


**American Medical Group Association
Human Resources Counsel**

Provider Compensation, Benefits Trends, and Models

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Agenda

Day 1

- I. Introductions
- II. Industry Trends
- III. Physician Performance Trends
- IV. Advanced Practice Clinician (APC) Trends
- V. Range of Compensation Models
- VI. Emerging Models

Day 2

- VII. Benefits Trends
- VIII. Case Study: Value Based Employee Health Plan

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I. Introductions

ECG Management Consultants, Inc.

For nearly 40 years, our mission has been to provide exceptional management consulting services to healthcare clients.

- ECG is a national consulting firm focused on offering strategic, management, and financial advice to healthcare providers.
- We are particularly known for our expertise in physician/hospital relationships, managed care contracting and strategy, strategic and business planning, and programmatic development.
- Our over 110 consultants operate out of offices in Boston, San Diego, Seattle, San Francisco, St. Louis, and Washington, D.C.



LEADING HEALTHCARE FORWARD

We serve as trusted advisers to the nation's leading healthcare providers.



I. Introductions

Overview of Our Custom Surveys

ECG's custom surveys emerged from our experience working with medical groups and academic departments to redesign their compensation plans. Today, our custom surveys are a core service and encompass a wide range of areas.

The screenshot shows the ECG Management Consultants website. The main heading is "Custom Surveys & Proprietary Research". Below this, there are several sections: "Strategic Services", "Midwest Provider Compensation, Production, and Benefits Survey (7 years)", "Northwest Provider Compensation, Production, and Benefits Surveys (12 years)", "National Pediatric Subspecialty Physician Compensation, Production, and Benefits Survey (5 years)", "Southeast Provider Compensation, Production, and Benefits Survey (2 years)", "Faculty Practice Plan Physician Reimbursement Survey", "ECG/Healthcare & Science business of Thomson Reuters Cardiovascular Service Line Management Survey – Key Findings and Implications, year 2009 based on 2008 data.", "ECG/AMGA Capitation and Risk Contracting Survey", "Emergency Department Call Coverage Survey", and "ECG/AMGA 2006 Pay-for-Performance Survey".

- Midwest Provider Compensation, Production, and Benefits Survey (7 years).
- Northwest Provider Compensation, Production, and Benefits Surveys (12 years).
- National Pediatric Subspecialty Physician Compensation, Production, and Benefits Survey (5 years).
- Southeast Provider Compensation, Production, and Benefits Survey (2 years).
- Faculty Practice Plan Physician Reimbursement Survey.
- ECG/Healthcare & Science business of Thomson Reuters Cardiovascular Service Line Management Survey – Key Findings and Implications, year 2009 based on 2008 data.
- ECG/AMGA Capitation and Risk Contracting Survey.
- Emergency Department Call Coverage Survey.
- ECG/AMGA 2006 Pay-for-Performance Survey.

www.ecgmc.com/custom-surveys-proprietary



I. Introductions

Source of Information

ECG conducts regional provider compensation and production surveys in the Northwest, Midwest, and Southeast, as well as a national pediatric survey. These surveys include data from 114 organizations, encompassing nearly 14,000 providers.

- Northwest Provider Compensation, Production, and Benefits Surveys.
- Midwest Provider Compensation, Production, and Benefits Survey.
- Southeast Provider Compensation, Production, and Benefits Survey.
- National Pediatric Subspecialty Physician Compensation, Production, and Benefits Survey.
- Merritt Hawkins & Associates' 2010 Review of Physician and CRNA Recruiting Incentives.

The ECG 2011 national data set includes data from the Northwest, Midwest, and Southeast surveys.

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II. Industry Trends

Overview

Fiscal Crisis

State fiscal conditions continue to deteriorate as declining revenues and growing Medicaid enrollment leave few options for addressing severe budget shortfalls.

Shortage of Subspecialists

While the impact of reform initiatives on the physician workforce remains uncertain, expanded coverage will further exacerbate access to timely care.

Focus on Operational Improvement

As a result of declining financial performance, organizations are focused on driving greater efficiencies and delivering more coordinated care to improve outcomes and operating margins.

Implementation of IT Systems

The demand for electronic medical records (EMRs) and their integration with other systems continues to be high in order to achieve "meaningful use" to qualify for incentive payments.

Strategic Planning for Reform

Hospitals and physicians are focused on better alignment through the development of integrated organizations driven by the concepts of accountable care.

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II. Industry Trends ACOs – Just Another Acronym?

There are 17,576 three-letter acronyms in the English language. Having survived previous frenzies related to PPOs, HMOs, PHOs, MSOs, PPMCs, and IPAs, some skepticism about ACOs is understandable.

“ACOs Are Just Another Fad”	“ACOs Are the Future”
<ul style="list-style-type: none"> • Republicans will overturn it anyway. • It must be way off in the future. • Beneficiaries will not stand for changes in their care. • We can just contract with someone else’s ACO. Let them do the work. 	<ul style="list-style-type: none"> • We are <i>really</i> out of money this time. • Unlike those other acronyms, this one is the law of the land. • Proposed regulations may undergo additional changes in response to industry reaction. • Several demonstration projects are under way for ACO-like structures, and they have had positive results so far. • We have never had meaningful healthcare reform before, and the delivery system needs to adapt. • Many of the actions that organizations would take to prepare for ACOs may be strategically appropriate even if ACOs never happen.

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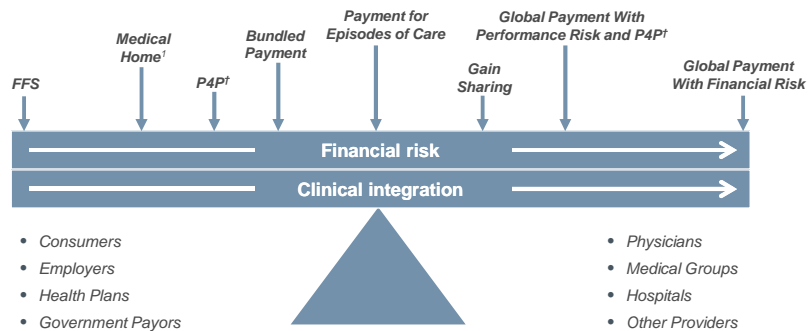
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II. Industry Trends Shifting Payment System

Reimbursement will change from payments based on fee-for-service (FFS) (volume) to a more value-based system and will shift some risk from payors to providers.

The Risk Continuum Associated With Existing and Proposed Reimbursement Structures



¹ Medical homes that receive extra dollars for patient management.

[†] P4P = pay for performance.

Source: Healthcare Financial Management Association, "Accountable Care: The Journey Begins," August 2010.

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II. Industry Trends Clinical Integration

Based on opinions from the FTC, it is reasonable to assume that a clinical integration model must include at least six key elements:

1. True integration and interdependence.
2. In-network referrals of both primary and specialty physicians.
3. Clinical protocols of a broad spectrum of diseases and disorders.
4. Investment in training and development of the system and standards, benchmarks, and protocols of the network.
5. Integrated IT:
 - Efficient exchange of information regarding the patient and practice experience.
 - Ability to gather, analyze, and communicate utilization claims information.
6. Enforceable consequences for noncompliance by physicians and institutions.

The assessment of clinical integration is an ongoing process; thus, organizations must continue to demonstrate significant integrative efficiencies or risk termination.

