CentraCare Health: Trends in Health Care

September 19, 2016
Presented by:
Courtney Helmstetter and Mark Ryberg

Presented to:
Today’s Agenda

1. About SullivanCotter
2. The Foundation for the Governance in Physician Compensation
3. State of Health Care Industry
   - Changing Reimbursement Environment
   - Trends in Physician Compensation Design
4. Physician Compensation Redesign Project Approach
5. Overview of CentraCare Redesign Project Governance
6. Questions
An independent firm deeply rooted in compensation advisory services for the health care industry, SullivanCotter has grown to become a leading human resources management consulting firm addressing all elements of total compensation planning.

**NOTABLE FACTS**

- **90%**
  - Our project leaders average over 20 years of experience consulting to not-for-profit organizations and boards.
  - Our client retention rate is over 90%.
  - 100% of our revenue is derived from our consulting and surveys; no conflicts of interest.

- **REAL TIME TRENDS**
  - Informed by work with clients.

- **Dedicated research staff**
  - Turn information into **INSIGHTS**

- **We are PRIVATLY OWNED**
  - By our Managing Directors and Managing Principals.

- **INNOVATIONS**
  - Developed by work with industry leaders and strategic partners.
Comprehensive Service Offerings

Executive Compensation
- Reasonableness assessments
- Annual and long-term incentive plan design
- Severance and change-in-control agreements
- Employment contracts
- IRS Form 990 analysis
- Development of media relations strategy and talking points
- Assistance in handling media inquiries
- Board compensation program evaluation/design

Physician Compensation
- Fair market value assessments
- Professional services arrangements
- Co-management arrangements
- Alignment strategy development
- Practice valuation and appraisal
- Practice acquisition strategy and due diligence
- Physician-sensing activities
- On-call pay program development

Executive and Physician Benefits and Perquisites
- Deferred compensation program design
- Retirement plan design and funding
- SERP administrative support and communications
- Split-dollar life insurance analysis
- Special issue areas (e.g., disability, PTO, post-retirement medical, etc.)
- Policy development for perquisites

Employee Compensation and Benefits
- Compensation design for all employees including advanced practice clinicians
- Alignment of pay and benefit programs post merger or acquisition
- Due diligence pre-and post merger or acquisition
- Audits of premium pay programs
- Competitive assessments of benefit plans

Our Total Compensation Core Services
- Total compensation philosophy development
- Cash compensation plan design
- Benefits plan design
- Market analysis of base and variable pay
- Benchmarking
- Custom surveys
Our Experience

We provide physician compensation services for the following representative clients

### Academic Medical Centers
- Atrius Health
- Baylor Scott & White Health
- Cedars-Sinai Health System
- City of Hope Cancer Center
- Cleveland Clinic
- Dartmouth-Hitchcock Medical Center
- Duke University Health System
- The Emory Clinic
- Henry Ford Health System
- Johns Hopkins Health System
- Loyola University Health System
- Memorial Sloan Kettering Cancer Center
- Montefiore Medical Center
- Mount Sinai Hospital
- Northwestern Memorial HealthCare
- Partners HealthCare
- Rush University Medical Center
- Texas Children’s Hospital
- University Hospitals Health System
- University of California
- University of Pittsburgh Cancer Institute
- University of Utah
- UNC Health Care System
- Yale New Haven Health System

### Large Health Systems
- Advocate Health Care
- Alegent Creighton Health
- Allina Health System
- BayCare Health System
- Cadence Health
- Centura Health
- Dignity Health
- Geisinger Health System
- Intermountain Healthcare
- McLaren Health Care
- Mission Health
- North Shore LIJ Health System
- Norton Healthcare
- Orlando Health
- Presence Health
- ProMedica
- Sentara Healthcare
- SCL Health
- SSM Health Care
- Spectrum Health
- Summa Health System
- Virginia Mason Medical Center

SullivanCotter’s roster of over 800 total clients provides access to real-time trends
Our Research and Data

We provide insightful, actionable information using our industry-leading surveys and research

Robust data allowing for targeted and customized analyses:
- Large integrated health networks
- Large academic health systems
- System-owned hospitals
- Children’s hospitals
- Physician groups
- Health plans

We also maintain a library of over 100 published compensation surveys and a proprietary Form 990 database

High quality, comprehensive data sets:
- Participants from leading organizations
- Strong focus on quality control
- Evolve surveys to capture emerging issues and trends
Courtney Helmstetter is a Principal in the Minneapolis office of Sullivan, Cotter and Associates, Inc. Prior to joining the Firm, Courtney was a Manager in the health care consulting group of RSM McGladrey. She has also held positions as a human resources generalist focusing on compensation, benefits, 401(k) administration and compliance, and recruitment responsibilities.

