Physician Compensation Plan Design at Roper-St. Francis Physician Partners

Thursday, March 23, 2017
Presentation Overview

- Tell you about Roper St. Francis Physician Partners (RSFPP)
- Outline our rationale and objectives for pursuing compensation plan redesign
- Describe the process we used
- Share the compensation philosophy
- Share the physicians’ feedback during the redesign
- Present the primary care model adopted including value-based metrics selected
- Share a specialty services example
- Discuss lessons learned
About Roper St. Francis

- Mission: Healing all people with compassion, faith and excellence
- More than 230 employed physicians across over 20 specialties
- Patient Centered Medical Home (PCMH) model of care
- Nearly 800 physicians on medical staffs of 3 hospitals
- More than 5,500 employees
- Clinics in five counties across the Lowcountry of South Carolina
- One of Charleston’s largest employers
Roper St. Francis Service Area Map
Rationale for Compensation Redesign

• Our market changed, including a risk-based arrangement with a large employer

• Need to align physicians with organizational objectives in the shift from fee-for-service to value-based care

• Prepare for changes in physician reimbursement linked to the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)

• These new models significantly tie reimbursement to demonstrating value-based care including high quality and low cost

• Support internal equity and physician recruitment needs (there were some differences based on historical employment contracts and timing of practice acquisitions)

• The goal of this effort was NOT to cut physician compensation, but to align physician compensation with a changing market
Compensation Plan Objectives

- Evaluate compensation methodologies and compensation levels relative to market
- Obtain an *independent* assessment of compensation and production levels
- Assess fitness of compensation approaches for alignment with market trends
- Promote patient-centered medical care
- Support RSF’s Clinically-Integrated Network to become the provider of choice in the Lowcountry
- Provide detailed implementation and transition planning
- Create a revised compensation program that was principle-based
Processes and Timeline

• **October-November 2015:** AMGA Consulting was selected as an advisor

• **December 2015:** AMGA Consulting interviewed approximately 30 RSF stakeholders over a 3-day period to identify issues with current compensation and areas of importance in the redesign

• **January-February 2016:** AMGA collected and analyzed physician data and led a planning retreat to discuss what is important for RSF in a compensation model

• **February 2016:** Developed RSFPP’s (Roper-St. Francis Physician Partners) guiding philosophy for physician compensation

• **February 2016-July 2016:** At least semi-monthly meetings with AMGA and Primary Care Workgroups to review data and develop an agreed-upon compensation model

• **July-August 2016:** Basic model approved by RSFPP Board of Directors; model presented with month-long opportunity for feedback from group

• **September 2016:** Contracts delivered to doctors for signature (start date 2/6/17)
Physician Online Survey Key Results

• **Highest-ranked questions linked to patient care:**
  – Physician-patient relationships
  – Satisfaction with quality of care able to provide
  – Ability to refer to high-quality specialists

• **Lowest-ranked questions included:**
  – Explanation of management decisions
  – Leadership’s response to physician concerns
  – Involvement of physicians in determining compensation approaches
  – Use of electronic medical records
  – Cost-related goals or efficiency as a factor in compensation
Generally, there was reasonable alignment between compensation and production levels.

There were some productivity issues and areas where similar work effort resulted in different compensation levels.
Primary Care Percentile Analysis
Compensation to wRVU – AMGA Data

The compensation design started with primary care. It was helpful to focus on family medicine and internal medicine given the number of physicians represented.

Graphic to be reviewed at meeting.
The Planning Retreat

• The planning retreat was a full day that started with review of market trends

• Then, we reviewed compensation and production of our doctors relative to market (national data using AMGA Survey)

• Also shared online provider satisfaction survey results

• Near the end of the day, we split into small groups to draft and prioritize the compensation principles

• The principles were eventually “merged” across the small groups and endorsed
Compensation Philosophy: Five Principles

Fairness

• Compensation formulas will be **well defined** and **understandable**. Each physician will receive a copy of the formula by which his or her specialty is compensated.

