and the entity furnishing DHS, the physician would be regarded as having a *direct* compensation arrangement with the entity. Consideration must be given to the “stand in the shoes” rules under the Stark Law to assess whether there is fewer than one intervening persons or entities. Under the “stand in the shoes” rules, physicians are deemed to stand in the shoes of their physician organization if the physicians have an ownership or investment interest in the physician organization (unless the ownership or investment interest is titular only), and are permitted (but not required) to stand in the shoes of their physician organization

in all other cases.⁷ For a typical AMC (depicted in *Figure 24*) where an academic physician does not have a non-titular ownership or investment interest in the faculty practice plan, the academic physician is not required to stand in the shoes of the faculty practice plan, and therefore, the faculty practice plan constitutes an intervening entity between the academic physician and the teaching hospital. As a result, in these cases, the first part of the three-part test for an indirect compensation arrangement is satisfied for purposes of a potential indirect compensation arrangement between the academic physician and the teaching hospital.

The second part of the three-part test is satisfied if the referring physician (or immediate family member) receives *aggregate* compensation from the person or entity in the chain with which the physician (or immediate family member) has a direct financial relationship that varies with, or takes into account, the volume or value of referrals or other business generated by the referring physician for the entity furnishing DHS. CMS has indicated that “many time-based or unit-of-service based fee arrangements will involve aggregate compensation that varies based on volume or value of services.”⁸ In addition, CMS has suggested that even with fixed compensation arrangements, aggregate compensation could possibly “take into account” referrals if, for example, the fixed compensation exceeds FMV or is inflated to reflect the volume or value of a physician’s referrals or other business generated.⁹ Thus, the second part of the test may be satisfied where a variable compensation component in an academic physician’s employment agreement results in a correlation between the physician’s compensation and the physician’s referrals to the affiliated teaching hospital or other AMC components furnishing DHS referred by the academic physicians. Further, even in cases where the physician is paid solely on a fixed periodic basis, the physician’s aggregate compensation could be found to take into account the physician’s referrals if compensation exceeds FMV.

The third part of the three-part test considers whether the entity furnishing DHS has actual knowledge of, or acts in reckless disregard or deliberate ignorance of, the fact

⁷ See 42 C.F.R. § 411.354(c)(2)(iv).

⁸ See 72 Fed. Reg. 51029 (2007).

⁹ See 69 Fed. Reg. 16059 (2004).

that the referring physician (or immediate family member) receives aggregate compensation that varies with, or takes into account, the volume or value of referrals or other business generated by the referring physician for the entity furnishing DHS. In most AMC settings, the teaching hospital and other AMC components furnishing DHS would likely know or be deemed to know of the terms of the physician's compensation arrangements with the faculty practice plan. As a result, the third part of the test is usually easily satisfied.

From the perspective of physician compensation plan design, the most significant factor in assessing whether an academic physician has an indirect compensation arrangement under this test is whether the physician's aggregate compensation varies with the volume or value of the physician's referrals. The aggregate compensation to a physician receiving a fixed periodic salary consistent with FMV would generally not be regarded as varying with the volume or value of the physician's referrals. In addition, if there is a variable component of a physician's compensation, but the performance measures used to award that component are unrelated to the physician's referrals to AMC components furnishing DHS, the physician's compensation also would not be regarded as varying with the volume or value of the physician's referrals. In those cases, since the physician would have neither a direct nor (under the three-part test) an indirect compensation arrangement with other AMC components, the Stark Law would not prohibit the physician's referrals to those AMC components. If, on the other hand, the physician compensation plan includes a variable component and there is a relationship between the metrics used to determine the amount of a physician's compensation and the physician's referrals, the three-part test may be satisfied, and the indirect compensation arrangements exception will need to be satisfied.

The Stark Law's Indirect Compensation Arrangements Exception

If, based on the application of the three-part test, an academic physician is determined to have an indirect compensation arrangement with an AMC's affiliated teaching hospital or other AMC component to which the physician makes a referral, the physician's referrals may nevertheless be permitted if the requirements of the indirect

compensation arrangements exception are satisfied. Many AMCs rely on the indirect compensation arrangements exception because its requirements are fewer and less technical than the requirements of the AMC exception.