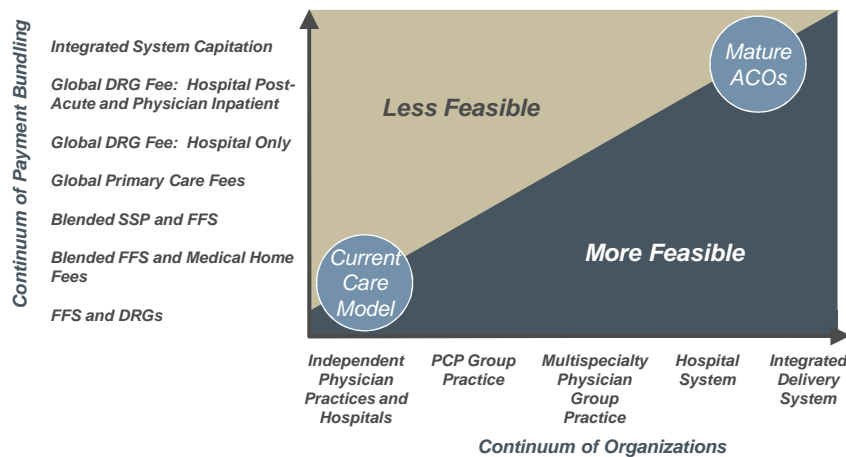
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II. Industry Trends Integration, Integration, Integration

As the ACO and other risk models mature, success will require a high degree of financial and clinical delivery integration.



Source: Marsha Gold, "Accountable Care Organizations: Will They Deliver?" Mathematica Policy Research, Inc., Princeton, January 2010.

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II. Industry Trends Provider Performance Outlook

In the next few years, we expect compensation and production trends to be most impacted by the continued shortage of primary care subspecialists, increased demand for specialty care, and implementation of key provisions of healthcare reform.

- The acute shortage of PCPs, exacerbated by expanded Medicaid coverage, will negatively impact access to timely patient care, resulting in an increasingly competitive recruiting environment and a continued upward trend in physician compensation, at least in the near term.
- Compensation methodologies will undergo a fundamental transition aimed at better aligning incentives toward value-based care, which will place a greater emphasis on resource management, outcomes, and quality of care. However, production will remain a primary incentive component as organizations limit their provider costs.
- RVU production is likely to remain stable or increase as a result of a higher number of insured, creating additional demand for specialty services.
- Compensation and production for APC will continue to increase as organizations expand employment of these providers as a strategy to address the physician shortage and as a lower- cost option than using physicians.
- The ability to demonstrate high-quality and superior outcomes will become a market differentiator, allowing organizations to negotiate/receive more favorable reimbursement from payors.

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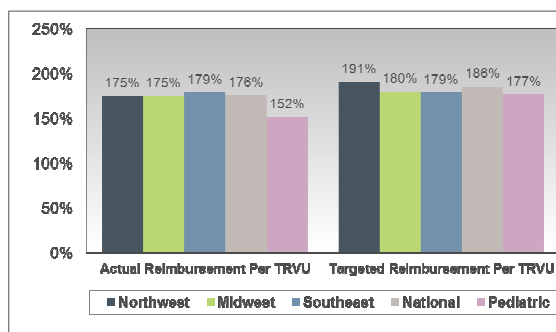
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III. Physician Performance Trends Reimbursement

On average, adult organizations are being reimbursed at 176% of Medicare for their commercial business, while 186% is the average targeted rate.

Commercial Contract Rates as a Percentage of Medicare



Source: ECG 2011 Surveys.

Pediatric organizations attempt to offset lower Medicaid reimbursement by targeting commercial rates at 177% of Medicare. Actual commercial rates, however, average 152%.

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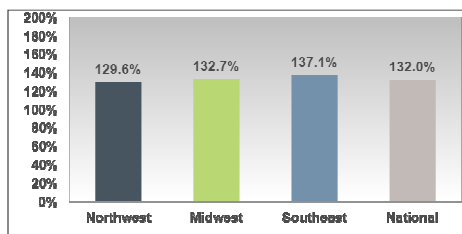
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III. Physician Performance Trends Investment Per Physician

Health system-sponsored organizations in our national database report significant investment/losses on the physician enterprise at nearly \$149,000 per physician.

Average Total Expenses as a Percentage of Net Collections



Integrated Health System Investment/Loss Per Physician

	ECG 2010	ECG 2011
Average Total Expense as a Percentage of Net Collections	129.7%	132.0%
Average Investment/Loss Per Physician	-\$138,724	-\$148,791

Source: ECG 2011 Surveys.

III. Physician Performance Trends Key Physician Metrics

Compensation for PCPs increased modestly from 2010 to 2011, while specialists compensation decreased. As a result of WRVU production decreasing for primary care, compensation per unit of work for PCPs continues to rise.

Percentage Change of Key Metrics From 2010 to 2011

Metric	ECG Adult Surveys	
	PCPs	Specialists
Compensation	2.57%	-1.31%
Compensation Per WRVU	3.25%	0.62%
Compensation to Gross Professional Revenue	-1.85%	13.54%
Compensation to Net Collections	3.52%	13.39%
Compensation to Net Professional Collections	-3.30%	9.99%
Gross Professional Revenue	5.53%	-9.46%
Net Collections	-0.87%	-14.42%
Net Collections Per Total RVU	0.08%	3.37%
Net Professional Collections	4.94%	-4.02%
Net Professional Collections Per Total RVU	3.11%	0.68%
Total RVUs	-1.08%	-0.37%
WRVUs	-1.39%	1.99%

Source: ECG 2011 Surveys.

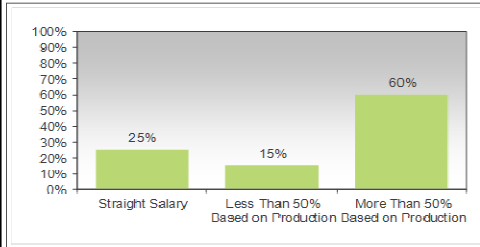
NOTE: All RVU calculations in the 2011 survey are based on the 2010 Medicare Physician Fee Schedule (PFS) published in October 2010, unless otherwise noted.

This represents multiple consecutive years of increased compensation coupled with decreased WRVU production for primary care.

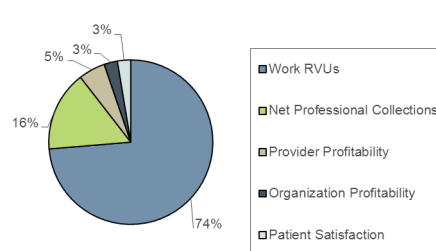
III. Physician Performance Trends Physician Compensation Plan Types and Metrics

In the next few years, we expect a shift in compensation models to better align incentives with value-based care that will reward a combination of physician production, resource management, and, ultimately, health outcomes.

Percentage of Physicians by Compensation Plan Type



Primary Performance Metrics for Variable Compensation



Source: ECG 2011 Surveys.

The increase in the insured population, coupled with the physician shortage, will require compensation plans to maintain production-based components.

III. Physician Performance Trends Compensation Incentive Plan Structures

Common elements utilized in provider compensation incentive plans include production tiers, pay for administrative effort and, to a lesser extent, provider profitability.

Compensation Incentive Plan Structures

Component	Percentage of Organizations
Tiered	67%
Administrative Pay	67%
Provider Profitability	31%
Governance Pay	27%
Direct Expenses	27%
Organization Profitability	20%
Indirect Expenses	18%
Expense Charge-back	8%

Indirect expenses and expense charge backs are not frequently incorporated into provider compensation incentive plans.

III. Physician Performance Trends Non-Production Compensation Plan Components

Currently, 10% of survey organizations measure quality as part of their provider compensation plans, with approximately 10% of earnings dependent on outcomes. Meanwhile, forty-eight percent of organizations plan to incorporate non-production based components into their provider compensation plans in the coming year.

Planned Non-Production Based Components

Component	Percentage of Organizations
Quality	35%
Patient Satisfaction	29%
Physician Satisfaction	2%
Cost	2%
Access	4%
Utilization	6%
Other	6%

Of the organizations that plan to incorporate non-production components, 35% wish to include quality metrics, while 29% would like to incorporate patient satisfaction.