• Core work expectations will be defined in advance for all providers and required as part of membership in the group. These expectations may include access, production, call, quality, citizenship, administrative contributions and other expectations.

• Individual compensation will vary with performance and outcomes, including clinical quality.

• Compensation approaches may vary across specialties where supported by market practice or organizational needs.

The philosophy is key to helping you determine the components of the plan.
Compensation Philosophy

Market Competitiveness

• Compensation will be market competitive and evaluated by market analysis, including use of national survey data (AMGA and MGMA).

• Compensation, inclusive of incentive opportunities, will be targeted to the level of performance.

• The compensation program will support recruitment and retention which promotes patient access to services for the community.

Alignment with Organizational Needs

• The compensation program must be synchronized with healthcare reform and supportive of a population health and value-based model.

• The compensation program will similarly support the organization’s care model, which will promote safe, timely, effective, patient-centered and efficient care delivery across the continuum.

• Given current market reforms, value-based metrics will form a material part of the compensation plan for all participants.
Compensation Philosophy

Sustainability in a Dynamic Market

• The compensation program must be fiscally prudent for the organization, which supports sustainability.

• Providers will be expected to meet certain performance expectations, including defined productivity standards.

• The compensation program will adapt over time as market conditions change.

Compliance

• Compensation methods and overall pay levels will be administered in a manner that meets all applicable regulatory requirements.

• Periodic reviews will be conducted and could result in compensation changes to support compliance.
### Philosophy and Compensation Design

#### Driving Forces

1. **Risk-based reimbursement is a local market reality with more risk anticipated**
2. **Weight of value-based metrics (VBM) in current compensation approaches is too low for some**
3. **RSF compensation formulas tend to have a large production component**
4. **Variation in production levels with some physicians below their specialty’s 30th percentile**
5. **Fairness and provider engagement**

#### Potential Actions

1. **Compensation models should include more emphasis on quality, coordination, and cost with less emphasis on each wRVU; Set minimum VBM component that is a larger proportion of compensation**
2. **Develop models that maintain access and revenue – and transition to meet VBM needs**
3. **Set minimum work expectations, including production threshold**
4. **Allow some autonomy with VBM; provide market-based pay; value certain other duties**

---

*AMGA Consulting*
All of this work led to the question, “How should we weight the components?”
Conceptual Model Design

• After the retreat, the first several workgroup meetings included initial formula development ("conceptual models")

• The primary care physicians did not necessarily support the first couple of attempts at the formula

• The direction emerged over time with several meetings and giving the physician’s options
Conceptual Model Design: A Starting Point for the Formula

~70%
- Performance Band 4 wRVU + Other Criteria
- Performance Band 3 wRVU + Other Criteria
- Performance Band 2 wRVU + Other Criteria
- Performance Band 1 wRVU + Other Criteria

10%
- Access Composite

20%
- Quality at Stretch
- Quality at Target of 20% of Median Pay
- Quality at Threshold
- High Production Bonus

It looks clean and simple, but setting the performance bands required a lot of fine tuning so each band represented a roughly equal range of work RVU production.
Conceptual Model Design: Performance Criteria

- **Performance Bands**
  - Form a material component of compensation (~70%)
  - Multiple bands linked to performance criteria
  - Criteria would include work RVU production and other factors (to be defined)

- **Access Composite**
  - Access composite (to represent access and panel) initially discussed at 10% of specialty median compensation
  - Could be stratified with multiple levels of achievement

- **Clinical Quality**
  - Initially discussed as 20% of specialty median compensation
  - Could be set up with three or more levels of achievement
Physician Feedback

So what did the physician leaders say about it?

• Provide **clear definitions** regarding performance bands and access composite

• Move to a 10-12 band model, with focus on the top producing physicians

• Allow for more variation in levels of achievement for access and quality

• Want to see all of primary care modeled (not just a sample to demonstrate the concept)

• How is citizenship recognized?