Specifically, the indirect compensation arrangements exception focuses on the compensation arrangement in the chain closest to the referring physician (in the example depicted in *Figure 24*, this would be the physician's employment agreement). If that compensation arrangement is an employment relationship (typical for most AMCs), the exception includes three requirements: (1) compensation received by the referring physician (or immediate family member) must be FMV for services and items actually provided and not determined in any manner that takes into account the volume or value of referrals or other business generated by the referring physician for the entity furnishing DHS; (2) employment must be for identifiable services and must be commercially reasonable even if no referrals are made to the employer; and (3) the compensation arrangement must not violate the Anti-Kickback Statute or any federal or state law or regulation governing billing or claims submission.

In most cases, whether an AMC's employment arrangements with academic physicians can meet the requirements of the indirect compensation arrangements exception depends mainly on the design of the physicians' compensation plan. Although not required, a written appointment letter usually memorializes the academic physicians' employment, which typically will adequately identify the services the physician will furnish. The requirement that the compensation arrangement not violate the Anti-Kickback Statute is discussed below. Therefore, compliance with indirect compensation arrangements exceptions usually hinges on the ability to demonstrate that the physician's employment compensation meets the "fair market value," "commercially reasonableness," and "volume or value" standards. These requirements are discussed below.

Application of the Anti-Kickback Statute to AMC Compensation Arrangements

The Anti-Kickback Statute,¹⁰ establishes criminal penalties with respect to any person who knowingly and willfully offers, pays, solicits, or receives any remuneration to induce or in return for: (1) referring an individual to a person for the furnishing or arranging for the furnishing of any item or service payable in whole or in part under federal health care programs; or (2) purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item payable under federal health care programs. In addition to the criminal sanctions under the Anti-Kickback Statute, a violation can lead to exclusion of an organization from participation in Medicare or Medicaid,¹¹ imposition of civil monetary penalties,¹² and liability under the False Claims Act.¹³ Several court decisions have held that the Anti-Kickback Statute is implicated when one purpose of the remuneration is to generate business reimbursable under a federal health care program.¹⁴

The Anti-Kickback Statute contains a limited number of statutory exceptions. In 1987 Congress enacted the Medicare and Medicaid Patient and Program Protection Act, which, among other things, directed the Office of Inspector General (OIG) of the U.S. Department of Health and Human Services to develop safe harbor regulations under the Anti-Kickback Statute. Over the years, the OIG has issued several safe harbors defining specific business relationships immune from sanction under the Anti-Kickback Statute.¹⁵ Generally, the safe harbors are written narrowly to cover arrangements for which the OIG has concluded that there is no risk of fraud and abuse. The failure of an arrangement to meet safe harbor requirements does not mean the arrangement is illegal; rather, in such cases, the focus is on the intent of the parties. Recognizing the need for additional guidance for arrangements not clearly covered by the safe harbors, in 1996, as part of the Health Insurance Portability and Accountability Act, Congress

¹⁰ See 42 U.S.C. § 1320a-7b(b).

¹¹ See 42 U.S.C. § 1320a-7.

¹² See 42 U.S.C. § 1320a-7a(a)(7).

¹³ See 42 U.S.C. § 1320a-7b(g).

¹⁴ See, e.g., *United States v. Greber*, 760 F.2d 68 (3d Cir.), cert. denied, 474 U.S. 988 (1985).

¹⁵ See 42 C.F.R. § 1001.952.

also required the OIG to issue advisory opinions to requesting parties regarding the application of the Anti-Kickback Statute and the safe harbor provisions.