Planned Quality Metrics

Metric	Percentage of Organizations
Internal Metrics	37%
External Metrics	29%
Do Not Know	34%

Planned Number of Quality Metrics

Average Number of Quality Metrics per Specialty	Percentage of Organizations
One	7%
Two to Four	37%
Five to Ten	13%
More than Ten	13%
Do Not Know	30%

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III. Physician Performance Trends Recruiting

PCPs continue to be the most sought-after physicians and among the most difficult to recruit. More than 50% of the recruited positions in 2010 within ECG's survey organizations were PCPS or Internal Medicine-Hospitalist.

Top 5 Recruited Specialties¹ – ECG

Specialty	Percentage of Organizations Recruiting	Percentage of Organizations Reporting Medium to High Difficulty	Percentage of Open Positions
Family Practice Without OB	68%	76%	17%
Internal Medicine	65%	88%	16%
Internal Medicine – Hospitalist	32%	44%	12%
Family Practice with OB	10%	61%	9%
General Pediatrics	19%	67%	3%

Top 5 Recruited Specialties – Merritt Hawkins

Specialty	Percentage of Positions Searched
Family Practice	13%
Internal Medicine	9%
Psychiatry	6%
Hospitalists	4%
Emergency Medicine	4%

¹ Based on number of recruited positions in 2010.
Sources: ECG 2011 Provider Compensation, Production, and Benefits Surveys and Merritt Hawkins & Associates' 2010 Review of Physician and CRNA Recruiting Incentives.

According to Merritt Hawkins, fewer providers sought new opportunities in 2009/2010 as a result of the economic downturn. This trend, coupled with the physician shortage, has led to the most challenging provider recruiting market in recent memory.

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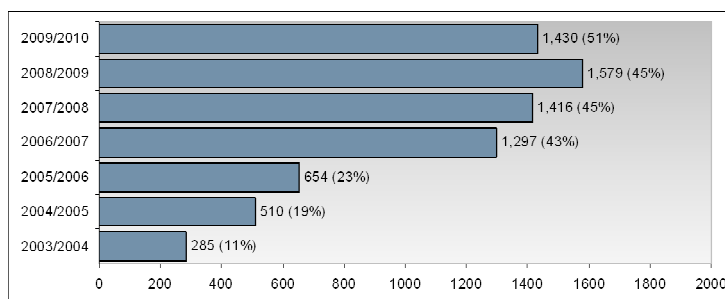
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III. Physician Performance Trends Recruiting (continued)

Physician employment by hospitals has increased dramatically since 2003 as hospitals seek to develop integrated delivery systems in preparation for healthcare reform.

Hospital Physician Recruitment, 2003 to 2010



Source: Merritt Hawkins' 2010 Review of Physician and CRNA Recruiting Incentives.

III. Physician Performance Trends Recruitment Offerings

Historically, organizations have relied on signing bonuses as a vehicle to attract new recruits. However, as a result of the challenging economy and physician shortage, more organizations are offering creative benefits, such as relocation assistance and education loan forgiveness.

Physician Recruitment Offerings – ECG

	Percentage of Organizations Offering Benefit	Percentage of Offers	Length-of-Service Requirement		Average Value Offered
			Percentage of Organizations With Requirement	Average Years	
Signing Bonuses	94%	70%	75%	1.9	\$20,445
Relocation Allowance	98%	73%	42%	1.7	\$10,459
Malpractice Nose Coverage	49%	75%	75%	2.9	\$39,254
Education Loan Forgiveness	28%	35%	100%	3.9	\$54,847

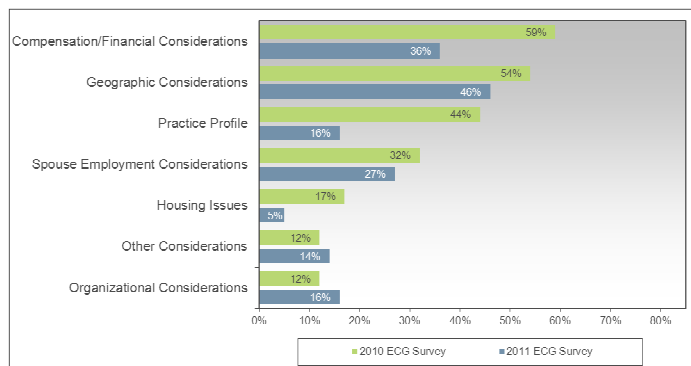
Physician Recruitment Offerings – Merritt Hawkins Findings

	Percentage of Organizations Offering Benefit	Average Value Offered
Signing Bonuses	76%	\$22,915
Relocation Assistance	96%	\$10,035

III. Physician Performance Trends Offers

Geographic considerations surpassed compensation/financial considerations as the number one reason why recruits turned down offers in 2011. Compensation/financial considerations remains high on the list with 36% of offers being rejected for this reason.

Reasons Offers Were Turned Down



Source: ECG 2011 Surveys.

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IV. APC Performance Trends Growth of Advanced Practice Clinicians

The number of APCs is growing faster than the number of physicians due to the shorter length of training required.

- Currently there are about 80,000 physician assistants (PAs) and 140,000 nurse practitioners (NPs) in the United States.¹
- Further projections indicate that 30,000 additional PAs and over 110,000 additional NPs will be active by 2025, partially helping to fill a shortage of approximately 45,000 physicians for a similar time frame.²
- Only 12,000 physicians are expected to be entering primary care specialties between 2010 and 2025.
- APCs improve efficiency in healthcare by providing routine or less complicated care, while allowing physicians to address more complex issues.
- APCs can also provide care in a number of medical and surgical subspecialties.
- The savings from employing an APC, relative to a physician, is causing most health systems to strongly consider them as an alternative.

¹ Statistics source: American Academy of Physician Assistants, <http://www.aapa.org/>, and American Academy of Nurse Practitioners, <http://aanp.org/>.
² <http://www.ncpa.org/pub/ba706>.

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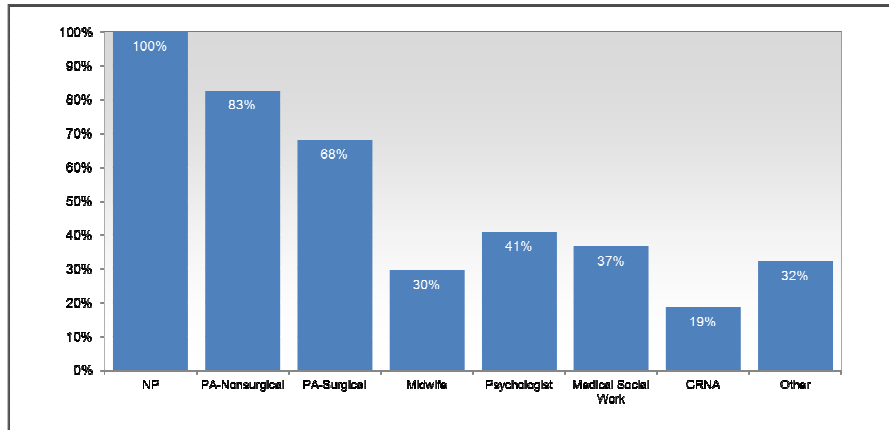
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IV. APC Performance Trends APC Employment

Nurse practitioners and physician assistants are the most common types of advanced practice clinicians employed by survey organizations.

