

# Physician Compensation Modeling

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**The program will begin at 3:00 pm ET  
July 25, 2022**

# Agenda.....

1. Welcomes and housekeeping
2. Brief presentations on Physician Compensation Modeling
3. Open forum and discussion

# Ground Rules and Expectations



1. Today's discussion is scheduled for an hour
2. What to expect
  - Our goal is for NAACOS members to share, answer questions and raise points of interest in a collaborative discussion.
  - Feel free to turn your video on and speak up when you feel the need. Please mute yourself when not talking.
3. Today's program is being recorded.

# Introductions.....



**Melody Danko-Holsomback**  
Vice President of Education  
NAACOS



**Dr. Rob Fields, MD, MHA**  
EVP, Chief Population Health Officer  
Mt. Sinai Health System

# 2022 Panel Based Productivity Bonus

July 2022



**Mount  
Sinai  
Health  
Partners**

# New Payment Methodology Benefits

- ▶ **One size does not fit all** in health care – this updated methodology takes into account the severity of illness of a patient population and **compensates physicians for the effort involved in managing higher-risk patients**

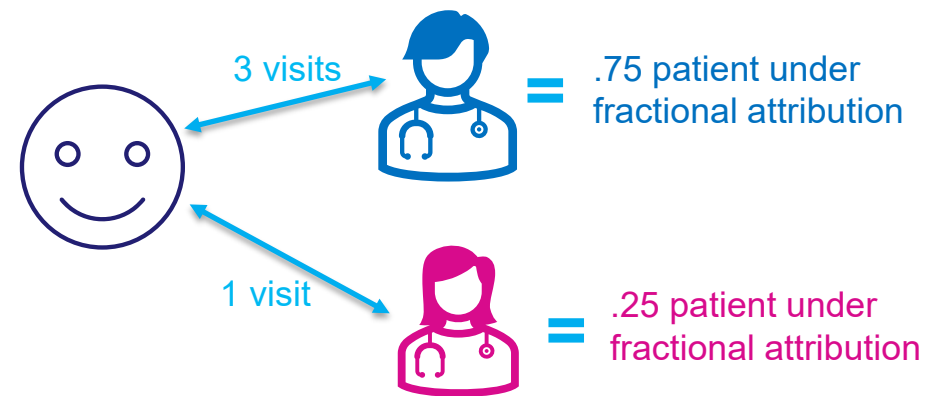
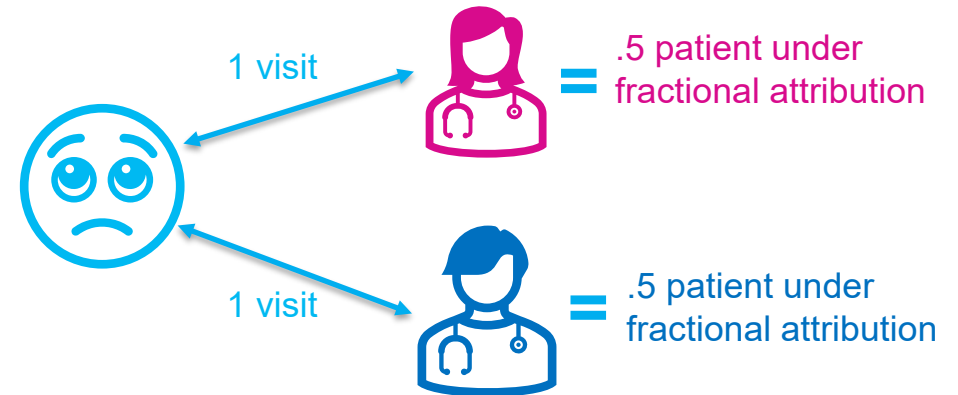


# New Payment Methodology Benefits

- ▶ **Health care is a team sport.**  
New fractionally-adjusted panel methodology allows providers to receive partial credit for a patient that was treated by multiple providers.



