Uniting Physicians Through a Common Compensation Structure

AMGA 2014 Annual Conference
Mercy and Sullivan Cotter
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Objectives

- Mercy's perceptions of industry headwinds and how we aligned incentives in anticipation and response
- How to organize the process of designing a plan architecture resulting in clinic trust and transparency
- How to engineer flexibility in a compensation plan for the future

MERCY HEALTH Sites & Statistics

Note:
Sites and Staff as of January 2014; Utilization does not include Booneville, AR; Financials represent all Mercy Health entities excluding Ada, OK & Booneville, AR; Operating Revenue does not include insurance proceeds related to tornado recovery in Joplin, MO

HOSPITALS & AMBULATORY SITES
30 acute care hospitals
3 managed hospitals
4 heart hospitals
2 children's hospitals
2 rehab hospitals
1 orthopedic hospital
276 clinic locations
8 outpatient surgery centers
18 urgent care sites
14 convenient care centers

MEDICAL STAFF & CO-WORKERS
40,000 co-workers
2,140 integrated physicians
880 advanced practitioners
5,300 active medical staff

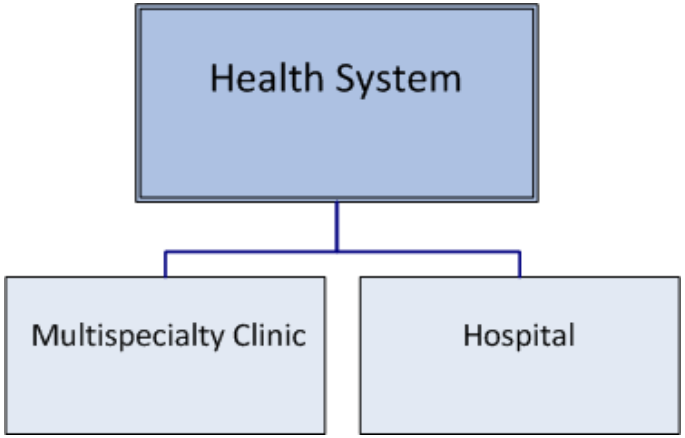
UTILIZATION FY13
4,291 staffed beds
650,702 ED visits
2,877,813 outpatient visits
5,483,870 physician office visits
158,768 inpatient discharges

FINANCIAL INFORMATION FY13
$4.4 billion total operating revenue
$5.8 billion total assets
$284 million in charity care, community benefit & uncompensated Medicaid
$2.6 billion salaries and benefits
$94 million state and local taxes

Mercy is the 7th largest Catholic Health System in the US (31st overall) based on Net Patient Service Revenue, serving in over 140 communities and seven states.
Source: Modern Healthcare Survey, June 2013

Mercy Clinic

- 7 Multispecialty Clinics
  - Codependent equal to hospitals
  - Elected Clinic Board
  - Selected Clinic President



Central	Doctors	President
Springfield	574	Alan Scarrow, MD
Joplin/Kansas	138	Tracy Godfrey, MD
Northwest Arkansas	112	Steve Goss, MD
Fort Smith Arkansas	114	Cole Goodman, MD
Oklahoma City	223	Cullen Thomas, MD
St. Louis	489	John Hubert, MD
Four Rivers	104	Dave Chalk, MD

Legacy Compensation Schema

- One general plan design …yet over 100 compensation plans
- Bottom line oriented plans…cost accounting, modified, ancillaries in or out, etc
- Current models drive our success and culture…continuous pursuit of integration for >20 years

Why at this Time?

- Government commitment to substantively change health care payment schemes
- Our new integrated communities need compensation plans
- Multiple compensation systems decrease our ability to be nimble in face of unpredictable change as well as internal need to drive transformation
- Need to quickly align cross-Ministry compensation incentives with value-based purchasing/medicine quality and service goals

Specific Mercy Needs (Part 1)

- 3 new integrated clinics need compensation plans
- Mercy's need to consistently reward integrated success through:
  - Participating in a culture that encourages teamwork and collaboration in delivery of medical services.
  - Driving growth
  - Exceeding patient expectations in both clinical outcomes & customer experience
  - Reorganizing cost structures

Specific Mercy Needs (Part 2)