• Access needs to be fair for new and existing physicians
The New Primary Care Model

Production Bands
- 11 bands
- Based on prior year’s work RVU production
- Based on AMGA and MGMA combined data
- Physician assigned to band annually

Citizenship
- Locking notes timely (average hours to lock)
- Attend ProAssurance annual meeting
- Meet meaningful use criteria
- Advisory group and Annual Physician meetings
- NetLearning completed by 12/1

Access
- % Same-day visits by practice
- Unique patients (Panel Size) by physician
- New patients seen by practice

Clinical Quality
- Formula similar to the current LEM Measures (5 point system, no payment for 1 or below)
- Based entirely on clinical quality data, includes CG CAHPS data
- Consensus Core Set: ACO and PCMH / Primary Care Measures
Incentive Compensation Design: Rising Risk – A Transitional Approach

“Rising Risk” Transition

<table>
<thead>
<tr>
<th></th>
<th>Year One</th>
<th>Year Two</th>
<th>Year Three</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access Composite</td>
<td>5%</td>
<td>7.5%</td>
<td>10%</td>
</tr>
<tr>
<td>Clinical Quality</td>
<td>10%</td>
<td>12.5%</td>
<td>15%</td>
</tr>
<tr>
<td>Citizenship</td>
<td>5%</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>20%</strong></td>
<td><strong>25%</strong></td>
<td><strong>30%</strong></td>
</tr>
</tbody>
</table>

Then it was decided that linking 30% of compensation to outcomes-based metrics will be phased in over three years.
The compensation target is based on wRVU 60% of the way into the band times the P55 conversion factor. This amount is then 80% earned as base and 20% at risk.

<table>
<thead>
<tr>
<th>Performance Bands</th>
<th>Prod %tile Range</th>
<th>WRVU Range</th>
<th>Comp Target</th>
<th>Base Salary 80%</th>
<th>Clinical Quality 10%</th>
<th>Access 5%</th>
<th>Citizenship 5%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Band 1</td>
<td>0-20</td>
<td>1,137-3,774</td>
<td>$134,236</td>
<td>$107,389</td>
<td>$13,424</td>
<td>$6,711</td>
<td>$6,711</td>
</tr>
<tr>
<td>Band 2</td>
<td>20-30</td>
<td>3,775-4,231</td>
<td>$199,877</td>
<td>$159,902</td>
<td>$19,988</td>
<td>$9,993</td>
<td>$9,993</td>
</tr>
<tr>
<td>Band 3</td>
<td>30-40</td>
<td>4,232-4,600</td>
<td>$219,849</td>
<td>$175,879</td>
<td>$21,985</td>
<td>$10,992</td>
<td>$10,992</td>
</tr>
<tr>
<td>Band 4</td>
<td>40-50</td>
<td>4,601-4,916</td>
<td>$236,490</td>
<td>$189,192</td>
<td>$23,649</td>
<td>$11,824</td>
<td>$11,824</td>
</tr>
<tr>
<td>Band 5</td>
<td>50-60</td>
<td>4,917-5,253</td>
<td>$252,719</td>
<td>$202,175</td>
<td>$25,272</td>
<td>$12,635</td>
<td>$12,635</td>
</tr>
<tr>
<td>Band 6</td>
<td>60-70</td>
<td>5,254-5,668</td>
<td>$271,663</td>
<td>$217,330</td>
<td>$27,166</td>
<td>$13,583</td>
<td>$13,583</td>
</tr>
<tr>
<td>Band 7</td>
<td>70-80</td>
<td>5,669-6,197</td>
<td>$295,506</td>
<td>$236,405</td>
<td>$29,551</td>
<td>$14,775</td>
<td>$14,775</td>
</tr>
<tr>
<td>Band 8</td>
<td>80-85</td>
<td>6,198-6,587</td>
<td>$317,624</td>
<td>$254,099</td>
<td>$31,762</td>
<td>$15,881</td>
<td>$15,881</td>
</tr>
<tr>
<td>Band 9</td>
<td>85-90</td>
<td>6,588-7,127</td>
<td>$341,235</td>
<td>$272,988</td>
<td>$34,124</td>
<td>$17,061</td>
<td>$17,061</td>
</tr>
<tr>
<td>Band 10</td>
<td>90-95</td>
<td>7,128-8,151</td>
<td>$382,214</td>
<td>$305,771</td>
<td>$38,221</td>
<td>$19,110</td>
<td>$19,110</td>
</tr>
<tr>
<td>Band 11</td>
<td>&gt;95</td>
<td>8,152-n/a</td>
<td>$402,455</td>
<td>$321,964</td>
<td>$40,246</td>
<td>$20,122</td>
<td>$20,122</td>
</tr>
</tbody>
</table>
**Internal Medicine**

