

# Physician Compensation Models that Support Transitions to Value



**NAACOS Fall Conference, 2021**  
**Moderator: Kimberly Kauffman,**  
**Best Value Healthcare / MAX Health**

# AGENGA



**The Who – panelists**

**The What – imperative for change**

**The Why – things to consider**

**The How – approaches used by panelists**

**The When – tipping point**

**Open Discussion**

# Stephen Nuckolls, MAC, CFO

Coastal Carolina Health Care, P.A.  
Coastal Carolina Quality Care, Inc.



**Coastal Carolina  
Health Care, P.A.**

*Advanced Medicine. Trusted Care.*

# Coastal Carolina Health Care, PA

60+  
Providers  
(60%  
PCP)

- Internal Medicine
- Family Medicine
- Emergency Medicine
- Cardiology
- Hematology/Oncology
- Gastroenterology
- Neurology
- Pulmonary/CC
- Rheumatology
- Endocrinology
- Podiatry

## 16 Clinic Locations

- Urgent Care
- Imaging Center
- Sleep Lab
- GI ASC

Single Enterprise-wide EHR

More Concentrated/Rural Market

78% of PCP Patients in Total Coast of Care Contracts

# CCHC Overview

- Medical Practice Owns Medicare ACO
- Started Medicare ACO - April 1, 2012
- >22,000 Attributed Beneficiaries (Medicare, BCBS of NC, Humana, UHC)
- \$200+ Million Combined TCC Budgets
- 2 Sided Risk with MSSP & BCBS of NC



## Ashish D. Parikh, MD

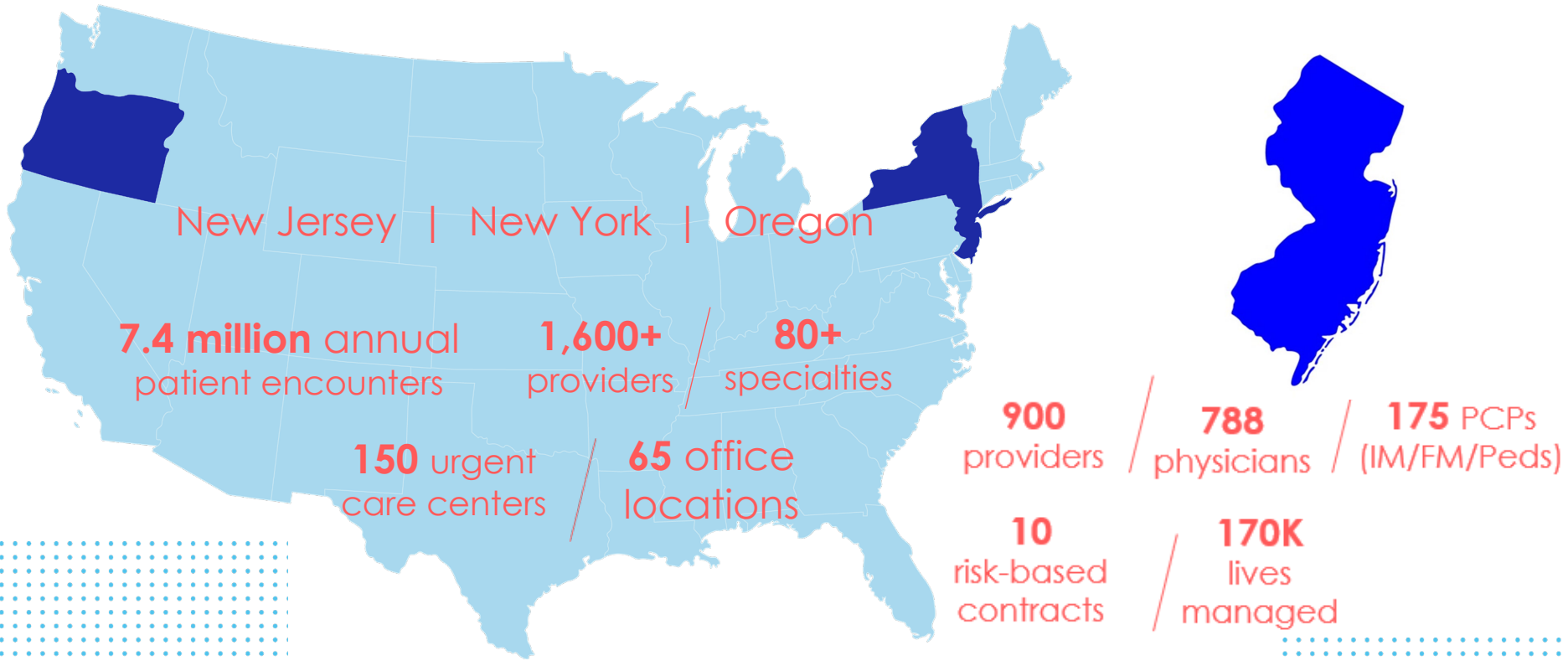
Chief Quality Officer  
Summit Health

As Chief Quality Officer at Summit Health, a leading physician-led health care network, Dr. Ashish Parikh is responsible for developing strategies for delivery of the highest quality of care with a focus on value through reduction in practice variation, evidence-based clinical care delivery, as well as provider and patient engagement. Ashish also oversees provider quality measurement and incentive programs. Ashish continues to practice Internal Medicine at Summit Health in Berkeley Heights, NJ.