- A consistent incentive structure to accommodate a changing environment and purpose for:
  - Quality, safety and service regulatory goals
  - Managing the health of populations
  - Financial Performance
- Mercy's desire to provide above average market compensation for physicians based upon above average work

System Investment in Physicians

- Was $291 million per year, including clinic and hospital based physicians ($196,000 per physician)
- Will be ???
- Primary concern of Ministry Board: What do we get for that investment?
  - **A Culture of Engagement**
  - **A Focus on Delivery of Accountable Care**

Culture of Engagement

- Critical success factors:
  - Physician Executive Leadership: Mercy's clinic presidents' compensation changed exclusively for administrative duties
  - Clinic Leadership: Created the Mercy Clinic Leadership Council
  - Community Clinic Leadership teams
  - Integration 1.0, Co-Dependent equals
  - Beginning Integration 2.0

Process

- Clinic Leadership began study of compensation sustainability approximately 7 years ago
- Foundational work embedded in 3 recent multi-specialty plans from 2008 to 2010
- Ministry-wide effort began in 2011
- Steering Committee made up of Clinic Presidents and Mercy leaders met throughout 2011 to determine the need to develop a Mercy-Wide compensation plan.
- Steering Committee outlined a process and commissioned work teams to make recommendations for a new compensation plan.
- Multi-disciplined work teams created the recommendations over 11 months.
  - Over 100 Integrated physicians from all specialties and communities.
  - Over 50 administrative leaders
- 5 teams focused on the following activities
  - Repeatable identification of market compensation
  - Equitably defining work by specialty
  - Establishing Quality, Safety and Service standards
  - Impact of transformational (intentional) change
  - Defined financial performance

Goals of the Compensation Plan

Presented to the Joint Work Teams, Clinic Leadership Teams (Exec and or Boards), Sr Ops and Exec Staff, Aug through October 2012

- Central premise
  - Healthcare revenues are/will be under assault from all sources. At a minimum the rate of increase will slow, more likely revenues will decline through new payment methodologies
    - We will not be paid for what we do, but what we deliver, outcomes
    - Payments will be risk based:
      - Bundled, risk is cost per procedure outcome, revenue driven by case volume
      - Gainshare, risk is global cost control revenue drivers to be determined (ffs, case rates with cost measured for population)
      - Population where revenue driven by population and we are exposed to all costs (capitation)
  - Sustainability relies upon
    - Achievement of market compensation for physicians must result from the Ministry achieving its financial targets as the case with executives
    - Compensation cannot be linearly variable to revenue collected or credited to individual physicians. Said differently, reimbursement models are moving to team based constructs eliminating direct reward for individual actions

Goals of the Compensation Plan

Presented to the Joint Work Teams, Clinic Leadership Teams (Exec and or Boards), Sr Ops and Exec Staff,
Aug through October 2012

- Implementation
  - Experience informs that acceptance of change in a compensation plan requires either extreme distress (current path is untenable) or opportunity for increased compensation
  - The proposed plan should provide for increased compensation (say 3 to 5%) for 80% of our physicians (1,300) assuming a doctor meets their QSS goals and Mercy achieves <u>targeted</u> financial performance. (Compensation within ACO waiver)
- Rebuttable Presumption
  - Mercy's plan will provide necessary predictability to allow prospective review and approval of compensation by the Mercy Board to allow attainment of rebuttable presumption for regulatory purposes