The apportionment will change each year until all it becomes 70% base, 15% Clinical Quality, 10% Access and 5% Citizenship

<table>
<thead>
<tr>
<th>Performance Bands</th>
<th>Prod %tile Range</th>
<th>WRVU Range</th>
<th>Comp Target</th>
<th>Base Salary 80%</th>
<th>Clinical Quality 10%</th>
<th>Access 5%</th>
<th>Citizenship 5%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Band 1</td>
<td>0-20</td>
<td>1,076</td>
<td>3,590</td>
<td>$139,128</td>
<td>$111,302</td>
<td>$13,913</td>
<td>$6,956</td>
</tr>
<tr>
<td>Band 2</td>
<td>20-30</td>
<td>3,591</td>
<td>4,067</td>
<td>$208,724</td>
<td>$166,979</td>
<td>$20,872</td>
<td>$10,436</td>
</tr>
<tr>
<td>Band 3</td>
<td>30-40</td>
<td>4,068</td>
<td>4,462</td>
<td>$231,754</td>
<td>$185,403</td>
<td>$23,175</td>
<td>$11,587</td>
</tr>
<tr>
<td>Band 4</td>
<td>40-50</td>
<td>4,463</td>
<td>4,810</td>
<td>$251,484</td>
<td>$201,187</td>
<td>$25,148</td>
<td>$12,574</td>
</tr>
<tr>
<td>Band 5</td>
<td>50-60</td>
<td>4,811</td>
<td>5,187</td>
<td>$271,166</td>
<td>$216,933</td>
<td>$27,117</td>
<td>$13,558</td>
</tr>
<tr>
<td>Band 6</td>
<td>60-70</td>
<td>5,188</td>
<td>5,620</td>
<td>$293,281</td>
<td>$234,625</td>
<td>$29,328</td>
<td>$14,664</td>
</tr>
<tr>
<td>Band 7</td>
<td>70-80</td>
<td>5,621</td>
<td>6,200</td>
<td>$321,340</td>
<td>$257,072</td>
<td>$32,134</td>
<td>$16,067</td>
</tr>
<tr>
<td>Band 8</td>
<td>80-85</td>
<td>6,201</td>
<td>6,622</td>
<td>$347,465</td>
<td>$277,972</td>
<td>$34,747</td>
<td>$17,373</td>
</tr>
<tr>
<td>Band 9</td>
<td>85-90</td>
<td>6,623</td>
<td>7,312</td>
<td>$378,833</td>
<td>$303,066</td>
<td>$37,883</td>
<td>$18,941</td>
</tr>
<tr>
<td>Band 10</td>
<td>90-95</td>
<td>7,313</td>
<td>8,338</td>
<td>$426,821</td>
<td>$341,457</td>
<td>$42,682</td>
<td>$21,341</td>
</tr>
<tr>
<td>Band 11</td>
<td>&gt;95</td>
<td>8,339</td>
<td>n/a</td>
<td>$448,946</td>
<td>$359,157</td>
<td>$44,895</td>
<td>$22,447</td>
</tr>
</tbody>
</table>
Incentive Compensation Design

• Clinical quality and access will use the following payout schedule:
  – Score 1: 0% payout
  – Score 2: 33% payout
  – Score 3: 67% payout
  – Score 4: 100% payout
  – Score 5: 110% payout

• Citizenship is achievable by all at the target payout level

• Scores are on a sliding scale; a score of 3.5 will get paid between 67% and 100%, for example
Incentive Compensation Design

So we went back and reviewed current state performance across all providers under our current 5-point scoring model.