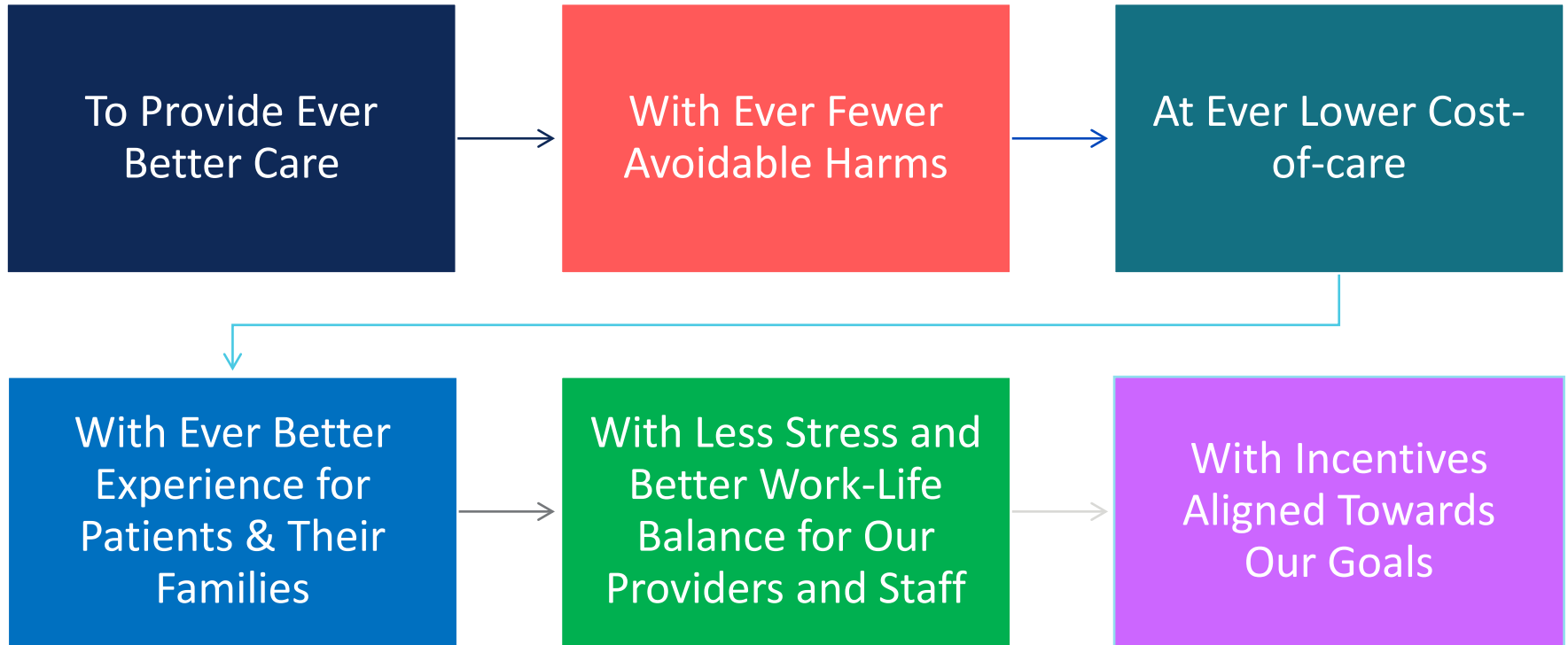
Prior to Summit Health, Ashish was the Senior Health and Quality Advisor at IBM and the Internal Medicine Residency Program Director at Saint Barnabas Medical Center.



# Summit Health: Independent Multispecialty + Urgent Care



# Our Shared Goals



**Rob Fields, MD, MHA**  
**EVP, Chief Population Health Officer**  
**Mount Sinai Health Partners**



**Mount  
Sinai  
Health  
Partners**

# Mount Sinai Health System: Positioned for Value

With breadth and depth of assets, Mount Sinai is well positioned as one of the highest-value providers in New York City

## Health System Assets

- ▶ Icahn School of Medicine at Mount Sinai
- ▶ Flagship academic hospital + 7 community hospitals
- ▶ >300 community care locations throughout NYC Metro
- ▶ >6,600 physicians on medical staff (~3,500 employed)
- ▶ Clinical affiliations that further our geographic reach

## Key Goals

- ▶ To become the purchaser's **partner of choice**
- ▶ Align financial incentives around **outcomes**
- ▶ Earn **trust** with our patients so that Mount Sinai is their provider of choice
- ▶ Manage outcomes, patient experience, and costs



# The What - Misalignment

Anyone see a navigation problem here?