Unlike the Stark Law, the Anti-Kickback Statute is not limited to the referral activities of physicians. Rather, it can apply to remuneration for referrals or other business generation activities of both physicians and non-physician parties. Thus, in the context of an AMC, questions can arise concerning the application of the Anti-Kickback Statute to the financial arrangements among the components of the AMC. A few OIG advisory opinions have touched on the application of the Anti-Kickback Statute to the financial relationships among AMC components.¹⁶ Since this Member Briefing focuses on physician compensation plan design, a full discussion of the application of the Anti-Kickback Statute to relationships among AMC components is beyond its scope. However, this Member Briefing will touch on the application of the Anti-Kickback Statute on the employment relationships of academic physicians who may make referrals to AMC components.

A statutory exception and a regulatory safe harbor exist for bona fide employment arrangements. The statutory exception covers “any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or services”¹⁷ The regulatory safe harbor uses similar language, and also adopts the usual common law rules used for federal income tax purposes to determine whether an individual has the status of an employee.

Although it may appear straightforward, in some situations there can be uncertainty in the applicability of the bona fide employee exception and safe harbor. For example, in one case, a court held that the statutory exception did not protect employees because they were not providing covered items and services in their capacities as employees.¹⁸

As a result of the uncertainty of the scope of the bona fide employee exception and safe harbor, a prudent approach to Anti-Kickback Statute compliance is to ensure that an

¹⁶ See AO 00-06, AO 02-11, and AO 05-11.

¹⁷ See 42 U.S.C. § 1320a-7b(b)(3)(B).

¹⁸ See *United States v. Starks*, 157 F.3d 833 (11th Cir. 1998).

employed academic physician's compensation is consistent with FMV, and is not based on the volume or value of referrals. Those concepts are discussed below.

FMV Standard

As discussed above, FMV compensation is a critical element in assuring that an applicable Stark Law exception can be met and, therefore, that an academic physician's referrals are not prohibited. The definition of "fair market value" under the Stark Law is, in relevant part, as follows:

Fair market value means the value in arm's-length transactions, consistent with the general market value. "General market value" means the price that an asset would bring as the result of bona fide bargaining between well-informed buyers and sellers who are not otherwise in a position to generate business for the other party, or the compensation that would be included in a service agreement as the result of bona fide bargaining between well-informed parties to the agreement who are not otherwise in a position to generate business for the other party, on the date of acquisition of the asset or at the time of the service agreement. Usually, the fair market price is the price at which bona fide sales have been consummated for assets of like type, quality, and quantity in a particular market at the time of acquisition, or the compensation that has been included in bona fide service agreements with comparable terms at the time of the agreement, where the price or compensation has not been determined in any manner that takes into account the volume or value of anticipated or actual referrals.¹⁹

In the context of compensation paid by academic physicians, CMS said in its Phase One regulations: "[W]e believe the relevant comparison is aggregate compensation paid to physicians practicing in similar academic settings located in similar environments. Relevant factors include geographic location, size of the academic institutions, scope of

¹⁹ See 42 C.F.R. § 411.351.

clinical and academic programs offered, and the nature of local health care marketplace. Nothing in this regulation is intended to preclude productivity bonuses paid to academic medical center physicians on the basis of services they personally perform.”²⁰ In the preamble to the Phase Two regulations, CMS added: “One commenter asked us to clarify that in establishing a referring physician’s compensation, an academic medical center is not limited to the fair market value at other academic medical centers if the fair market value for comparable private practice physicians in its area is higher. . . . The commenter is correct. An academic medical center can use either measure of fair market value.”²¹

The Internal Revenue Code Revenue Ruling 59–60 defines the term “fair market value” as “the price at which the property would change hands between a willing buyer and willing seller when the former is not under any compulsion to buy and the latter is not under any compulsion to sell; both parties have reasonable knowledge of relevant facts.” The term “medical services” can be substituted for “property” in the above definition to determine the FMV compensation in a service or employment relationship.

Under Internal Revenue Service (IRS) final regulations concerning excess benefit transactions, the term “fair market value” means, with respect to both the transfer and the right to use property, the price at which the property or the right to use property would change hands between a willing buyer and a willing seller, neither being under any compulsion to buy, sell, or transfer property, or the right to use property, and both having reasonable knowledge of relevant facts. Furthermore, such IRS regulations also indicate, with respect to services provided, that the FMV of services is the amount ordinarily provided for like services by like enterprises (whether taxable or tax exempt) under like circumstances (i.e., reasonable compensation).