With her expertise in the areas of physician compensation, Courtney’s projects have included:

- Physician compensation plan design and implementation
- Physician productivity benchmarking reviews and analysis
- Fair market value assessments
- Executive compensation analysis
- Market pricing and salary range development
- Custom salary surveys
- Physician benefits analysis

Courtney is a Certified Compensation Professional (CCP) and is a member of the WorldatWork Organization and the Twin Cities Compensation Network (TCCN). She is a frequent speaker at conferences and contributes regularly to industry publications in the areas of physician compensation and benchmarking.

Courtney was awarded a Bachelor of Arts degree in business administration with a concentration in human resources from the University of St. Thomas in St. Paul, Minnesota.
Mark Ryberg is a Principal in the Physician Services Practice of Sullivan, Cotter and Associates, Inc. With nearly ten years of experience in health care consulting, he specializes in developing strategic management and total compensation solutions for hospitals and health systems nationwide.

As health care continues its transition towards value-based care and physician compensation arrangements become increasingly more complex, Mark is committed to helping clients thrive in an ever-changing market. He has extensive background working with a diverse variety of health care organizations, including large multi-specialty clinics, integrated health care systems, academic medical centers, and children’s hospitals, to develop, implement and oversee all aspects of the physician compensation design process.

With a deep understanding and focus on the legal and regulatory requirements surrounding physician compensation design, Mark’s expertise includes the following:

• Leading the design, implementation and communication of physician compensation programs in the face of an evolving market.

• Working with boards and physician leaders to develop effective compensation strategies that are competitive, compliant and consistent with market dynamics.

• Facilitating fair market value compliance evaluations and assisting in the valuation of professional service agreements across an array of physician specialties.

• Assisting organizations in the merger and acquisition of physician practices.

• Assessing current processes and policies related to the governance of physician compensation, and educating boards and committees on best practices in governance.

Prior to joining the firm, Mark was a Vice President in the Physician Services Practice of INTEGRATED Healthcare Strategies. He was awarded a Juris Doctorate from the University of Minnesota Law School and a bachelor’s degree in biology from the University of St. Thomas in St. Paul, Minnesota.
The Foundation for the Governance of Physician Compensation
Overview of Key Regulations

Foundation for the regulation of physician compensation in not-for-profit health care

Physician Compensation

- Stark Law
- Insurance Laws
- Anti-Trust Laws
- False Claim Acts
- Anti-Kickback Statute
- Civil Monetary Penalties
- Tax Exempt IRS Laws
Enacted in 1863 because Congress was concerned that Union Army suppliers were defrauding the government

Any person who submits false claims to the government is subject to a per claim penalty

Whistleblower receives up to 30% of the recovery

The FCA provides a private citizen the ability to bring a suit on behalf of the Government (i.e. qui tam)

FCA was amended in 1986 to provide a lucrative incentive to whistleblowers to report fraud

FCA
# Regulatory Overview – AKS and Stark

<table>
<thead>
<tr>
<th>Anti-Kickback Statute</th>
<th>Stark Law</th>
</tr>
</thead>
<tbody>
<tr>
<td>(42 U.S.C. §§1320(a) – 7b(b))</td>
<td>(42 U.S.C. §1395nn)</td>
</tr>
</tbody>
</table>

- **Prohibits** offering, paying, soliciting or receiving **anything of value to induce or reward referrals** or generate Federal health care program business

- Applies to **referrals from anyone**

- Requires intent (i.e., knowing and willful)

- **Prohibits** a physician from referring a Medicare patient for **designated health services** to an entity with which the physician (or immediate family member) has a financial relationship, unless an exception applies

- Applies to **referrals from a physician**

- **No intent** requirement
<table>
<thead>
<tr>
<th>Enforcement Activity</th>
</tr>
</thead>
</table>