## Examples of Fractional Attribution



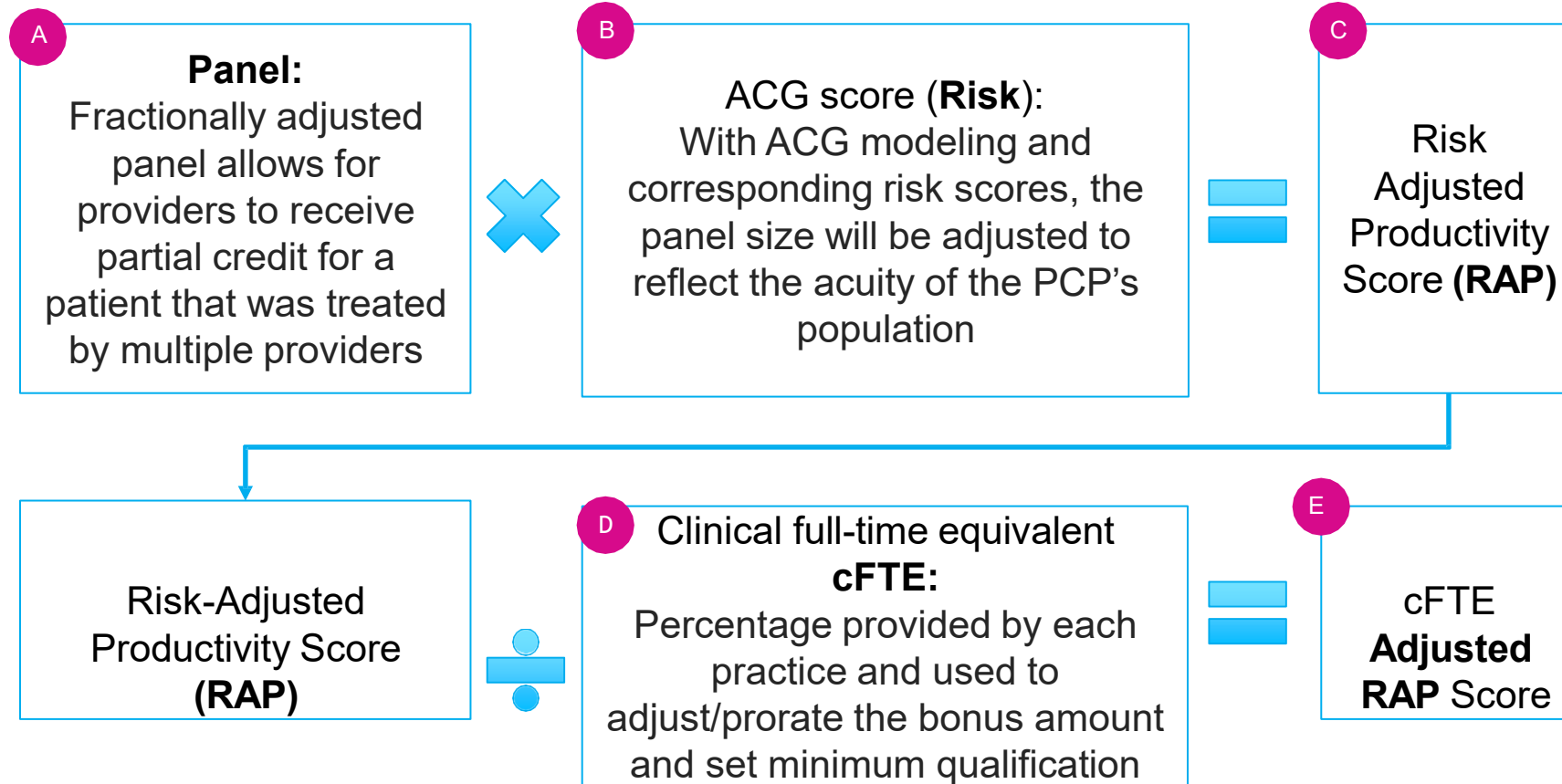
# Adjusted Clinical Groups (ACG)



## Adjusted Clinical Groups

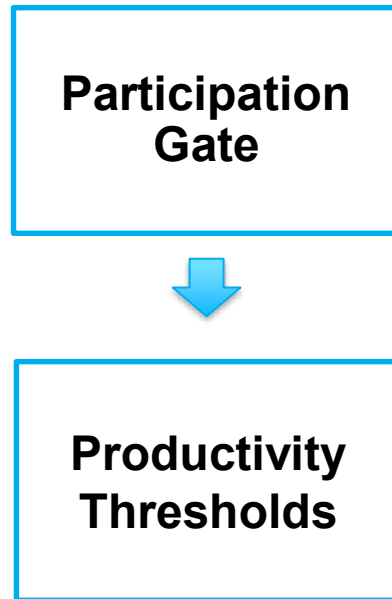
- ▶ Stratifies all of your practice's patients into one of 90+ adjusted clinical groups (ACGs) based on age, gender and **medical diagnoses**
- ▶ Individuals within an ACG are expected to use the same level of **resources** – even if they have very different illnesses (e.g., 2 comorbid conditions, pregnant female, etc.)