Ministry Compensation Principles

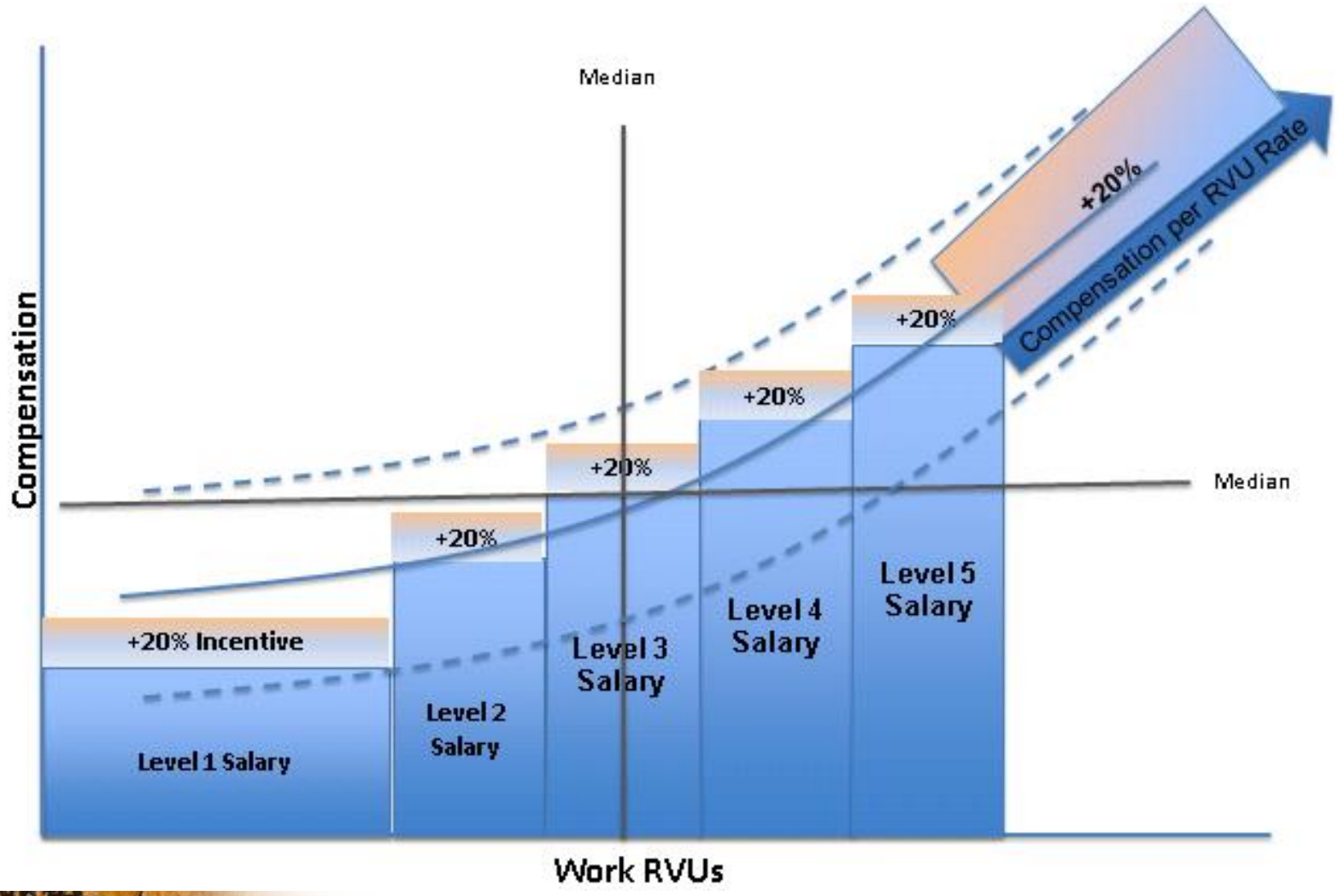
The Compensation Plan will:

1. **Support Mercy's Mission**.
2. **Drive fiscal health/security** for physicians and financial sustainability for Mercy in a commensurate fashion.
3. **Provide market competitive compensation** to attract and retain high quality physicians by appropriately converting physician work to compensation both in terms of economics and fairness.
4. **Provide clear understanding of the mechanics**, how the plan works.
5. **Ensure equity** in determining market across specialties.
6. **Incentivize transformational change** that physicians can impact, including the implementation of new models of care, and improvements in patient safety, quality and satisfaction.
7. **Incentivize appropriate utilization** of resources and management of controllable costs.
8. **Be sustainable** through rapidly changing markets by allowing for periodic changes/adjustments.
9. **Promote a common culture** across Mercy encouraging teamwork, collegiality and collaboration.
10. **Allow for flexibility** in practice (e.g. part time and retiring physicians, physicians in leadership roles).
11. **Comply with all laws and regulations** including properly incentivizing physicians in full compliance with regulatory constraints.