## Fines and Penalties

<table>
<thead>
<tr>
<th>Stark</th>
<th>IRS</th>
<th>Anti-Kickback</th>
<th>False Claims Act</th>
</tr>
</thead>
</table>
| ✓ Overpayment/refund obligation  
 ✓ FCA liability  
 ✓ Potential for CMP of $15,000 per claim | ✓ Exclusion from Medicare/Medicaid programs  
 ✓ Intermediate sanctions, excise taxes and disgorgement | ✓ Criminal fines up to $25,000 per violation  
 ✓ Up to a five-year jail term per violation  
 ✓ CMP (i.e., up to $50,000 per violation) and FCA applicability | ✓ 3x damages of overpayment  
 ✓ $5,500 to $11,000 per claim penalty |

### Reputational Risk

### Burden on Resources

### High Settlements
## Enforcement Activity

<table>
<thead>
<tr>
<th>Hospital System</th>
<th>Medical Center</th>
<th>Amount</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Robinson Health System</td>
<td>-</td>
<td>$10M</td>
<td>March 2015</td>
</tr>
<tr>
<td>Westchester Medical Center</td>
<td>-</td>
<td>$18.8M</td>
<td>May 2015</td>
</tr>
<tr>
<td>North Broward Hospital District</td>
<td>-</td>
<td>$69.5M</td>
<td>September 2015</td>
</tr>
<tr>
<td>Columbus Regional Healthcare System</td>
<td>-</td>
<td>$25M</td>
<td>September 2015</td>
</tr>
<tr>
<td>Citizens Medical Center</td>
<td>-</td>
<td>$21.75M</td>
<td>April 2015</td>
</tr>
<tr>
<td>Vanguard Health Systems</td>
<td>-</td>
<td>$2.9M</td>
<td>June 2015</td>
</tr>
<tr>
<td>Adventist Health System (Sunbelt)</td>
<td>-</td>
<td>$118M</td>
<td>September 2015</td>
</tr>
<tr>
<td>Tri-City Medical Center</td>
<td>-</td>
<td>$3.3M</td>
<td>January 2016</td>
</tr>
</tbody>
</table>
The New Reality

1. Compensation should/must be structured to satisfy various exceptions and safe harbors.

2. Compensation from organization must not exceed Fair Market Value (FMV).

3. Compensation cannot take into consideration volume or value of Medicare referrals.

4. Compensation above FMV may be re-characterized as payment for referrals; however, business justification can support TCC levels above the market range.

5. In addition to FMV standard, compensation arrangement(s) must be commercially reasonable.
State of Health Care Industry

Changing Reimbursement Environment
The 2016 CMS Quality Strategy includes the following six goals:

1. Make care safer by reducing the harm caused in the delivery of care
2. Strengthen person and family engagement as partners in care
3. Promote effective communication and coordination of care
4. Promote effective prevention and treatment of chronic disease
5. Work with communities to promote best practices of healthy living
6. Make care affordable

**Reimbursement**
- Medicare payments tied to quality and value through alternative payment models:
  - By end of 2016: 30%
  - By end of 2018: 50%
- Medicare FFS payments tied to quality and value:
  - By end of 2016: 85%
  - By end of 2018: 90%
Changing Reimbursement: MACRA

Medicare Access and Chip Reauthorization Act (MACRA) will impact the pace of change from volume to value

March 26
- Congress repealed the sustainable growth-rate (SGR) physician fee schedule

April 15
- Congress signed MACRA into law

WE ARE HERE


- 0.5% annual increases to physician reimbursement

- 0% annual increases based on 2019 performance starting in 2020

- No more Physician Quality Reporting System (PQRS), value-based payment modifier, meaningful use payments

- 2020 payments based on 2019 performance
Changing Reimbursement: MACRA

Merit-Based Incentive Payment System (MIPS)

<table>
<thead>
<tr>
<th>Year</th>
<th>Baseline Payment Adjustment</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019</td>
<td>4% (+/-)</td>
</tr>
<tr>
<td>2020</td>
<td>5% (+/-)</td>
</tr>
<tr>
<td>2021</td>
<td>6% (+/-)</td>
</tr>
<tr>
<td>2022</td>
<td>7% (+/-)</td>
</tr>
<tr>
<td>2023</td>
<td>9% (+/-)</td>
</tr>
<tr>
<td>2024</td>
<td>9% (+/-)</td>
</tr>
<tr>
<td>2025</td>
<td>9% (+/-)</td>
</tr>
</tbody>
</table>