Employment of Advanced Practice Clinicians



Source: ECG 2011 Surveys

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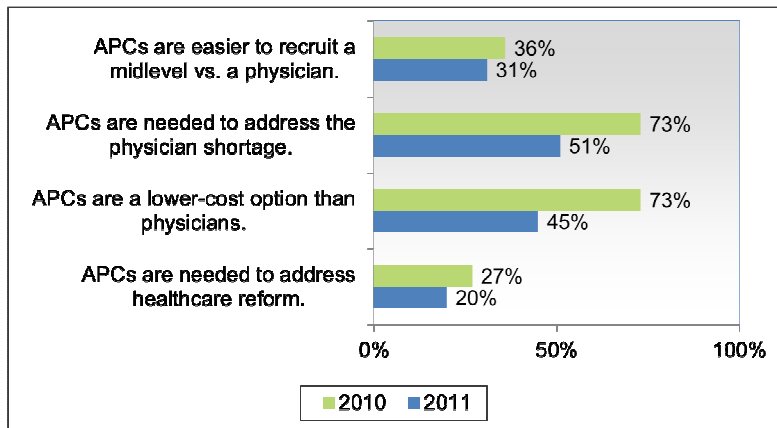
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IV. APC Performance Trends APC Employment Rationale

Organizations reported that the reason they have increased the number of APCs within their organization is because it is an effective strategy to address the physician shortage.

Primary Reason for Hiring Advanced Practice Clinicians



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IV. APC Performance Trends Reimbursement Implications

The utilization of APC services has significant implications on reimbursement; incentive compensation plans should align with the organization's billing practices.

Direct Billing

- New problems and consults.
- Not part of a physician-initiated plan of care.
- Physician not in the office
- Reimbursed at 85% of the physician fee schedule.
- Bill under the APC's own provider number.

Incident-to Billing

- Established patient services.
- Part of a plan of care previously established by the physician.
- No new problems or consults.
- Physician in the office.
- Reimbursed at 100% of the physician fee schedule.
- Bill under the physician's provider number.

Determining which providers receive WRVU credit for specific visits is an important step in developing an appropriate compensation plan for APCs.

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IV. APC Performance Trends Key Metrics

Compensation for nurse practitioners increased by over 5%, while physician assistant compensation remained flat from 2010 to 2011. Conversely, physician assistants increased production over 2010, while nurse practitioners realized a decline in WRVU production.

Key Metrics Medians From 2010 to 2011

Metric	Nurse Practitioners		Physician Assistant: Non-Surgical		Physician Assistant: Surgical	
	2010	2011	2010	2011	2010	2011
Compensation	\$89,397	\$94,186	\$103,426	\$102,796	\$119,569	\$119,686
Compensation Per WRVU	\$32.54	\$36.91	\$31.55	\$31.10	\$49.60	\$52.42
WRVUs	2,815	2,681	3,154	3,282	2,237	2,348

Percentage Change of Key Metrics Medians From 2010 to 2011

Metric	Nurse Practitioners	Physician Assistant - Nonsurgical	Physician Assistant - Surgical
Compensation	5.4%	-0.6%	0.1%
Compensation Per WRVU	13.4%	-1.4%	5.7%
WRVUs	-4.8%	4.1%	5.0%

Source: ECG 2010 and 2011 Surveys.

NOTE: All RVU calculations in the 2011 survey are based on the 2010 Medicare Physician Fee Schedule (PFS) published in October 2010, unless otherwise noted.

Non-surgical physician assistants earn less per work RVU than nurse practitioners, while surgical physician assistants are earning more than \$50 per work RVU.

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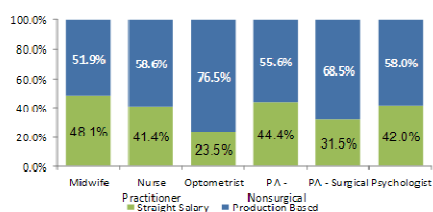
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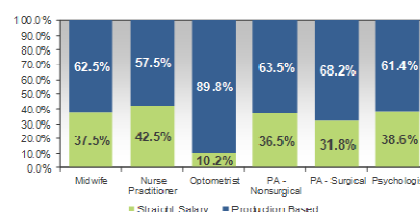
IV. APC Performance Trends Compensation Plan Types

More than half of advanced practice providers are being paid under compensation plans that are, at least in part, based on provider productivity.

**2010 Advanced Practice Clinicians
Compensation Plan Types**



**2011 Advanced Practice Clinicians
Compensation Plan Types**



Source: ECG 2010 and 2011 Surveys.

Similar to physician compensation plans, organizations are migrating away from salary based compensation plans for advanced practice providers.

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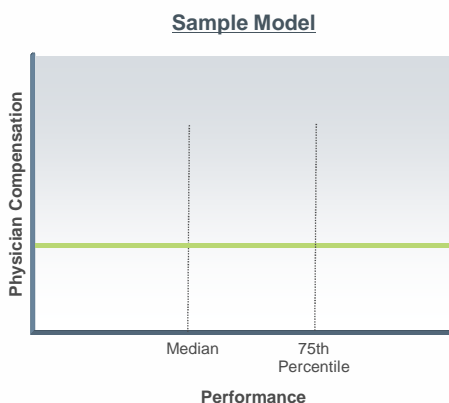
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V. Range of Compensation Models Base Salary

The base salary compensation model is comfortable to many providers but provides little incentive to maintain or increase performance.

- Limits the physicians' downside risk by placing a floor on compensation levels.
- Provides the same income regardless of physician performance.
- Accordingly, provides little incentive for physicians to maintain or increase performance.
- Most commonly used for:
 - Newly recruited providers (initial 12 to 24 months).
 - Physicians with significant administrative roles.
 - Physician specialties that do not control their own demand.
 - Academia.



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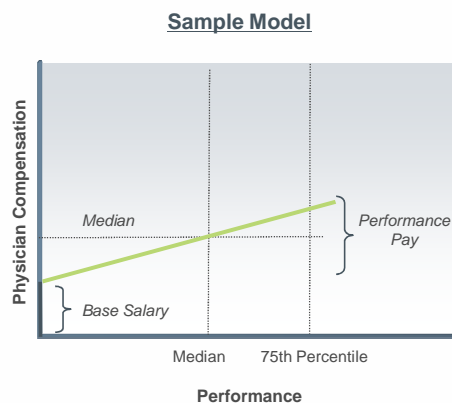
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V. Range of Compensation Models Base Salary With Incentive

The base salary with incentive model gives physicians moderate incentives to increase productivity if they are producing near or above the threshold level.

- Limits the physicians' downside risk by placing a floor on compensation levels.
- Provides additional income for performance above a given threshold.
- May not provide a meaningful incentive if the base salary is set too high.
- Most commonly used:
 - For faculty practice plans/academic medicine.
 - For newly formed employed medical groups or medical foundations.
 - To pay physicians when you are initiating a new program/service line.



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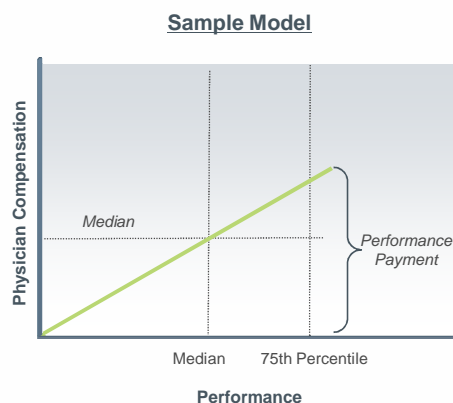
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V. Range of Compensation Models Straight Incentive

The straight incentive model is often a starting point for hospitals that do not have significant experience with employed physician models.

- Includes no base compensation; under this type of model, providers' earnings are entirely dependent on performance.
- Provides strong incentives, regardless of the physicians' current performance levels.
- Tends to skew overall compensation:
 - The highest performers tend to be underpaid.
 - The lowest performers tend to be overpaid.