FMV concepts should be applied on a case-by-case basis with the facts and circumstances of each transaction carefully considered. Furthermore, FMV is typically viewed in the marketplace as a range of potential payments rather than a single dollar amount. Importantly, since, under the Stark Law, FMV must be consistent with what

²⁰ See 66 Fed. Reg. 916.

²¹ See 69 Fed. Reg. 16110.

parties who are not in a referral relationship would agree to, what parties who are in a referral relationship may actually negotiate is presumed not to be indicative of FMV. Accordingly, it is prudent in many cases for AMCs to obtain some independent comfort that compensation terms are consistent with FMV. Below, this Member Briefing discusses the accepted methodologies used to assess FMV.

Commercial Reasonableness Standard

The requirement for commercially reasonable compensation is an additional standard (distinct from the FMV requirement) in several of the exceptions discussed above. However, the Stark Law does not define the term “commercially reasonable.” CMS’ preamble to its 1998 proposed Stark Law regulations interpreted “‘commercially reasonable’ to mean that an arrangement appears to be a sensible, prudent business agreement, from the perspective of the particular parties involved, even in the absence of any potential referrals.”²² Later, in the preamble to the Phase Two regulations, CMS noted that an arrangement “will be considered ‘commercially reasonable’ in the absence of referrals if the arrangement would make commercial sense if entered into by a reasonable entity of similar type and size and a reasonable physician (or family member or group practice) of similar scope and specialty, even if there were no potential DHS referrals.”²³

The commercial reasonableness requirement appears to focus on whether the referral relationship between the parties affected the terms of the arrangement in question. Examples of terms that could raise questions of commercial reasonableness include the purchase of services from a physician not qualified to furnish the services,²⁴ arrangements far outside of the normal and usual activities of the parties (e.g., a hospital financing a car for a physician), leasing equipment from a physician on a per-click basis where the volume of procedures would justify the lessee purchasing the

²² See 63 Fed. Reg. 1700 (1998).

²³ See 69 Fed. Reg. 16093 (2004).

²⁴ See *United States v. Campbell*, 2011 WL 43013 (D.N.J.).

equipment,²⁵ terms far outside the bounds of what is normally seen (e.g., extraordinarily long terms or the provision of valuable benefits to part-time employed physicians), and compensation at levels that will result in operating losses for the employer.²⁶

Set-in-Advance Standard

As described above, many of the Stark Law exceptions relevant to AMCs require that the compensation paid to a physician must be set in advance. This requirement does allow variable compensation methodologies, such as performance incentives.

Specifically, under the Stark Law:

Compensation is considered “set in advance” if the aggregate compensation, a time-based or per-unit of service- based (whether per-use or per-service) amount, or a specific formula for calculating the compensation is set in an agreement between the parties before the furnishing of the items or services for which the compensation is to be paid. The formula for determining the compensation must be set forth in sufficient detail so that it can be objectively verified, and the formula may not be changed or modified during the course of the agreement in any manner that takes into account the volume or value of referrals or other business generated by the referring physician.²⁷

Thus, in designing an academic physician compensation plan to meet this standard, the plan should be reflected in a written document, and should be sufficiently detailed and specific so that it can be objectively verified. The plan should not include wholly discretionary and arbitrary elements.

Volume or Value Standard

Many of the Stark Law exceptions also require that the compensation paid to a

²⁵ See 73 Fed. Reg. 48714 (Aug. 19, 2008).

²⁶ See *United States ex rel. Drakeford v. Tuomey Healthcare Sys., Inc.*, 675 F.3d 394 (4th Cir. 2012).