Physician Performance Measures

- 0
- 100

- Quality
- Resources
- Meaningful Use Payments
- Clinical Practice Improvements

Additional Pool of $500 Million for Exceptional Performance

SCORES WILL BE PUBLISHED!
Changing Reimbursement: MACRA

Alternative Payment Models

Accountable Care Organization + Demonstrations + CMS Innovation Models

Physicians receiving substantial payments from APMs = Annual 5% lump sum payments from Medicare based on fee schedule

Physicians receiving smaller payments from APMs = No adjustment or a MIP adjustment

Must be qualifying participant

2019 2024
State of Health Care Industry

Trends in Physician Compensation Design
Transition of Compensation Models

The transition from volume to value will be an evolution, not a revolution.
Transition Challenges

Challenges directly impacting the transition to value-based compensation models

**Measurement**
- Developing measurement systems for use in an environment that compensates for value
  - Clinical outcomes
  - Population health management
  - Total cost of care

**Pace of Change**
- Implementing change at a pace that matches changes in reimbursement

**Leadership Development**
- Developing the physician leadership that is necessary to achieve the desired cultural change
The Shift from Volume to Value: Primary Care Structures

- The market definition of “performance” is shifting from per wRVU productivity (although still main component) to include panel size and quality/financial metrics

<table>
<thead>
<tr>
<th>Component</th>
<th>Overall</th>
<th>Change from 2015</th>
<th>% of Comp if Used</th>
<th>Change from 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>wRVUs</td>
<td>75%</td>
<td>4%</td>
<td>69%</td>
<td>2%</td>
</tr>
<tr>
<td>Quality Incentives</td>
<td>69%</td>
<td>9%</td>
<td>10%</td>
<td>2%</td>
</tr>
<tr>
<td>Base Salary</td>
<td>47%</td>
<td>-1%</td>
<td>66%</td>
<td>1%</td>
</tr>
<tr>
<td>Financial Incentives</td>
<td>19%</td>
<td>-2%</td>
<td>7%</td>
<td>1%</td>
</tr>
<tr>
<td>Panel Size</td>
<td>33%</td>
<td>12%</td>
<td>10%</td>
<td>-7%</td>
</tr>
<tr>
<td>Discretionary</td>
<td>14%</td>
<td>-5%</td>
<td>5%</td>
<td>0%</td>
</tr>
<tr>
<td>APC Supervision</td>
<td>49%</td>
<td>5%</td>
<td>2%</td>
<td>0%</td>
</tr>
<tr>
<td>Net Collections</td>
<td>3%</td>
<td>-2%</td>
<td>82%</td>
<td>-9%</td>
</tr>
</tbody>
</table>

Note: Percentages will not add to 100% due to multiple response categories

Source: SullivanCotter 2015-2016 Large Clinic® Physician Compensation Survey Report
The Shift from Volume to Value: Primary Care

Percentage of Groups Using wRVUs Versus Quality Incentives and Panel Size in Primary Care Compensation Plans

Source: SullivanCotter 2010-2016 Large Clinic® Physician Compensation Survey Report
The Shift from Volume to Value:
Incentive and Discretionary Measures

![Bar chart showing incentive and discretionary measures]

- Patient Satisfaction: 70%
- Outcomes: 57%
- Access: 37%
- Individual Production And Profitability: 27%
- Citizenship: 20%
- Department Or Group Relative Value Units: 20%
- HEDIS: 20%
- Cost Containment And Effectiveness: 17%
- Department Profitability: 17%
- Peer And Chart Review: 17%
- Seniority: 17%
- Institutional Contribution: 13%
- Other Incentives: 13%
- Clinic Administrative Duties: 7%
- Controlling Ancillary Utilization: 7%
- Hospital Utilization: 7%
- Accepting Call And Hospital Duties: 3%
- Adjusting Physicians To Market Salaries: 3%

Source: SullivanCotter 2016 Large Clinic® Physician Compensation Survey Report

n = 30
Strong Demand for APCs

Organizations continue to report significant growth in the APC workforce

63% have **increased** the number of APCs **within the past year**

<table>
<thead>
<tr>
<th>Year</th>
<th>Mean Increase</th>
<th>Median Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>17%</td>
<td>13%</td>
</tr>
<tr>
<td>2013</td>
<td>16%</td>
<td>10%</td>
</tr>
<tr>
<td>2014</td>
<td>15%</td>
<td>10%</td>
</tr>
<tr>
<td>2015</td>
<td>15%</td>
<td>12%</td>
</tr>
</tbody>
</table>

67% **plan to increase** the number of APCs **within the next year**

<table>
<thead>
<tr>
<th>Projected Increase</th>
<th>Mean</th>
<th>Median</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>11%</td>
<td>10%</td>
</tr>
</tbody>
</table>

The Shift from Volume to Value: Medical, Surgical and Hospital-Based Structures

Medical and surgical specialties continue to have the majority of compensation tied to productivity or base salary; however, value-based incentives are becoming more prevalent.