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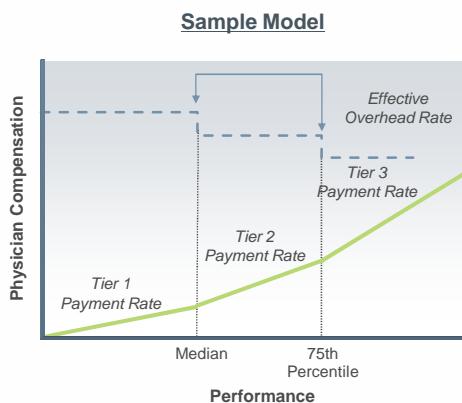
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V. Range of Compensation Models Tiered Incentive

Under this model, tiered overhead rates increase the provider's incentive as his/her performance moves beyond established thresholds.

- Provides stronger incentives at every level of performance.
- More common when linking market-level compensation with production / revenue levels that impact individual effective overhead rates.
- Allows for additional tiers to be added so as to increase incentives (a curve is also sometimes utilized rather than multiple tiers).
- Most commonly utilized model in employed multispecialty groups.



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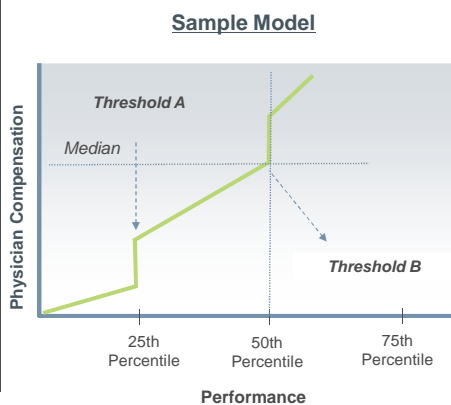
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V. Range of Compensation Models Tiered Incentive Plus Bonus

The tiered incentive plus bonus model provides significant incentives to improve performance.

- Is similar to the tiered incentive model, with the addition of a bonus that is paid when a threshold is reached.
- Typically utilized when physician production is clustered below desired levels.



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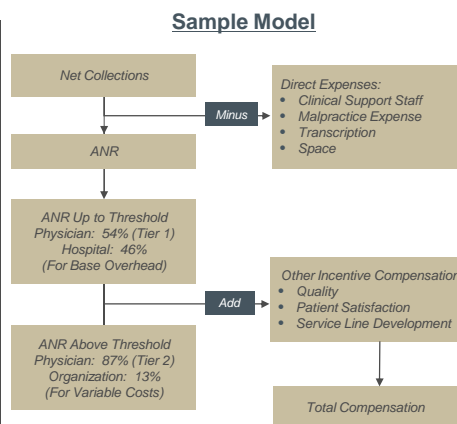
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V. Range of Compensation Models Contribution Margin Approach

The contribution margin approach measures providers surplus of revenues over expenses that are directly attributable and therefore providing some incentives for cost control.

- Typically, providers are paid based on a percentage of adjusted net revenue (ANR), which represents net collections for clinical services minus direct expenses.
- The physician is accountable for direct expenses like support staff costs.
- The organization is responsible for managing all other expenses.
- A higher percentage of ANR may be paid at higher levels of performance to mirrors the economics of private practice.



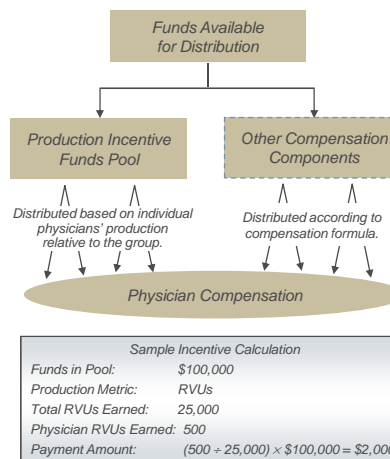
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V. Range of Compensation Models Relative Performance Incentives

Relative performance incentives establish a pool of funds that is divided among participating physicians based on their relative performance.

- Pools can be set at:
 - An established dollar amount.
 - A percentage of funds available.
- Pools can be set at the specialty, clinic, or intermediate level.
- Advantages:
 - Provides a quantity of funds that is guaranteed to be paid out.
 - Limits the organizations financial risk.
- Disadvantages:
 - Holding other performance constant, an increase in individual performance will not yield a same-sized increase in incentive payment.
 - As others increase their performance, high performers must also increase to maintain their share of the pool.
 - Market-competitive compensation may not be generated if funding is inadequate.



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VI. Emerging Models

With upcoming payment changes that may fundamentally alter the way provider organizations obtain reimbursement, it is important that provider compensation plans can adjust to these new incentives/revenue streams.

- In this new environment, compensation models must focus on more than just productivity.
- Broadly, we believe there are two fundamental approaches to designing a compensation plan that recognizes these new realities:
 - *Metric-Driven* – Measure and pay for all the variables that drive the new definition of performance.
 - *Balanced* – Pay a base salary that covers the most difficult-to-measure portions of physician effort, coupled with explicit incentives for easier-to-measure metrics.

VI. Emerging Models Typical Plan Components

The basic structure of a compensation plan must match organizational goals to achieve clear and definable incentives.

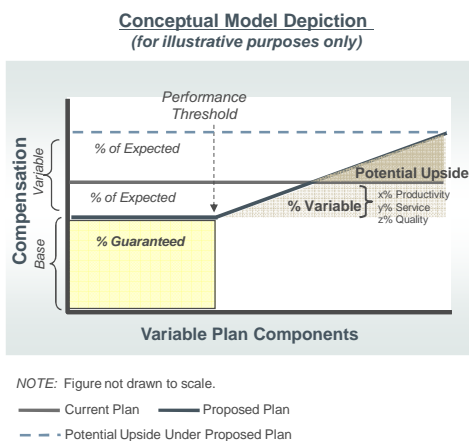
Typical Plan Goals	Incentive	Performance Metrics	Ease of Measurement/ Availability of Benchmarks
Reward a high level of clinical activity that will result in increased revenues and/or improved patient access.	Work Effort	Charges, net revenues, RVUs, panel size, visits/encounters, and office hours/availability.	High
Encourage cost-effective and clinically appropriate care.	Medical Management/ Quality	HEDIS indicators, inpatient days per thousand population, ambulatory visits per thousand population, and selective utilization rates (e.g., ER visits, MRIs).	Medium
Acknowledge a patient-oriented focus and the importance of patient satisfaction to enrollment growth.	Patient Satisfaction	Patient satisfaction surveys, patient complaints and compliments, and panel retention.	Medium
Reward the performance of nonclinical activities that benefit the organization.	Group Citizenship	Governance participation, committee participation, peer review, specific work group outcomes, and staff surveys.	Low

VI. Emerging Models

Case Study 1: Quality, Volume, and Service

Striking a balance between productivity, service, and quality, is critical to supporting organizational value based payments and incentives.

- Salary targets are set using mean values by specialty from a combination of national surveys.
- A percent of compensation is guaranteed as base salary.
- A percent of base compensation is performance-driven, based on the combination of three incentives:
 - Productivity.
 - Service.
 - Quality.



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VI. Emerging Models

Case Study 1: Incorporating Quality and Volume

Situation: A 300-physician primary care group wanted to implement a quality incentive component to its compensation plan, as well as reward clinicians who successfully manage a large panel of patients.

- The group initially focused on 14 high-priority HEDIS metrics:
 - Colorectal cancer screening.
 - Breast cancer screening.
 - Cervical cancer screening.
 - Control of hypertension.
 - Comprehensive diabetes care (HbA1c screening, HbA1c control, LDL screening, LDL control, nephropathy, retinopathy).
 - Cholesterol management.
 - Well-child visits – 0 to 15 months and 3 to 6 years.
 - Immunizations.
- We worked with the group to develop a points system that rewards achieving target quality scores on each of these metrics, as well as on the volume of patients seen.