Plan Design Components

- Individual Work, what a doctor or team does every day, yields competitive market compensation.
  - Relevant definitions across 5 natural groupings of doctors (primary care, office based specialty, procedural specialty, hospital based, pediatric sub specialty)
  - Progressive from low end of range to optimal earnings at the 65 to 85%tiles
  - Doctors earn market compensation on their individual work with 10% at risk (a doctor recommended withhold) for Quality, Safety and Service targets.
    - Work is generally measured by wRVU, Shifts, Panel Size, etc.
    - Work is paid at a predetermined variable salary level based on a rolling 4 historical quarters.
- Incentive Compensation of 20%.
  - 15% based on Mercy achieving its financial targets. (Compensation within ACO waiver)
  - 5% based on achievement of transformational goals (e.g. Key Initiatives).
  - Identical measurement criteria with Ministry executive leadership
- Designed to be commercially reasonable, Stark Compliant and to achieve rebuttable presumption

Variable Salary Model Concept



Designers Commentary

- Variable Salary based on a rolling 4 quarters
  - Provides prospective predictability
  - Eliminates draw maintenance and settlement
- Width of steps
  - Wide enough for stability (comfort of midpoint)
  - Tall enough for incentive
- Target compensation within range mimics private practice
- Support is self funding in that achievement of incentives are budgeted
- 20% incentive exceeds any current payor driven reimbursement incentive

Implementation and Timeline

- July 1, 2013 Pilot Implementation.
  - All of Mercy Clinic Oklahoma,
  - Adult Primary Care Springfield Communities
  - Cardiology in Springfield.
- July 1, 2014 Implementation for all Mercy Clinic Physicians.
- A transition plan will provide income protection while physicians adjust their performance in the new plan.
  - Limited in amount.
  - Limited in duration.
- Creation of Governance oversight by a Mercy Board Committee for philosophy, strategy, regulatory compliance and administration.