# Risk-Adjusted Productivity (RAP) Score Calculation



# Updated Productivity Bonus Methodology Detail

Productivity bonus for practices will be calculated via the following methodology –



PCPs who are employed with the practice,  $\geq .2$  cFTE,  $\geq$  30th percentile Risk Adjusted Productivity Score (RAP).

The bonus amount is prorated according to the PCP's cFTE

PCPs to receive payment for their full panel based on RAP percentiles from prior year.

Meet or exceed productivity threshold to receive bonus dollars

	0-60 <sup>th</sup> Percentile	>60 <sup>th</sup> -75 <sup>th</sup> percentile	>75 <sup>th</sup> percentile
<b>Bonus Dollars/RAP Unit</b>	\$5	\$10	\$15

Percentiles based on prior year RAP scores

A PCP's bonus payment would be calculated by applying the dollar figure above on a per unit basis for the relevant percentile. For example, a PCP in the 80<sup>th</sup> percentile would receive \$5 for each RAP unit up to and including the 60<sup>th</sup> percentile, \$10 for each rap unit above the 60<sup>th</sup> percentile through the 75<sup>th</sup> percentile, and \$15 per RAP unit above the 75<sup>th</sup> percentile.

# Risk Adjusted Productivity Score Examples

	A	B	C	D	E				
Panel	Risk	RAP	cFTE	Adjusted RAP	Qualify cFTE ≥ .2	Qualify Adj RAP ≥ 30 <sup>th</sup>	Payment calculation	Prorating cFTE	
183	1.87	343	.10	3,423	No	NA	NA		
419	3.28	1374	.63	2,180	Yes	No	NA		
900	2.5	2,250	.70	3,214	Yes	Yes	$\frac{3,214 \times \$5}{\$16,070}$	$\frac{\$16,070}{X .7}$ \$11,249	
650	3.25	2,113	.5	4,226	Yes	Yes	$3,594 \times \$5$ $410 \times \$10$ $\frac{222 \times \$15}{\$25,400}$	$\frac{\$25,400}{X 0.5}$ \$12,700	

**Notes:**

Using 2021 data, 30<sup>th</sup> percentile = 2,582; 60<sup>th</sup> percentile = 3,594 RAP units; 75<sup>th</sup> percentile = 4,004 RAP Units

A-E rounded to the .00 in example

cFTE proration is always the last step because it keeps RAP score calculation consistent and avoids conflicting thresholds.

# Phase-In Plan for Providers

What is the phase-in plan?

How will this phase-in plan help providers and patient care?

PCPs would receive the **greater of their last RVU bonus or the new RAP bonus** for the first two years of the program as long as they **maintain/grow productivity level.**

This allows time for providers that earned an RVU bonus but do not qualify for a RAP bonus or previously earned an RVU bonus that is higher than their RAP bonus to increase their panel sizes and optimize their coding to be successful in this new productivity model.

The 2 year phase-in keeps providers whole without penalizing them for adopting this new model and gives them time to learn how to optimize their performance.