²⁷ See 42 C.F.R. § 411.354(d)(1).

physician may not vary with or take into account the volume or value of referrals or other business generated between the parties. Based on CMS' guidance, an arrangement involving fixed periodic compensation paid to a physician can be found to take into account the volume or value of referrals if the fixed compensation exceeds FMV. More significantly, for purposes of physician compensation plan design, the Stark Law acknowledges that unit-based compensation is consistent with the volume or value standard. Specifically, the Stark Law regulations state: "Unit-based compensation (including time-based or per-unit of service based compensation) is deemed not to take into account 'the volume or value of referrals' if the compensation is fair market value for services or items actually provided and does not vary during the course of the compensation arrangement in any manner that takes into account referrals of DHS."²⁸

Thus, in designing an academic physician compensation plan, it is permissible to include performance incentives that cause a physician's aggregate compensation to vary based on meeting specified metrics. Care must be taken, however, to ensure that the metrics used do not cause any physician's compensation to vary with the volume or value of the physician's referrals. In addition, the methodology used for awarding performance-based compensation may not be adjusted based on the volume or value of referrals.

Overview of Pertinent Valuation Approaches

In assessing FMV, valuation firms commonly use three approaches: the income, cost, and market. A brief overview of each methodology and its potential applicability to valuing compensation arrangements is outlined below:

Income Approach

The income approach is a forward-looking premise of value based on the assumption that the value of a service or ownership interest is equal to the sum of the present values of the expected future benefits of providing a service or owning that interest. Due

²⁸ See 42 C.F.R. § 411.354(d)(2).

to the nature of the professional services expected to be provided by the physician, the total expected benefits are not known, relevant, or applicable in an analysis such as this. The compensation paid for professional services is typically based on market rates (supply and demand) and the cost associated with providing the services.

Cost Approach

The cost approach is a general way of determining the value of a business, business ownership interest, or security using one or more methods based on the value of the assets. The cost approach often involves a calculation of the cost to replace or replicate an asset.

Market Approach

The market approach is a valuation approach in which market data is analyzed to determine what is actually being paid in the marketplace for comparable services. Data is gathered and analyzed, and a comparison is made between the facts of the subject being valued and the facts of the particular market from which the information is obtained.

Valuation consultants often rely on the market approach to assess FMV reasonableness in light of the availability of published and proprietary physician and production benchmarks for academic and non-academic physician services, and the nature of the professional services being valued.

Additional FMV Considerations

The criteria or factors to be considered when determining reasonable compensation may go well beyond a comparison to market compensation studies. Although market data are often used as a guiding factor of alignment, additional data related to the arrangement also may be considered. Among the myriad of factors that may be considered in the assessment of reasonable compensation are: (1) physician

experience, education, length of service, time devoted to service, and contribution to total enterprise output; (2) the combined nature of position duties; (3) the general and local economic conditions; (4) the competitive nature of the business in the local market; (5) supply and demand for services and providers; and (6) pertinent comparisons of compensation for similar providers in the service region and broader market.

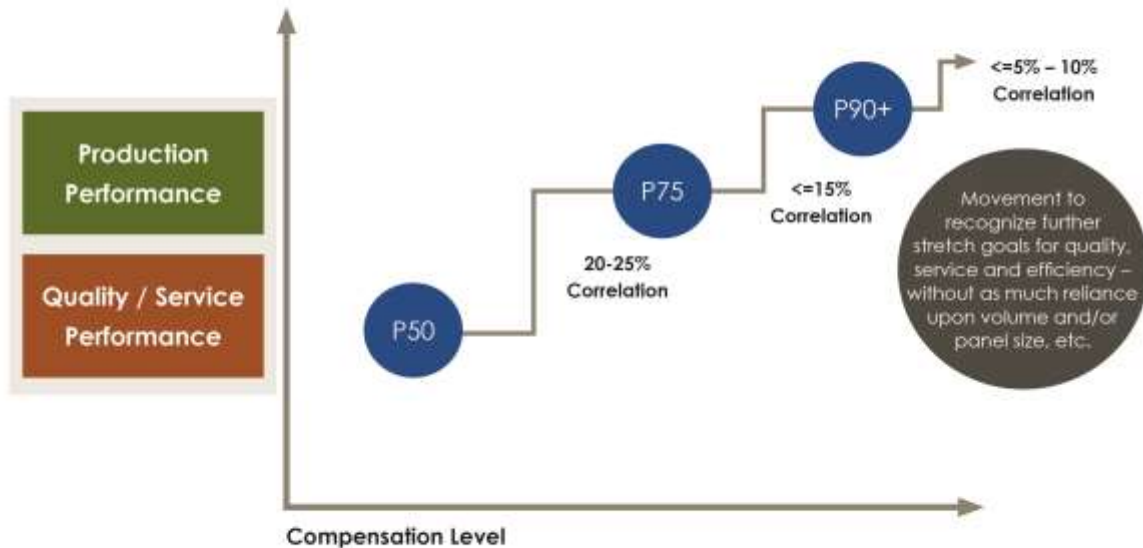
Taking those factors into account, a valuation consultant will frequently apply multiple reasonableness tests for clinical compensation, including the following:

- Compensation-per-FTE (with evaluation of the total compensation level to pertinent physician benchmarks, including any adjustments to ensure more apples-to-apples comparisons);
- Compensation-to-wRVU production ratio (with evaluation of the calculated ratio or conversion factor by dividing the compensation per the wRVU productivity and comparison to pertinent benchmarks);
- Compensation-to-professional collections ratio (with evaluation of the calculated ratio by dividing the compensation per professional collections and comparison to pertinent benchmarks); and
- Correlation of compensation-to-production (with comparison of the variance levels of compensation, as a percentile of the pertinent benchmarks, to the production levels, as a percentile of pertinent benchmarks).

When assessing FMV reasonableness, many valuation experts assess the correlation between the level of physician compensation and physician production. Higher levels of compensation typically require closer levels of correlation between compensation and production. *Figure 25* illustrates an example of this type of correlation test (comparing the variance of the compensation level as a percentile of pertinent benchmarks to production as a percentile of pertinent benchmark).

Figure 25

INCREASING IMPORTANCE OF NON-PRODUCTIVITY BEHAVIORS ARE REQUIRING REVISION OF PRIOR "CORRELATION TESTS"



There will be increasing challenges for each of these tests as the market demands higher levels of physician focus on value, service, efficiency, and other activities not necessarily focused on production. Therefore, AMCs can expect a higher reliance on the compensation-per-FTE tests and a reassessment of the correlation tests often evaluated.

Assessing the Necessity of Compensation Limits and Potential “Caps”

Increased scrutiny from both a FMV and commercial reasonableness perspective can be expected with higher levels of physician compensation. To further ensure that the physician compensation arrangements remain within a reasonable range, many of the compensation plans and related employment agreement terms include limits or caps on

the aggregate compensation paid in a single year. This approach will better prevent “stacking”—when the individual components may or may not be FMV reasonable, but often include duplicative services resulting in unreasonable compensation when aggregated without accounting for the duplicative payments and/or inclusion of caps on total compensation. The inclusion of some level of compensation limits further underscores that the budgets and assumed performance expectations are reasonable—particularly in the context of physicians whose compensation exceeds the 90th percentile of pertinent published benchmarks.

A number of AMCs have *superstar* physicians who are some of the best and brightest individuals within their subspecialty and leadership areas of focus. Many of these individuals are often some of the hardest working physicians in the market, with the legitimate ability to document hours well beyond a 1.0 FTE level. Given that direct market comparable benchmarks often do not exist and that utilization of other published and proprietary data may be required, the inclusion of a cap on the adjustments to the available benchmarks and overall total compensation is generally advisable to support the reasonableness of the arrangement with these *superstar* physicians.