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VI. Emerging Models Case Study 1: Incorporating Quality and Volume (continued)

Physicians earn points for every patient for whom they apply the proper care protocol, as well as bonus points if they reach organizational quality targets.

	Patients Not Receiving Proper Care Protocol	Patients Receiving Proper Care Protocol
Target Was Met	0.00 Points	1.25 Points + 30.00 Bonus Points for Meeting Target
Target Was Not Met	0.00 Points	1.00 Point

Example Calculation

Colorectal Cancer Screening

- Target – 65%.
- Physician performance – 62% for 100 patients.
- Points – $(100 \times 62\% \times 1.00) = 62.0$.

Breast Cancer Screening

- Target – 80%.
- Physician performance – 82% for 300 patients.
- Points – $(300 \times 82\% \times 1.25) + 30 = 337.5$.

Control of Hypertension

- Target – 75%.
- Physician performance – 87% for 150 patients.
- Points – $(150 \times 87\% \times 1.25) + 30 = 193.1$.

Total points = 592.6.

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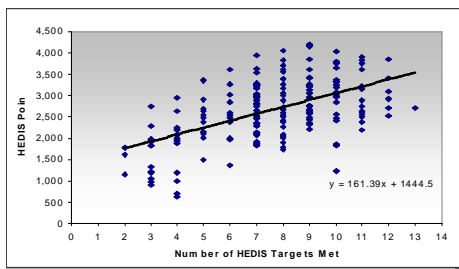
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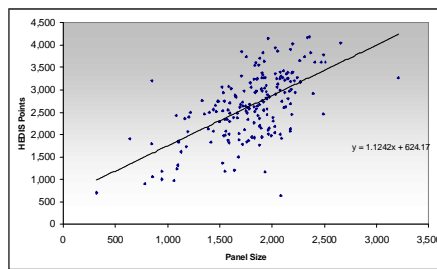
VI. Emerging Models Case Study 1: Incorporating Quality and Volume (continued)

Analysis showed that both meeting quality targets and the size of the physician's panel were well correlated with the outcome measure of total HEDIS points.

HEDIS Points Versus Number of HEDIS Targets Met



HEDIS Points Versus Panel Size



HEDIS bands were set, based on the initial distribution of total points, and physicians were paid correspondingly more for reaching higher bands.

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VI. Emerging Models

Case Study 1: Incorporating Service: Patient Satisfaction and Access

Physicians can earn a percent of their pay for meeting patient satisfaction and group access targets.

Patient Satisfaction

- A minimum target is set at 75% delighted with "MD listened" to establish a threshold for payment.
- Physicians who achieve scores of 75% or above receive incentive pay equal to 2.5% of their base pay.

Access – Percentage to ED (Regional/Department)

- Targets are set relative to the baseline percentage-to-ED results to incentivize physicians to maintain current performance.
- 2.5% of base pay is allocated to each physician, assuming current performance is maintained.

Percentage to ED – Targets and Most Recent Performance

Department	Target ¹	Most Recent Performance ²
Department 1	13.6%	10.5%
Department 2	15.2%	14.5%
Department 3	17.3%	13.9%
Department 1	11.7%	10.6%

¹ Target was set based on 2008 performance.

² Represents first quarter 2009 results.

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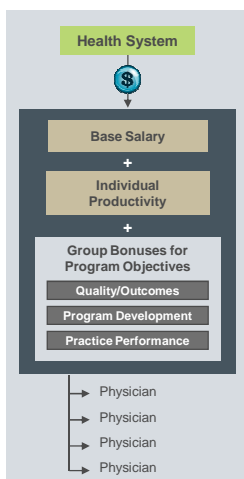
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VI. Emerging Models

Case Study 2: Service Line

Implementing a model that provides various service line bonuses could reward physicians for nonclinical services that contribute to overall program development.



Description

- Physicians receive a base salary based on a predetermined industry percentile (e.g., 40th percentile).
- Physicians receive a productivity bonus based on WRVUs above a threshold level.
 - The threshold is typically based on the level tied to base salary (e.g., 70% of median RVUs).
 - The payment rate per WRVU is based on survey benchmarks.
 - Optionally, the payment rate can be tiered.
- Additionally, the physicians will be eligible to receive bonuses related to the service line's key objectives.
 - Bonuses could reflect service line objectives related to (among others) cost control, citizenship, program development, and research.
 - Service line bonuses would likely be provided to the physician group at a fixed rate (i.e., compensation for achieving each discrete set of service-related objectives).

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VI. Emerging Models Case Study 2: Service Line (continued)

A compensation model that incorporates service-related bonuses could potentially utilize the following metrics:

Potential Metrics	Examples
Clinical Quality	<ul style="list-style-type: none"> Adherence to selected Physician Quality Reporting Initiative (PQRI) quality guidelines. Achievement of three unique quality metrics as approved by the service line governance committee.
Practice Operations	<ul style="list-style-type: none"> Participation in at least three service line committees. Active involvement in supply chain improvement initiatives.
Patient Satisfaction Scores	<ul style="list-style-type: none"> Achievement of predetermined patient satisfaction scores (e.g., internal benchmarks; indicators from the Press Ganey Associates, Inc., survey).
Financial Indicators	<ul style="list-style-type: none"> Cost reductions in excess of target each year. Revenue gains of 5% each year.
Outreach/Referral Relationships	<ul style="list-style-type: none"> At least 12 hours per month provided to community outreach in designated key areas. Market share gains of 2.5% each year.
Program Development	<ul style="list-style-type: none"> Achievement of program targets related to clinical research and/or program development (e.g., percutaneous valve program). At least 16 hours per month provided to clinical research initiatives.

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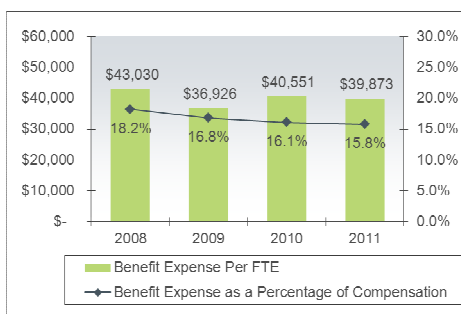
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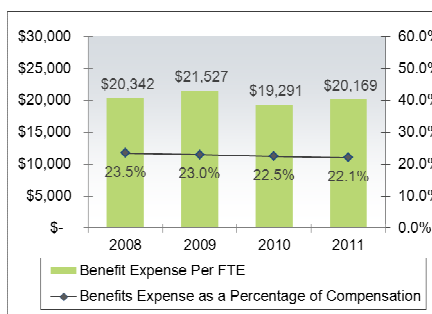
VII. Benefit Trends Provider Benefit Expense

Benefit expense as a percentage of compensation for providers has decreased steadily since 2008. Benefit expense per FTE physician decreased slightly in 2011, while APC's realized a slight increase in benefits.

Physician Benefit Expense Trend



APC Benefit Expense Trend



Source: ECG 2008-2011 Surveys.

Prior to 2009, benefit expense as a percentage of compensation had increased steadily for approximately a decade.

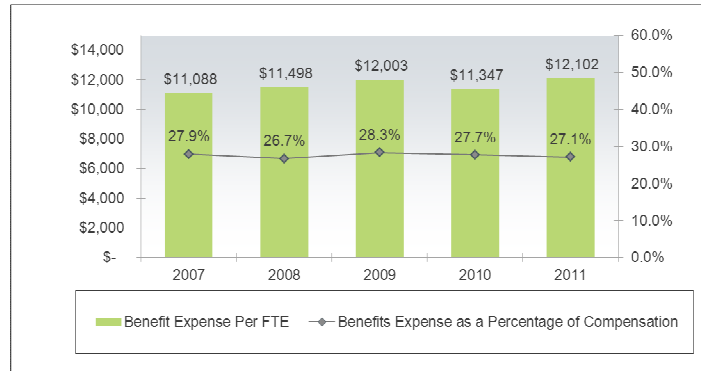
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VII. Benefit Trends Support Staff Benefit Expense

Similar to 2009, benefit expense per support staff FTE topped \$12,000 in 2011. Benefits as a percentage of salaries has fluctuated between 26 and 28% since 2007.