# Frequently Asked Questions

Category	Question	Answer								
<b>Practice Qualification for Pilot Bonus</b>	Why was my site included?	At least 75% of employed PCPs at the practice have at least 50% of their attributed lives from Medicaid, Medicare Advantage, and MSSP								
<b>Provider Qualification (at a qualifying practice)</b>	How was the cFTE adjusted RAP score cutoff determined?	30 <sup>th</sup> percentile allows for similar portion of providers in these practices to be eligible for the RAP bonus as under the RVU bonus								
	What if I don't meet the minimum cFTE thresholds?	0.2 FTE ( <i>current PC bonus cutoff</i> ) . You would need to work more clinical sessions to be eligible.								
<b>Bonus payout calculation for an individual qualifying provider</b>	How do I calculate how much I would be paid if I increased my panel?	<p>If you qualify, payments are made on your full panel as follows:</p> <table border="1"> <thead> <tr> <th>Percentile</th> <th>0-60<sup>th</sup> percentile</th> <th>&gt;60<sup>th</sup> -75<sup>th</sup> percentile</th> <th>&gt;75<sup>th</sup> percentile</th> </tr> </thead> <tbody> <tr> <td><b>Bonus \$/ RAP unit</b></td> <td>\$5</td> <td>\$10</td> <td>\$15</td> </tr> </tbody> </table>	Percentile	0-60 <sup>th</sup> percentile	>60 <sup>th</sup> -75 <sup>th</sup> percentile	>75 <sup>th</sup> percentile	<b>Bonus \$/ RAP unit</b>	\$5	\$10	\$15
Percentile	0-60 <sup>th</sup> percentile	>60 <sup>th</sup> -75 <sup>th</sup> percentile	>75 <sup>th</sup> percentile							
<b>Bonus \$/ RAP unit</b>	\$5	\$10	\$15							
<b>Keep whole mechanism (for years 1 and 2)</b>	My bonus is projected to be smaller than last year. I was told not to worry because of the keep whole program. What is that?	For the initial 2 years, PCPs would receive the greater of their last RVU bonus (2021) or the new RAP bonus as long as they maintain/grow productivity level.								
<b>Bonus Payment Timing</b>	How often will this bonus be distributed?	Like the current bonus, this will be distributed annually by your service line/practice.								
<b>Improvement</b>	How do I grow my panel size?	Contact your population health manager if you are interested in adding value based contract patients to your panel								

# Discussion!

# Upcoming Events

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We are early this year! Don't miss your opportunity to participate in our Fall Conference!

A horizontal banner with a grey background. On the left side, there is a photograph of the United States Capitol building in Washington, D.C., showing its iconic dome and classical architecture under a dramatic, cloudy sky. The text is centered on the right side of the banner. At the top, it reads "Fall 2022 Conference" in a large, dark teal, sans-serif font. Below that, in a smaller, dark teal font, it says "September 7-9" and "Marriott Marquis, Washington D.C.". At the bottom of the text block, it says "IN PERSON AND VIRTUAL" in a smaller, dark teal, all-caps font. On the right side of the banner, there is a white version of the NAACOS logo, which consists of the acronym "NAACOS" and the full name "National Association of ACOs" inside a white oval with small circles at the top and bottom.

# Upcoming Events

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**Webinar:** Going Deeper on Financial Changes in the Proposed 2023 Medicare Physician Fee Schedule

**Date / Time:** July 28th, 2022, 02:00 PM - 03:00 PM (Eastern)

**Webinar:** Going Deeper on Financial Changes in the Proposed 2023 Medicare Physician Fee Schedule

**Date / Time:** July 28th, 2022, 02:00 PM - 03:00 PM (Eastern)

**Webinar Title:** Healthier patients and bottom line: A real journey to value

**Date / Time:** August 10<sup>th</sup>, 2022, 02:00 PM - 03:00 PM (Eastern)

**Affinity Group Meetings:** Peer-to-peer discussion that will focus on peer-to-peer exchange of current ACO and population health issues.

**Learning Lab:** New series on to focus on the needs of our member's Medicaid ACO questions, concerns and best practices.

Sign up for all these events on our website events tab. <https://www.naacos.com/events>



**Thank you!**

# Appendix

# Reporting and Payment Operations

# Payment and Reporting

## Payment

- ▶ Risk-Adjusted Productivity (RAP) based bonus calculated using 24 months of data (November- October)
- ▶ Payments will be made once annually; in Q1 of the year following the performance period (to align with timeline for RVU-based bonus)
  - *Q1 2023: Payments made using final data from November 2020-October 2022*
- ▶ MSHP will produce practice and PCP level reports indicating payment amounts
- ▶ Department/practices responsible for funding and making payments to PCPs