### Compensation Plan Components for Experienced Physicians by Specialty Area

<table>
<thead>
<tr>
<th>Component</th>
<th>Medical</th>
<th>Surgical</th>
<th>Hospital-Based¹</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% Using</td>
<td>% of Comp if Used</td>
<td>% Using</td>
</tr>
<tr>
<td>wRVUs</td>
<td>79%</td>
<td>70%</td>
<td>79%</td>
</tr>
<tr>
<td>Quality Incentives</td>
<td>64%</td>
<td>9%</td>
<td>64%</td>
</tr>
<tr>
<td>Base and Guaranteed Salary</td>
<td>50%</td>
<td>63%</td>
<td>39%</td>
</tr>
<tr>
<td>Panel Size</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Financial Incentives</td>
<td>14%</td>
<td>5%</td>
<td>14%</td>
</tr>
<tr>
<td>APC Supervision</td>
<td>11%</td>
<td>1%</td>
<td>11%</td>
</tr>
<tr>
<td>Discretionary</td>
<td>7%</td>
<td>12%</td>
<td>14%</td>
</tr>
<tr>
<td>Net Production</td>
<td>4%</td>
<td>88%</td>
<td>4%</td>
</tr>
<tr>
<td>Cost Accounting</td>
<td>4%</td>
<td>7%</td>
<td>4%</td>
</tr>
<tr>
<td>Equal Share</td>
<td>0%</td>
<td>0%</td>
<td>7%</td>
</tr>
<tr>
<td>Other</td>
<td>25%</td>
<td>9%</td>
<td>25%</td>
</tr>
</tbody>
</table>

¹Hospital-based specialties include anesthesiology, critical care, emergency medicine, hospitalists, pathology and radiology

Note: Percentages will not add to 100% due to multiple response categories.

**Source:** SullivanCotter 2016 Large Clinic® Physician Compensation Survey Report
The Shift from Volume to Value: Specialists – Medical, Surgical and Hospital-Based

Percentage of Groups Using wRVUs Versus Quality Incentives in Specialist Compensation Plans

Source: SullivanCotter 2010-2016 Large Clinic® Physician Compensation Survey Report
Strong Demand for APCs

APCs are still among the fastest growing occupations in the U.S. Labor Force

Projected Growth 2014 - 2024¹

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Growth Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse Practitioners</td>
<td>35%</td>
</tr>
<tr>
<td>Physician Assistants</td>
<td>30%</td>
</tr>
<tr>
<td>Nurse Midwives</td>
<td>25%</td>
</tr>
<tr>
<td>Nurse Anesthetists</td>
<td>19%</td>
</tr>
</tbody>
</table>

Total Projected Growth from 2014 to 2024 for Physicians and Surgeons is 14%

¹ Source: U.S. Bureau of Labor Statistics, Employment Projections Program
Implications for Compensation

• Given **rapid employment growth** and **high vacancy rates**, compensation strategies are changing rapidly.

• **High expectations** of new graduates.

• **Equity issues** with experienced staff.

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**Average vacancy rates**

- **2013**: 8.1%
- **2014**: 7.7%
- **2015**: 9.3%

Pay Compression

Reported Salary Range Widths
50% Wide Range from Minimum to Maximum

2013

19% Differences in Pay Around the Median

Less than 2 years
About 13%
BELOW Median

10 or more years
About 6%
ABOVE Median

2014

14% Differences in Pay Around the Median

Less than 2 years
About 9%
BELOW Median

10 or more years
About 5%
ABOVE Median

2015

11% Differences in Pay Around the Median

Less than 2 years
About 5%
BELOW Median

10 or more years
About 6%
ABOVE Median

Increasing Specialization

Increasing specialization is resulting in pay differences between specialty groups.