Plan Design Components

- Variable Base Salary: Reflective of Individual Work, what a doctor or team does every day, yields competitive market compensation.
  - Doctors earn market compensation on their individual work with 10% at risk (a doctor recommended withhold) for Quality, Safety and Service targets.
    - Work is generally measured by wRVU, Shifts, Panel Size, etc.
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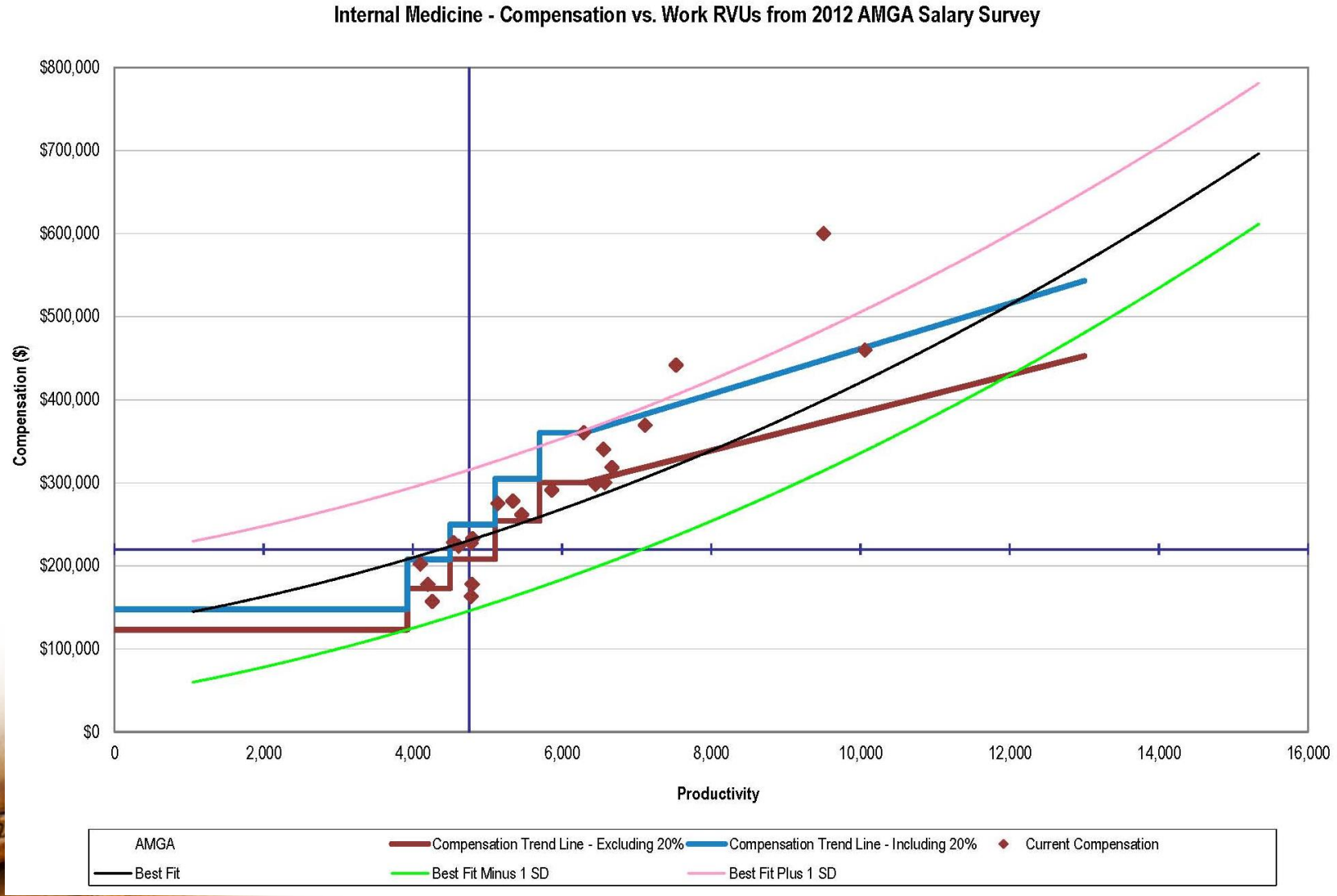
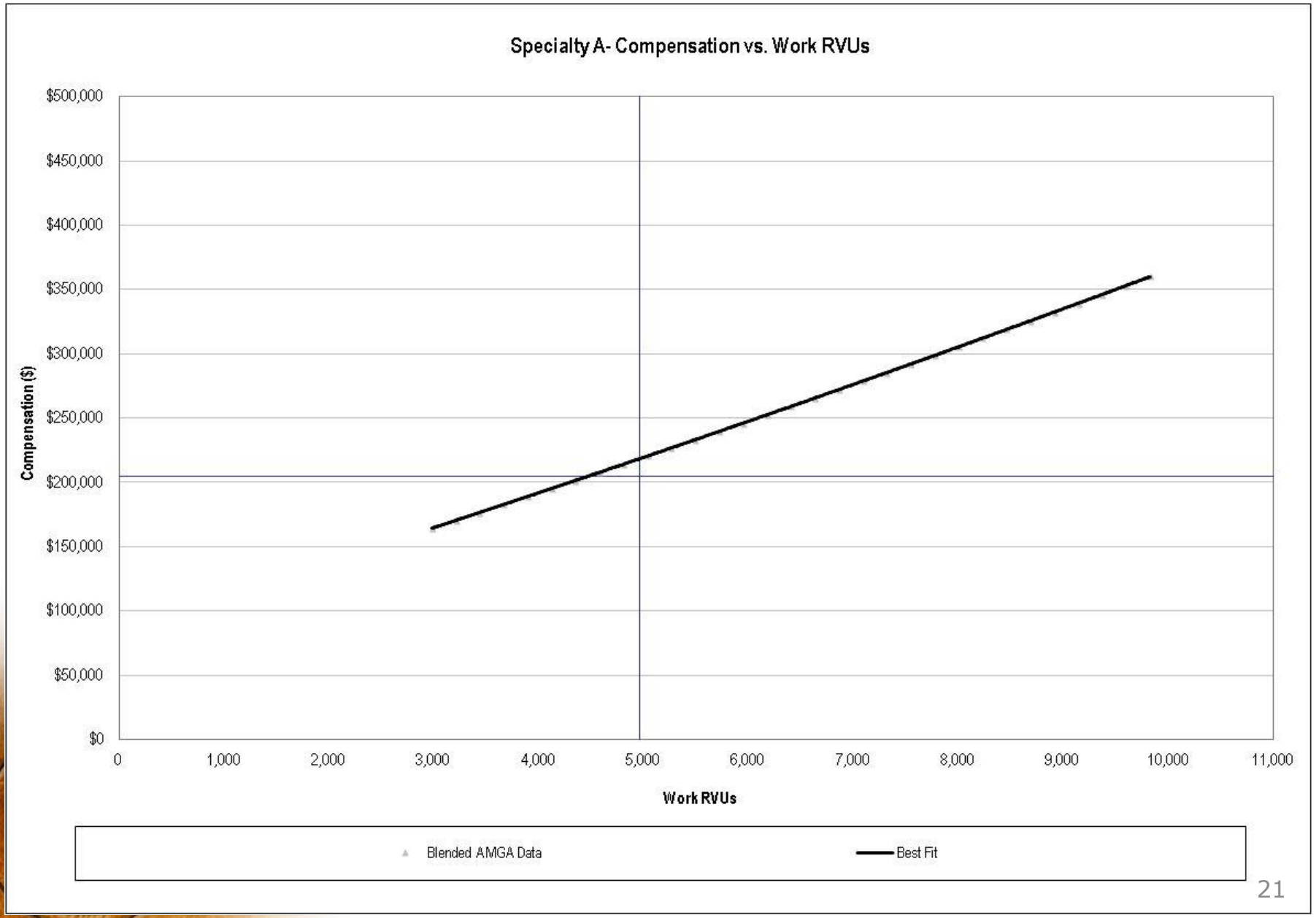
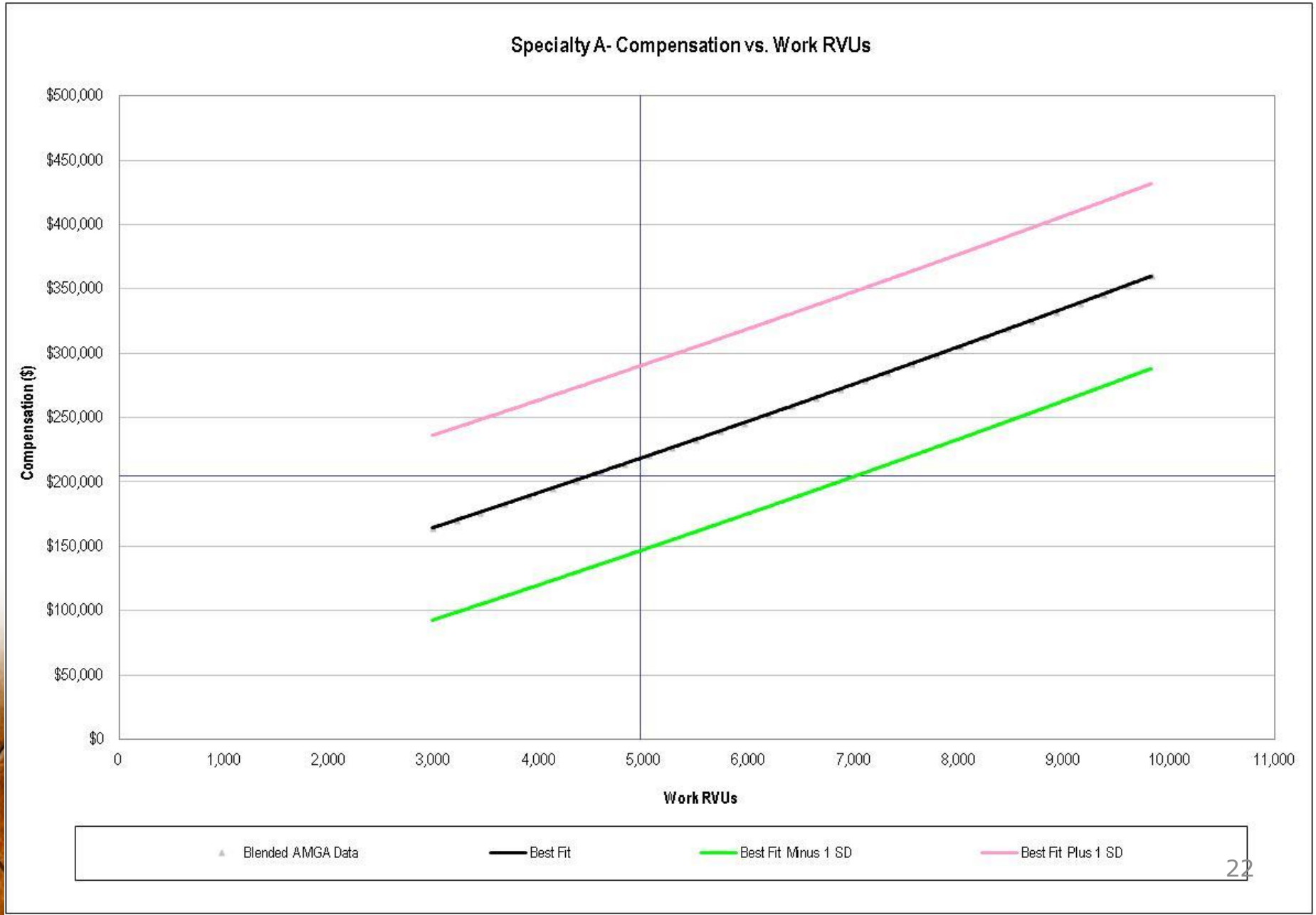