Source: ECG 2007–2011 Surveys.

Similar to staff salaries, benefit expenses have remained relatively stable since the onset of the economic downturn.

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VII. Benefit Trends Benefit Expense Per Category

Health insurance, retirement and payroll taxes represent the majority of benefit expenses for physicians and APCs.

Physician

Benefit Category	Percentage of Organizations	Average \$ Expense
Health Insurance	98%	\$10,612
Life Insurance	96%	\$731
Short-Term Disability	66%	\$2,418
Long-Term Disability	89%	\$1,808
Retirement	91%	\$13,467
Payroll Taxes	N/A	\$11,779
Other	64%	\$5,879

APC

Benefit Category	Percentage of Organizations	Average \$ Expense
Health Insurance	100%	\$7,620
Life Insurance	98%	\$423
Short-Term Disability	67%	\$764
Long-Term Disability	91%	\$608
Retirement	93%	\$4,486
Payroll Taxes	N/A	\$6,491
Other	61%	\$2,240

Source: ECG 2011 Surveys.

The amount of retirement funding has declined over the last 4 years as a result of the economic downturn and a transition of income into cash. However, there may be a return to income protection as uncertainty regarding rising income taxes persist.

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VII. Benefit Trends Health Insurance

Organizations have been able to stabilize health insurance expenses by shifting a portion of the premium cost to physicians. In 2011, the organization cost of providing health insurance coverage averaged \$10,612 per physician.

Health Benefits Physician

	Percentage of Organizations
100% coverage for physician, spouse, and dependents.	23%
100% coverage for physician. Partial payment for spouse and dependents.	16%
Partial expense coverage for physician, spouse, and dependents.	52%
No coverage for physician, spouse, or dependents.	5%
None of the above choices represent your organizations health benefit.	5%

Source: ECG 2011 Surveys.

Organizations continue to pass a portion of health benefit costs on to the physician, with 52% of organizations reporting that they cover partial health benefit expense for the employed physician, spouse, and dependents.

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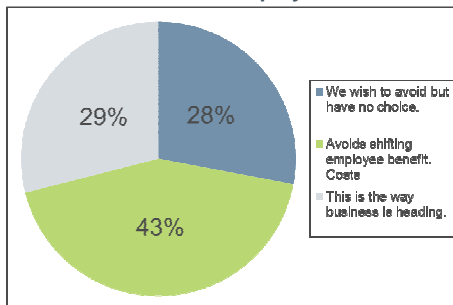
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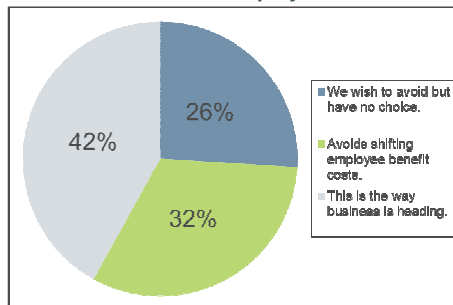
VII. Benefit Trends Health Insurance (continued)

In a 2010 study conducted by MetLife regarding employee benefit trends, a majority of organizations reported shifting benefit expenses to employees.

Under 500 Employees



Over 500 Employees



Source: 9th Annual Study of Employee Benefit Trends, MetLife.

Smaller organizations are more reticent to shift employee benefit costs to its employees compared to larger organizations.

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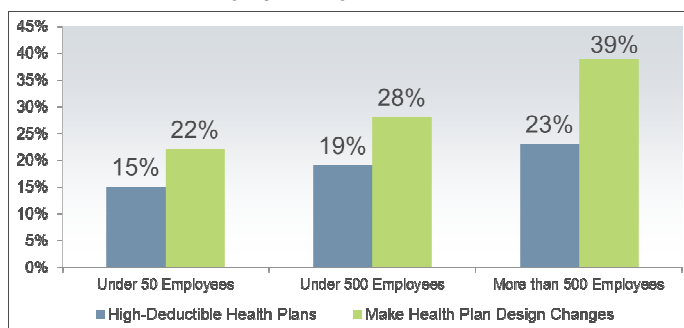
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VII. Benefit Trends Health Insurance *(continued)*

According to the MetLife study, a third of employers indicated that they expect to make health plan design changes in response to the Patient Protection and Affordable Care Act (PPACA). Making health plan changes increases in popularity with company size.

Employer Response to PPACA



Source: 9th Annual Study of Employee Benefit Trends, MetLife.

Smaller organizations are less likely to consider making health plan design changes than larger organizations.

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VII. Benefit Trends Employee Medical Plan In-Network Features

A 2011 industry survey has highlighted the most common features of medical insurance plans across the nation.

Deductible	2011	2010	2009	2008
Not applicable	22%	24%	31%	32%
< \$200	8%	8%	11%	13%
\$200 to \$399	23%	25%	27%	30%
\$400 to \$999	25%	27%	20%	17%
\$1,000 or greater	22%	16%	11%	8%

Out of Pocket Maximum (excluding deductible)	2011	2010	2009	2008
Unlimited	9%	11%	13%	18%
< \$1,000	10%	10%	11%	11%
\$1,000 to \$1,999	27%	28%	34%	30%
\$2,000 to \$2,999	27%	29%	22%	24%
\$3,000 or greater	27%	22%	20%	17%

Employee Coinsurance for Most Services	2011	2010	2009	2008
Not applicable*	26%	-	-	-
0% to 9%	6%	6%	13%	15%
10% to 19%	30%	41%	47%	45%
20% to 29%	34%	49%	35%	32%
30% or greater	4%	4%	5%	8%

* Not an option in prior years.

Source: PwC Health and Well-Being Touchstone Survey Results, May 2011.

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VII. Benefit Trends Employee Preventative Benefits

Health reform has limited cost sharing of specific preventative services.

Covered In-Network Services

	100% Coverage		Covered Similar to Other In-Network Services		Not Covered	
	2011	2010	2011	2010	2011	2010
Physical Examination ¹	78%	67%	21%	31%	1%	2%
Vision Evaluation ²	33%	24%	35%	35%	32%	41%
Hearing Evaluation ³	35%	24%	42%	50%	23%	26%
Electrocardiogram	38%	33%	59%	63%	3%	4%
Cardiac Stress Test	33%	27%	62%	68%	5%	5%
Chest X-Ray	36%	32%	60%	64%	4%	4%
Complete Blood Count including Cholesterol ¹	61%	61%	38%	37%	1%	2%
Metabolic Profile	46%	44%	49%	48%	5%	8%
Urinalysis	53%	48%	45%	50%	2%	2%
Pap Test ¹	77%	73%	23%	26%	0%	1%
Mammography ¹	77%	76%	23%	26%	0%	1%
Prostate Specific Antigen Screening	71%	69%	28%	30%	1%	1%
Colonoscopy ¹	65%	54%	34%	44%	1%	2%

Source: PwC Health and Well-Being Touchstone Survey Results, May 2011.

¹ Required without cost-sharing under the Patient Protection and Accountable Care Act (PPACA).

² Required for children under 5 without cost-sharing under the PPACA.

³ Required for newborns without cost-sharing under the PPACA.

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VII. Benefit Trends Physician Life Insurance

Term life insurance paid by the organization costs on average \$731 per physician FTE, up from 2010. The average benefit expressed as a multiple of salary was 1.5 times the salary, up to a maximum of \$276,563.