Use of Incentive Compensation

- 47% reported utilizing **incentive pay** for at least some of their APCs
- Of those that do, **maximum incentive opportunities** were approximately 7% of base pay for NPs and PAs

Physician Compensation Redesign Project Approach
Compensation Design Process: Overview

1. Planning:
   - Project plan, team members, committee formation, interviewees

2. Framework:
   - Guiding principles, compensation plan goals

3. Approval:
   - Final plan approval by Steering Committee

   - Design:
     - Model(s), mechanics

   - Communication:
     - Explaining the plan, administration, reporting

   - Refine:
     - Rate setting, financial impact, risk assessment

   - Transition:
     - Establish feedback mechanism

Typically 3-4 Months

Typically 4-6 Months

Typically 6+ Months

Shadow Period

PRIVATE AND CONFIDENTIAL
Overview of Compensation Plan Design Timeline

**Phase One: Discovery**
- Project Planning
- Current State Assessment
- Provider Education

**Phase Two: Design**
- Compensation Guiding Principles
- Compensation Plan Design
- Compensation Plan Approval

**Phase Three: Implementation**
- Administration
- Shadow Period
- Plan Go Live

**Timeline**
- September to October
- October to January
- To Be Determined
- To Be Determined
Overview of CentraCare Redesign Project Governance
**Structure to Support the Compensation Design Process**

**Role:** Set direction and manage project timeline/deliverables

**Composition:** 3-6 senior administrative and physician leaders

**Role:** Provide final recommendations for Board approval

**Composition:** 5-15 physician leaders/influential physicians (Overlap with RSC)

**Role:** Support groups with plan design mechanics and implementation

**Composition:** 5-7 individuals per work group
Structure to Support the Compensation Design Process

*Redesign Support Committee Roles and Responsibilities*

- **Redesign Support Committee (RSC)**
  - **Role**
    - Day-to-day project planning and oversight
    - **Lead** the design process, ensure project timeline completion, participate in the development of physician compensation philosophy, guiding principles and model mechanics
    - For decisions with less than 70% consensus, RSC will be responsible for making final decision
    - Present recommendations for approval to the Compensation Committee of the Hospital or Health System Board
  - **Members**
    - Dr. Dave Tilstra
    - Dr. Joe Blonski
    - Dr. Mark Matthais
    - Dr. Tom Schrup
    - Tom Feldhege
    - Greg Von Elbe
Structure to Support the Compensation Design Process

Physician Compensation Redesign Committee Roles and Responsibilities

- **Physician Compensation Redesign Committee (PCRC)**
  - Includes the RSC plus 5-15 additional senior administrative and physician leaders from various specialties (representation from primary care, medical/surgical specialties and hospital-based specialties)
- **Role**
  - Make decisions on the physician compensation philosophy, compensation model structures and mechanics, and implementation strategies
  - For final decision recommendations:
    - Consensus must be reached, which is defined as 70% of Committee members
    - *Note: Committee members must be present (in person or via conference call/video conference) on key decisions for vote to be included. No proxy votes will be included*
Structure to Support the Compensation Design Process

Work Group Roles and Responsibilities

• **Work Groups**
  • Typical Work Groups include: Primary Care Specialties, Medical/Surgical Specialties, Hospital-Based Specialties, Operational/Communication, and Value Based Metrics
  • Includes participation from members of the RSC and PCRC along with other physicians

• **Role**
  • Develop recommendations related to the assigned Work Group (includes model mechanics, value-based metrics, communication strategies, implementation strategies, etc.)
  • Each Work Group will have a identified lead who will be responsible for:
    • Setting meeting schedule
    • Facilitating Work Group discussions
    • Assisting with the development of presentations and recommendation deliverables
    • Ensuring participation of membership
    • Being a resource for feedback/communication from peers

• **Membership TBD by PCRC**
Opportunities for Participation

• To ensure the physicians participation throughout this process, SullivanCotter will be providing an additional opportunity for physician feedback.
  − Focus Groups Interviews
    • Purpose:
      ✓ Gain a deeper understanding of the culture at CentraCare
      ✓ Determine strengths of the current compensation structure and opportunities for future enhancements
      ✓ Broader understanding of specialty specific market trends
      ✓ Ability to ask consultants questions about process and project outcomes
    • Participation:
      ✓ Please send interest in Focus Group participation to your Division Leadership
      ✓ Dates and times TBD
Questions

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