Additional Considerations for the Development of Progressive Faculty Compensation Plans

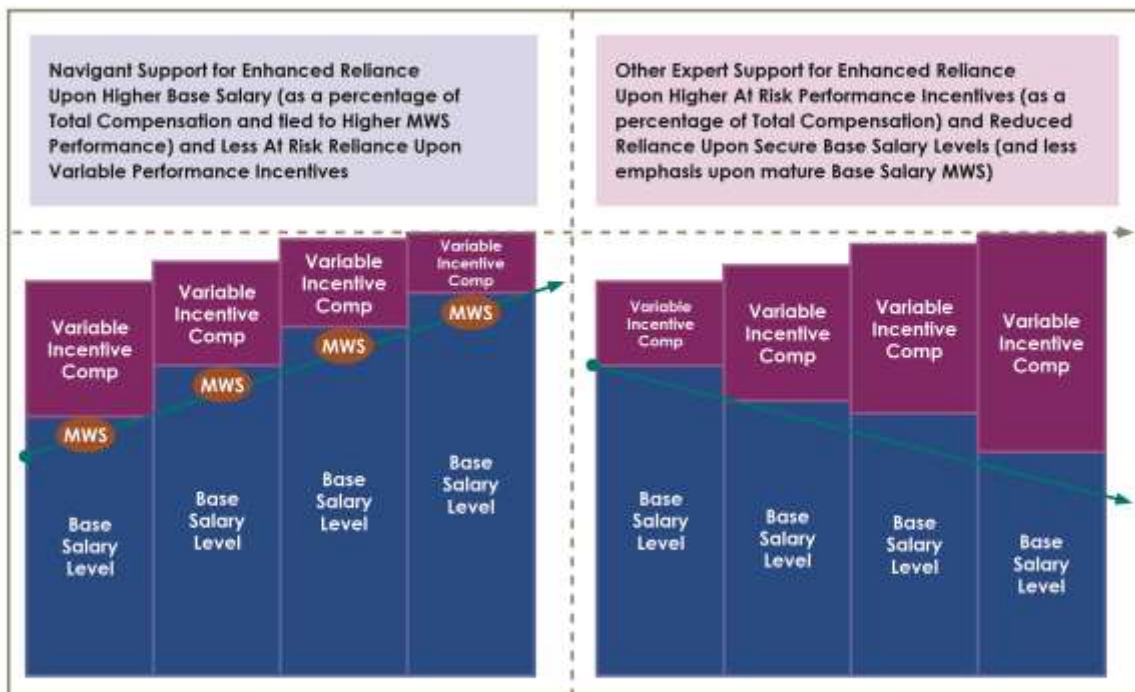
Developing a Strategic Direction for Your Plan Designs and Performance Expectations

Currently, the market is often divided about the best means to introduce Curve 2 incentives within current plan designs, and inconsistent about the varying physician employment models. One of the key challenges is to determine the best means to enhance Curve 2 behaviors, while still requiring accountability for several Curve 1 behaviors. More specifically, most physicians will likely not tolerate reduced base salaries solely to allow more at-risk compensation for greater Curve 2 behaviors. Although the best practice will include higher levels of accountability for Curve 2

behaviors, a practical approach is an increasing expectation in the MWS to maintain and/or raise base salary levels, with remedies for failure to meet those MWS.

In short, as summarized in *Figure 26*, multiple plan design changes can be implemented to reinforce team behavior and higher levels of quality, service, and efficiency (and not just through-put), with less focus on transaction mindsets reinforced through most of the current Curve 1 production-focused incentive plans. Some of the initial selected MWS performance targets (including stretch goals for full payout of quality, service, and efficiency incentives), will be insufficient within one to two years of plan implementation. Therefore, the MWS bar will likely need to be raised. As those requirements are met and the overall practice environment becomes more stable, less reliance on variable incentive compensation may be needed.

Figure 26



This approach will allow the organization to establish varying base salaries and more-balanced performance incentives with an increasing level of joint accountability and reward for meeting more-balanced system-aligned performance expectations.

Other Development and Implementation Considerations

Joint Faculty Compensation Planning Processes

A Joint Faculty Compensation Planning Steering Committee charged with confirmation of the unified faculty plan goals and revised plan design recommendations that include consistent MWS and performance incentive categories across all departments/divisions and institutes will be highly beneficial. Although the categories may be similar, development of recommended metrics and weighting of the points to earn full payout of selected performance incentives also will require further internal department/division meetings, with coordinated summaries to ensure that the Steering Committee receives full and timely input. Additional opportunities for joint education/briefing sessions of the faculty members, as well as confirmation of the “go live” implementation dates, should be confirmed in advance.