Term Life Insurance

	Average	Median
Premium Cost	\$731	\$500
Benefit as a Multiple of Salary: FT	1.5	1.8
Benefit as a Multiple of Salary: P T	1.5	1.5
Maximum Benefit: F T	\$276,563	\$250,000
Maximum Benefit: PT	\$220,357	\$225,000

Supplemental Life Insurance

	Average	Median
Premium Cost	N/A	N/A
Benefit as a Multiple of Salary: FT	3.7	3.0
Benefit as a Multiple of Salary: PT	3.8	4.0
Maximum Benefit: F T	\$670,200	\$550,000
Maximum Benefit: PT	\$ 577,174	\$500,000

Source: ECG 2011 Surveys.

Supplemental life insurance, which organizations can make available to physicians to purchase, provided a benefit of 3.7 times the salary, up to a maximum combined benefit of \$670,200, on average.

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VII. Benefit Trends Physician Disability Insurance

The average percentage of a physician's income replaced by short-term disability insurance is 71%, up to an average maximum benefit (payout) per month of \$10,689. Meanwhile, organizations typically provide long-term disability insurance to replace 60% of a physician's income, up to an average maximum benefit (payout) per year of approximately \$146,178.

Short-Term Disability

	Average	Median
Premium Cost	\$2,418	\$1,231
Percentage of Income Replaced	71%	60%
Maximum Benefit Per Month	\$10,689	\$10,000
Additional Coverage Available	31%	17%
Length of Time Allowed for STD Plan	114	90

Long-Term Disability

	Average	Median
Premium Cost	\$1,808	\$1,580
Percentage of Income Replaced	60%	60%
Maximum Benefit Per Year	\$146,178	\$120,000
Additional Coverage Available	13%	13%
Number of Days Until LTD Plan Begins	130	90

Source: ECG 2011 Surveys.

The average length of time that physicians receive STD benefits is 114 days, while the average number of days until the LTD plan begins is 130 days.

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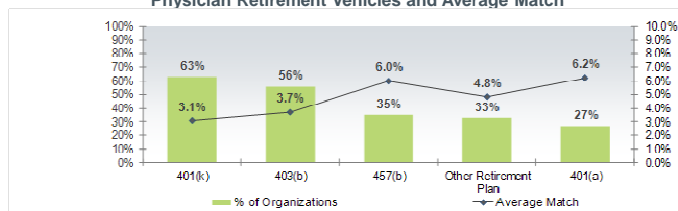
VII. Benefit Trends Physician and APC Retirement Benefits

The most common plan types offered to physicians continue to be 401(k), 403(b), and 457(b) retirement plans. Retirement plans are often offered in combination with one another. The most popular combination is a 403(b) plan and a 457(b) plan. Of the organizations offering a 403(b) plan, 43% also offer a 457(b) plan.

Retirement Benefits

	Physicians	APC
Average	\$13,467	\$4,486
Median	\$10,369	\$3,471
Minimum	\$1,935	\$542
Maximum	\$34,300	\$11,331

Physician Retirement Vehicles and Average Match



Source: ECG 2011 Surveys.

The average organization match for physicians across all retirement vehicles is 4.5%.

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VII. Benefit Trends Time-Off Policies

The median CME and vacation time available for physicians has declined in recent years as organizations emphasize increased provider productivity. Meanwhile, APC time-off is beginning to approximate that of physicians.

Physician, APC and Staff Time-Off Policies

Days Provided	Physicians Median Days Per FTE	ACP Median Days Per FTE	Support Staff Median Days Per FTE
Continuing Medical Education	5.0	5.0	1.0
Vacation	20.0	18.4	15.0
Sick	11.0	10.0	10.0
Personal	1.5	1.5	1.0
Holiday	6.0	6.3	6.5

Physician, APC and Staff General Personal Time-off Policies

Days Provided	Physicians Median Days Per FTE	ACP Median Days Per FTE	Support Staff Median Days Per FTE
General PTO	25.0	25.0	22.0

Source: ECG 2011 Surveys.

Several organizations have chosen to provide a set amount of general PTO days that can be used for various purposes. For these organizations, they typically allocate 25 days for provider PTO.

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VII. Benefit Trends Time-Off Policies (continued)

A majority of organizations do not allow physicians to carry over PTO days, however few do with restrictions.

Physician Time-Off Policies

Days Provided	Physicians Median Days per FTE
No Carry Over	32.7%
Carry Over with No Maximum	4.1%
Carry Over with Maximum	42.9%
PTO - Cash Payout Option	20.4%
Other Option for Unused PTO	14.3%

Source: ECG 2011 Surveys.

43% of organizations allow physicians to carry over PTO days up to a maximum amount.

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VII. Benefit Trends CME and Dues

Physicians and advanced practice clinicians are being offered 5.0 CME days per year, however, physicians are offered a higher CME allowance.

Provider CME and Dues

Days Provided	Annual CME Days	CME Dollars
Physicians	5.0	\$3,000
Advance Practice Clinicians	5.0	\$1,760

Category	% of Organizations - Physicians	% of Organizations - APC
Board Certification Fee	86%	70%
Hospital Dues – Survey Participant Hospital	78%	73%
Hospital Dues – Other Hospitals	47%	44%
Association Membership Dues	80%	79%
Licensing Dues	98%	92%

Source: ECG 2011 Surveys.

In addition to providing a CME allowance, a majority of organizations are paying for providers dues, board certification fees and association membership fees.

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VIII. Case Study: Value Based Employee Health Plan

Situation: A 7 hospital system with over 250 employed physicians and significant aligned (e.g. co-management) relationships seeks to demonstrate competencies in value based delivery through adjustments to its own employee health plan.

- System is developing Health Plan Plus (HPP) an enhanced employee health plan that will be available in mid-2012. HPP is built on a desire to create a network of providers focused on maintaining employee/dependent health and active management of identified chronic conditions.
- Specifically, HPP will require each member to:
 - Receive an initial health screening and biometric assessment through SSM Corporate's enhanced wellness offering.
 - Elect a PCP and share annual health screening/biometric information with his/her physician.
 - Actively engage with his/her PCP through an annual physical exam that, coupled with annual screening/biometric information, will be the platform for continuous assessment and maintenance of the member's health.
 - Adhere to clinical programs provided to address specific chronic conditions identified as network priorities.

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VIII. Case Study: Value Based EHP *(continued)*

- HPP provider network will be composed of core and contracted services conveniently located throughout System service area through its ACO.
- ACO providers must adhere to evidence-based, peer-reviewed guidelines aimed at maintaining patient health, reducing variation of care provided to the chronically ill, and providing ongoing management of secondary and tertiary care of their patients.
 - Chronic conditions being focused on for 2012 include: heart failure, obesity, diabetes, and hypertension, and mental health (depression and bipolar disorder, initially).
 - These areas will also be the initial focus for HPP.
 - As such, HPP members identified with these conditions will receive enhanced/evidence-based care aimed at improving overall health and reducing cost through a proactive rather than reactive care model.

VIII. Case Study: Value Based EHP *(continued)*

- Accordingly, the payment and funds flow model must support initial investment in the screening, identification, treatment planning, and care delivery for the HPP members while providing these members with reduced healthcare premiums in return for their active participation and compliance with clinical direction.
- The internal funds flow arrangement between will be based on an initial investment period of at least 2 years, with the goal of achieving shared savings in Year 3 demonstrated by a reduction in the predicted spending trend.
 - A thin capitation payment is needed to invest in the initial infrastructure and systems necessary to prepare for value-based care delivery.
 - A majority of the shared savings will be retained by the provider network to support its transition from volume-based care to value-based delivery.
 - Ultimately, system will seek a transition to a capitated model where it will maintain the full financial risk for care delivery to HPP members.

Questions & Answers

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