Internal Medicine - Compensation vs. Work RVUs from 2012 AMGA Salary Survey
$800,000
$700,000
$600,000
$500,000
$400,000
$300,000
$200,000
$100,000
$0
Compensation ($)
0
2,000
4,000
6,000
8,000
10,000
12,000
14,000
16,000
Productivity
AMGA
Compensation Trend Line - Excluding 20%
Compensation Trend Line - Including 20%
Current Compensation
Best Fit
Best Fit Minus 1 SD
Best Fit Plus 1 SD

Creating a "Best Fit"



Creating the Range



Variable Based Salary Scale

- Compensation delta between the 25th percentile and 80th percentile distributed in five levels
  - Third level targets approximately the median of the market
- RVU delta between the 25th percentile and 80th percentile distributed <u>equally</u> between levels
- Sixth level for high producers; compensation per RVU rate

Variable Salary Levels

Total Potential Cash Compensation

Other Modules

- Majority of specialties in variable salary plan
- Some specialties incentive alignment have been adjusted i.e.
  - Primary Care includes population management (indexed panel size)
    - Family Medicine and Internal Medicine: 2,100
    - General Pediatrics: 2,200
  - Hospitalists
  - ED
  - Intensivists

Scoring Criteria

Metric	Measure	Points	Reasoning
Readmission Rates	30 day all cause rate < 12%	1 (target)	Key cost driver, in the Senior population
Timely Discharge	Target 7 days	1 (target)	Key to success in reducing readmissions
Coding Accuracy	RAF Scores: 0-.949 0.95-1.05 1.06-1.15	 0 1 (target) 2	Key driver of Revenue in Senior population, accurately reflects the complexity of the population served
IDP Usage	Meets IDP Usage Measures	1 (target)	Ensures comprehensive care is being delivered, particularly in Chronic population
Preventive Health Initiative	Mercy's Health Metrics 0-69% 70% - 79% >80%	 0 1 2 (target)	Ensures that wellness and preventive health guidelines are being followed.
Medical Loss Ratio for ACO and Gainshare contracts	0-70% 71-80% 81-90% 91-100% >100%	3 2 (target) 1 0 -1	Measure of profitability for risk based contracts
Commercial Utilization	Days/1000 ER Visits/1000 Referrals/1000 Prescrip Generic >90%	.5 .5 .5 .5 = 2 (target)	Measure of financial performance in the non-medicare population
wRVU Production	<40th Percentile 40th – 60th >60th	0 1 (target) 2	Ensure that there is reward in seeing patients in FFS world, as well as ensuring that physicians will be willing to see patients not in their panel.
Open schedules on MyMercy	Number of open slots/mo. 0 -11 >11	 0 1 (target)	Incentives patient access.
Total		12 Target 15 Max	

Compensation in Practice

- Market ranges are reviewed/established annually
  - Local variation when evident
- Compensation known and approved annually for reputable presumption
- Work, measures, and incentive goals are adjusted and determined annually
- Incentives and awards are aligned with management
- Work definition and its relationship to compensation TBD by January 1, 2015