Typical planning processes require four to six months and several key additional considerations should be addressed early, including due diligence to confirm:

- Clarification of the funding sources for CARTS missions (e.g., confirmation of the source and range of funds to support the respective CARTS activities, including annually funded and contingent funded incentive pools);
- Benchmarking and selection of performance metrics (e.g., confirmation of the selected survey sources (e.g., AAMC, MGMA, UHC, etc.), and methodologies for weighting and adjusting to ensure as much of an apples-to-apples comparison of benchmark sources and the faculty practice plan situation, as well as confirmation of the report outs from the assessments); and
- Performance measurement and reporting (e.g., confirmation of the nature and types of data required for consistent update/scorecard reports and frequency of reporting

(e.g., quarterly, each six months, annually, etc.), as well as other inputs from related physician performance review processes (e.g., 360 reviews, accomplishment of chair/chief assignments, etc.)).

Final Approvals and Implementation and “Phase-In” of Plan Revision

Leadership also should clearly communicate to the Compensation Planning Steering Committee the levels and timing of approvals required to ultimately implement any significant new plan revisions, including what forms of further governance approvals, if any, are required. Best practice planning processes also should include opportunities for three to six months of “shadowing” of the potential new plan results, with update reports to the potentially affected faculty and confirmation of the final “go live” full implementation dates for the respective participants. At the outset, leadership may not be aware of the potential need for phase-in of the results of the new plan (e.g., potential limitations of the full impact, whether up or down, of the new plan results within defined percentage change levels). However, as described in the Market Example Plan above, any phase-in limits should be symmetrical and of relatively short duration. Finally, the members of the Steering Committee should be retained and provide further ongoing review of the impact of the revised plans through at least the full first year of implementation.

Securing Timely Compliance and Performance Reviews

Annual reviews are needed, even for the faculty compensation plans that rely most heavily on base salary and more limited additional payments for higher levels of performance. However, most of the plans will include some forms of additional performance payments for productivity or other qualitative targets, and the inclusion of mid-year compliance reviews and interim FMV testing will generally be most helpful to ensure that the plan remains compliant. In addition to at least quarterly updates and feedback to the physicians, including withholds from mid-year bonuses also has helped prevent the unpleasant situation where the year-end reconciliation demonstrates that a

reduction in year-end compensation or incentive payments is needed to ensure that the total compensation remains FMV. Similarly, inclusion of mid-year score card performance reviews of the quality, service, or other non-production incentives also will assist in the same manner and help reduce misunderstandings or expectations of the likely year-end results without changes in physician/team behaviors.

Expanding Physician Faculty Education and Related Communications

The market and AMC demands for more progressive and aligned physician faculty compensation plans will only increase for the foreseeable future. Continued education sessions focused on the key market drivers affecting the AMC, as well as ongoing updates of related faculty compensation trends and valuation considerations, have been and will be very helpful in winning greater understanding and buy-in from the key physician participants and those charged with implementing the revised plans. Ongoing opportunities for feedback and transparency will better support ongoing revisions—and ultimately achievement of higher MWS and team-focused interdisciplinary CARTS behaviors.

Other Considerations and Next Steps

For AMCs and virtually all health systems across the nation, the reliance on aligned physician and other care team members to develop higher levels of efficiency, quality, and service to compete within a Curve 2 world will be paramount. Yet, most health care organizations are within a reimbursement market that does not provide sufficient rewards for solely value-based activities. Consequently, the development of more-progressive physician/faculty compensation plans and arrangements that provide accountabilities and performance incentives to balance both Curve 1 and Curve 2 behaviors is often required. However, the regulatory compliance requirements and valuation limitations on the potential plan design options require careful development of bridge designs for implementation during these transitions. The Market Example Plan option and other considerations set forth in this Member Briefing have been provided to

help members evaluate their current market conditions, faculty plan designs, and to hopefully outline additional considerations for enhancements that may be tailored for their respective market conditions.

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