• **Family Medicine Averages**
  - Access: 4.20
  - Quality: 2.57

• **Internal Medicine Averages**
  - Access: 2.79
  - Quality: 2.87
### Summary Compensation Changes with Current Access/Quality Scores

The model is set so that current access and quality performance yield increases for many physicians. There were some needed market adjustments.

<table>
<thead>
<tr>
<th>Physicians' Change in Compensation</th>
<th>Count</th>
<th>% of Phys.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Greater than 10% Increase</td>
<td>15</td>
<td>23.8%</td>
</tr>
<tr>
<td>Greater than 5%, less than 10% Increase</td>
<td>13</td>
<td>20.6%</td>
</tr>
<tr>
<td>Greater than 0%, less than 5% Increase</td>
<td>15</td>
<td>23.8%</td>
</tr>
<tr>
<td>Greater than 0%, less than 5% Decrease</td>
<td>10</td>
<td>15.9%</td>
</tr>
<tr>
<td>Greater than 5%, less than 10% Decrease</td>
<td>3</td>
<td>4.8%</td>
</tr>
<tr>
<td>Greater than 10% Decrease</td>
<td>7</td>
<td>11.1%</td>
</tr>
</tbody>
</table>
Summary Compensation Changes
Target Performance with Access/Quality = 4

<table>
<thead>
<tr>
<th>Physicians' Change in Compensation</th>
<th>Count</th>
<th>% of Phys.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Greater than 10% Increase</td>
<td>32</td>
<td>50.8%</td>
</tr>
<tr>
<td>Greater than 5%, less than 10% Increase</td>
<td>9</td>
<td>14.3%</td>
</tr>
<tr>
<td>Greater than 0%, less than 5% Increase</td>
<td>13</td>
<td>20.6%</td>
</tr>
<tr>
<td>Greater than 0%, Less than 5% Decrease</td>
<td>4</td>
<td>6.3%</td>
</tr>
<tr>
<td>Greater than 5%, less than 10% Decrease</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Greater than 10% Decrease</td>
<td>5</td>
<td>7.9%</td>
</tr>
</tbody>
</table>

The incentive is clear for reaching a 4 out of 5 on access and quality measures. Note that the model provides a steep penalty for low producers (exempting new hires under a guarantee).
Proposal for Physicians Increasing or Decreasing Production in a Given Year

**Increase above Band**, paid at additional wRVUs over band multiplied by the specialty wRVU rate at 55\(^{th}\) percentile.

**Decrease below Band**, semi-annual review. If 10% or more below bottom of band, then decrease to projected band at mid-year review.

- Access will be paid quarterly
- If Band decreases, incentive will be paid in Band earned
Primary Care Implementation Plan

✓ **August 1 & 2, 2016**, Present to Advisory Groups; individual handouts to physicians

✓ **August 2016**, discussions with physicians and receive/respond to feedback

✓ **September-October 2016**, finalize contract language, drafting and distribution of individual agreements

✓ **November-December 2016**, obtain signatures on agreements, develop and distribute 2017 clinical quality metrics, finalize changes to access measure

✓ **December 31, 2016**, cut-off date for wRVU measurement to determine band placement

✓ **January 1, 2017**, begin measuring 2017 clinical quality and access

✓ **January 2017**, accounting department and management work on determining base compensation and submission to payroll

✓ **February 6, 2017**, new agreements began
Specialty Services Example: Psychiatry

Consistent with the Compensation Philosophy, we may apply similar approaches to several non-interventional specialties but with some adjustments:

- Psychiatry would probably not have a quality component at this time thus only 15% incentive
- The Bands are 500 wRVU intervals between Bands 2 and 10 (not based on deciles)

<table>
<thead>
<tr>
<th>Performance Bands</th>
<th>wRVU Range</th>
<th>Base Salary</th>
<th>Incentive Target</th>
<th>Comp. Target</th>
<th>wRVU Index</th>
</tr>
</thead>
<tbody>
<tr>
<td>Band 1</td>
<td>0-2500</td>
<td>$74,792</td>
<td>$13,199</td>
<td>$87,990</td>
<td>1500</td>
</tr>
<tr>
<td>Band 2</td>
<td>2501-3000</td>
<td>$139,631</td>
<td>$24,641</td>
<td>$164,271</td>
<td>2800</td>
</tr>
<tr>
<td>Band 3</td>
<td>3001-3500</td>
<td>$164,561</td>
<td>$29,040</td>
<td>$193,601</td>
<td>3300</td>
</tr>
<tr>
<td>Band 4</td>
<td>3501-4000</td>
<td>$189,492</td>
<td>$33,440</td>
<td>$222,931</td>
<td>3800</td>
</tr>
<tr>
<td>Band 5</td>
<td>4001-4500</td>
<td>$214,422</td>
<td>$37,839</td>
<td>$252,261</td>
<td>4300</td>
</tr>
<tr>
<td>Band 6</td>
<td>4501-5000</td>
<td>$239,353</td>
<td>$42,239</td>
<td>$281,591</td>
<td>4800</td>
</tr>
<tr>
<td>Band 7</td>
<td>5001-5500</td>
<td>$264,283</td>
<td>$46,638</td>
<td>$310,921</td>
<td>5300</td>
</tr>
<tr>
<td>Band 8</td>
<td>5501-6000</td>
<td>$289,214</td>
<td>$51,038</td>
<td>$340,251</td>
<td>5800</td>
</tr>
<tr>
<td>Band 9</td>
<td>6001-6500</td>
<td>$314,144</td>
<td>$55,437</td>
<td>$369,581</td>
<td>6300</td>
</tr>
<tr>
<td>Band 10</td>
<td>6501-7000</td>
<td>$339,075</td>
<td>$59,837</td>
<td>$398,911</td>
<td>6800</td>
</tr>
<tr>
<td>Band 11</td>
<td>7001-7500</td>
<td>$349,077</td>
<td>$61,602</td>
<td>$410,679</td>
<td>7001</td>
</tr>
</tbody>
</table>

Other Compensation Components

<table>
<thead>
<tr>
<th>Access Component</th>
<th>10%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Citizenship</td>
<td>5%</td>
</tr>
</tbody>
</table>
Lessons Learned

• What worked well during the process:

✓ Having a transition period so the doctors have an opportunity to plan for their future

✓ Sharing the modeling at the individual physician level (even blinded) was important to buy-in

✓ We reviewed each physician whose compensation would go down under the new model and are prepared to provide coaching and support

✓ Should physicians “max out” their earning potential, we will have solid clinical quality, access and/or patient satisfaction scores to support it

✓ Workgroup involved a diverse group of individuals, not just the usual leadership team; administration selected a small group of representative physicians to give input from differing points of view
Lessons Learned

• What didn’t work as well:
  ❌ Presentations without choices for the physician leaders were just an opportunity to criticize and slowed down progress
  ❌ Getting the performance / clinical quality data is one of our biggest challenges and needs more physician involvement

• What we might change for the future/other considerations:
  – Evaluating use of an acuity adjustment as we think panel size will be more important in the future or potential adjustment to quality for high volumes of Medicaid patients
  – Looking at top band to make 500 wRVU wide and see if we want to pay 60% of wRVU for performance over with qualifiers
  – As we get started with specialties, we will concentrate on work RVU performance, access (ability of the patient to timely get into the doctor), and clinical quality; panel size is not as important at this time
Questions and Comments?