## Reporting

- ▶ Monthly:
  - Practices will receive scorecards (see example on next slide) – produced by MSHP
  - Reports will use most recent 24 months of data available, typically lagged by ~2 months
    - Example: In September of 2022, PCPs would receive reports covering Sept 2020-July 2022*
  - Percentiles set using prior year data
- ▶ Annually:
  - PCP and Practice Level Reports to include PCP payout amount and determination of whether keep whole mechanism is needed for given PCP

# Scorecard Sample

	Practice	PCP	Raw Panel Size	Risk Score	Risk- Adjusted Productivity (RAP) Score	cFTE	Adjusted RAP	Percentile
Description	Name of Practice	Physician Name	Number of patients attributed to PCP under fractional attribution with 24-month lookback period	ACG Risk Score	Panel x Risk Score	Portion of time in clinical sessions	RAP if PCP were 1.0 cFTE	Percentile into which PCP's RAP falls for time period covered by report
<b>Example A</b>	Practice 1	Dr. A	1,500	2.4	3,600	1.0	3,600	60 <sup>th</sup>
<b>Example B</b>	Practice 1	Dr. B	819	4.04	3,309	0.6	5,515	90 <sup>th</sup>

## Notes:

30<sup>th</sup> percentile is the Qualifying Gate for RAP-based Bonus

### Eligible for RAP-based Bonus:

- *Adjusted RAP >= Qualifying Gate = Yes;*
- *If Adjusted RAP <= Qualifying Gate = No;*
- *This is based on RAP from the prior year*

*Examples are hypothetical not actual providers*

# Why was my practice selected to participate in this model?

- ▶ At least 75% of employed PCPs in the practice have a panel with **at least 50% of patients in Medicaid, Medicare Advantage, and MSSP lines of business**
- ▶ This population often has polychronic illness and complex psycho-social needs, putting them at high risk for disease progression and increased utilization – and **requiring more care coordination and intervention from their physician and care team**
- ▶ This revised methodology rewards the effort that PCPs and the practice undertake to manage patients' health while also aligning incentives with value-based contracting goals

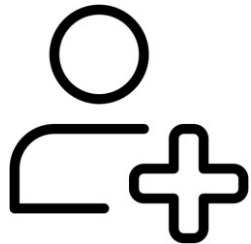
**Moving from an RVU-based productivity incentive to a risk-adjusted, fractionally-attributed panel-based incentive allows PCPs to receive credit for the work it takes to achieve outcomes when managing higher- risk patients.**

# How Can My Practice Maximize Bonus Potential?



## Document and code chronic conditions

- Respond to Epic recapture BPAs
- Use patients not seen reports to outreach and schedule patients
- Consider under-captured diagnoses (e.g. Heart failure, vascular diseases, diabetes w/ complications)



## Continue to grow your patient panel

- Contact your Population Health Manager if you are interested in adding value-based contract patients to your panel



## Maximize use of team

- Through a multidisciplinary approach, additional time can be spent providing care to patients

# A Panel: Fractionally Adjusted Attribution

## Definition of Panel:

- Fractionally adjusted attributed panel based on patients' age and sex

## Primary Contact for Methodology

- Damon Myers

## Time period:

- 24 month look back

## Methodology rationale:

- The methodology is best suited to get the accurate distribution of panel between the providers. It attributes patients to each providers who provided clinical service in the timeframe

## Impact (fractionally adjusted attribution vs raw panel):

- It gives credit to all providers for the clinical time spent with patient even if not fully attributed to them

# B ACG for Risk-Adjusted Utilization Performance

## Methodology rationale:

- Since its creation 30+ years ago by Johns Hopkins School of Public Health, it has been widely used in healthcare to compare populations' prior health resource use, while accounting for morbidity or illness burden.
- Referenced in 1,000+ articles and recognized for impact on health policy and practice
- Improved continuously to anticipate health care needs/changes

## Methodology:

- Stratifies all of your practice's patients into one of 90+ adjusted clinical groups (ACGs) based on age, gender and **medical diagnoses**
- Individuals within an ACG are expected to use the same level of **resources** – even if they have very different illnesses (e.g., 2 comorbid conditions, pregnant female, etc.)
- ACG Risk score uses Demographics (age and sex), ACG category, Pregnancy and delivery, Selected Diagnostic markers, and several other variables to determine concurrent risk score.
- ACG concurrent risk model does not consider the utilization and prior cost measures. One key difference to the CMS HCC model is that ACG uses pharmacy data.
- Truncation thresholds: none set currently

## Data Source





- MSHS Billing data from most current ACG 12 month period available. Currently through 2020-12

# Adjusted Clinical Groups (ACG)

## Why Use the Johns Hopkins ACG System for Risk-Adjusted Utilization Performance?

- ▶ Widely used by health systems, governments, ACOs, insurance companies, employers, technology companies, and public health institutions to compare populations' prior health resource use, while accounting for morbidity or illness burden.

**Our Most Advanced Tool**  
The Johns Hopkins ACG® System

-  Developed 30+ yrs ago at the Johns Hopkins Bloomberg School of Public Health
-  Improved continuously to meet and anticipate health care needs
-  Referenced in 1,000+ articles in peer-reviewed journals worldwide
-  Recognized for impact on health policy and practice

**Close to 200M lives impacted worldwide**

**acg**  
JOHNS HOPKINS

# **D** cFTE: Clinical FTE

## **Use:**

- Adjust/prorate the bonus amount
- Set minimum qualification

## **Source:**

- Provided by each practice (Practice Admins and Service line leaders)

## **Current methodology description:**

- Based on the providers and their actual clinical time at the practice
- Time period for calculation – Nov(last year) to Oct (current year)
- Methodology changes in cFTE for future years might impact the payout but the RAP score calculation will not change

# Practice Recommendations for Panel-Based Productivity Bonus

## Panel /Attribution Analysis: Approach

- ▶ In order to identify practices that could be good candidates to switch from an RVU-based productivity bonus to a panel-based productivity bonus, took the following approach:

### 1 Step 1: Define PCP panel thresholds

- Identify practices in scope
- Identify total employed PCPs at those practices
- Identify PCPs with MA/MSSP/MCD % of panel over a certain threshold (50%, 75%, 90%); *only did this for PCPs that had panel data provided*

### 2 Step 2: Identify practices with a majority of providers who met one of MA/MSSP/MCD % panel thresholds

- Narrow down to PC Bonus Practices that have  $\geq 75\%$  of their Employed PCPs (for which there was panel data available) meeting the thresholds established in Step 1 (50%, 75%, or 90% of panel is MA/MSSP/MCD)

### 3 Step 3: Calculate total VBC lives attributed to providers in those qualifying practices

- Includes VBC lives attributed to all providers at those practices – whether or not panel data was available
- Roll up total VBC lives attributed to providers at those practices by groupings of high priority contracts (MSSP, HF MA, HF MCD, Other MA)

### 4 Step 4: Calculate total VBC attribution by high priority contract grouping

### 5 Step 5: Calculate portion of VBC attribution covered by qualifying practices

- For example,  $\frac{\text{Total MSSP VBC lives attributed to providers at practices who have } \geq 75\% \text{ of providers meeting the 50\% MA/MSSP/MCD panel threshold}}{\text{All MSSP VBC Attribution}}$

All MSSP VBC Attribution

Total Practices w/ $\geq 1$ doc eligible to participate in PC bonus program:	48
Total Employed PCPs at those practices:	364
Employed PCPs in 2020 PC bonus roster	267
Employed PCPs not in 2020 PC bonus roster <sup>1</sup>	97
Total Employed PCPs <b>with panel data provided</b> :	247
Employed PCPs in 2020 PC bonus roster (at a PC bonus practice)	215
Employed PCPs not in 2020 PC bonus roster (at a PC bonus practice)	20
Employed PCPs not in 2020 PC bonus roster (not at a PC bonus practice)	12
Employed PCP Denominator	235

**Thesis is that employed practices with a majority of providers having a certain portion of their panel concentrated in MCD/MSSP/MA would be the strongest candidates to switch to a panel-based productivity bonus. By looking at the share of VBC lives attributed to these practices, we can start to get a sense for how much impact we might have on contract performance by incentivizing specific behaviors at these practices in line with the panel based bonus**

<sup>1</sup> Employed PCPs not included in the 2020 PC bonus roster but tagged as PCPs in the internal Sinai database (these would have to be validated later)