## COMPENSATION BASIS

We pay physicians based on productivity

1

## BUT

We want them to focus on the **Patient's Experience of Care**

2

## AND

We want them to focus on **Improving Health Outcomes**

3

## AND, AND

We want them to focus on **Decreasing the Total Cost of Care**

4

## GOAL

Align Compensation Model with Organization's Value-Based Goals

7

## AND, AND, AND

We want them to **Not Burnout and Find Joy in Practicing Medicine**

5

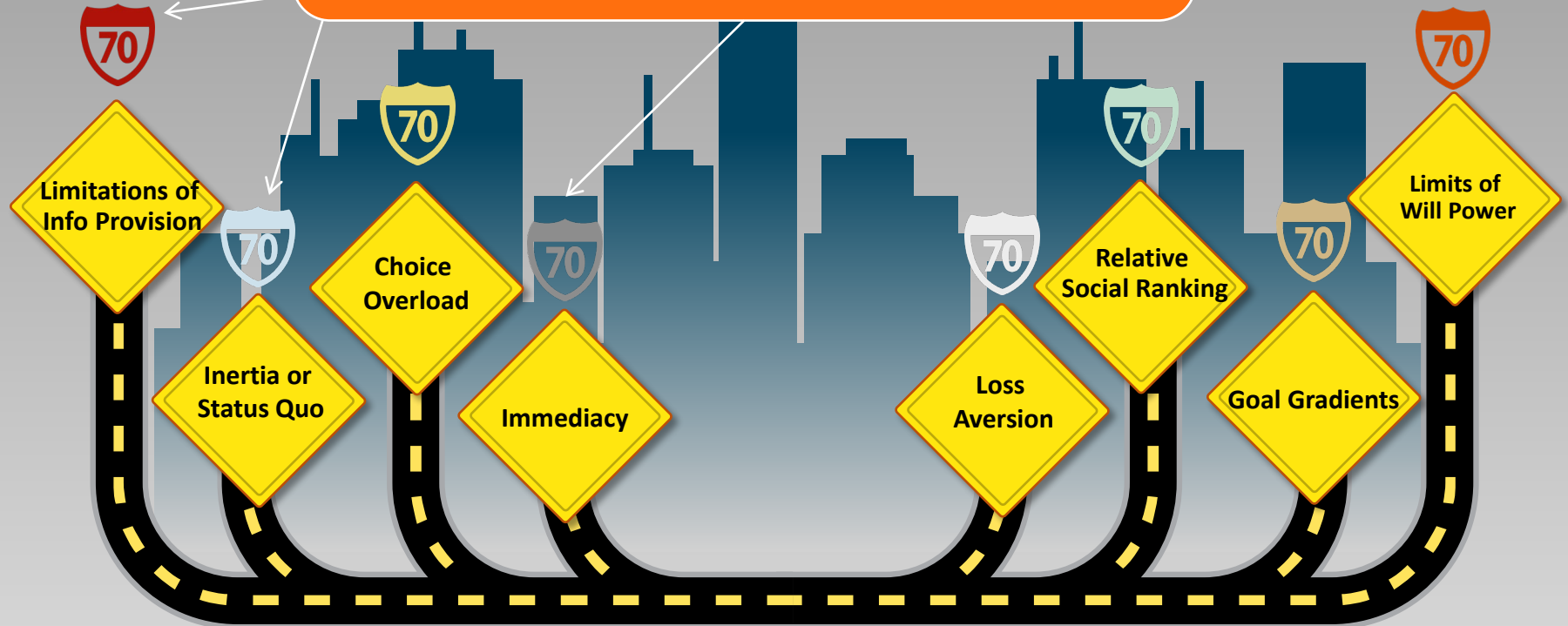
"CRASH AHEAD?"

waze



6

## Using Behavioral Economics to Design Physicians Incentive That Deliver High-Value Care<sup>1</sup>



# Physician Compensation

## CCHC's Model to Support Value Base Care

Stephen W. Nuckolls, MAC, CEO

Coastal Carolina Health Care, P.A.

Coastal Carolina Quality Care, Inc.

October 1, 2021

# Select Quality Measures

	2013			2018			2020		
	CCQC	ACO	%ile	CCQC	ACO	%ile	CCQC	ACO	%ile
	Score	Mean	Rank	Score	Mean	Rank	Score	Mean	Rank
<b>Mammography Screening</b>	<b>91.22</b>	<b>62.05</b>	<b>100%</b>	<b>91.46</b>	<b>71.96</b>	<b>99%</b>	<b>91.92</b>	<b>74.05</b>	<b>99%</b>
<b>Colorectal Cancer Screening</b>	<b>88.94</b>	<b>59.30</b>	<b>100%</b>	<b>86.33</b>	<b>68.27</b>	<b>97%</b>	<b>91.96</b>	<b>72.56</b>	<b>99%</b>
<b>% of Pts W/DM &amp; A1c &gt;9</b>	<b>11.03</b>	<b>22.11</b>	<b>92%</b>	<b>7.36</b>	<b>15.51</b>	<b>97%</b>	<b>5.07</b>	<b>13.99</b>	<b>100%</b>
<b>Hypertension</b>	<b>69.22</b>	<b>67.79</b>	<b>55%</b>	<b>90.68</b>	<b>73.1</b>	<b>99%</b>	<b>89.49</b>	<b>72.87</b>	<b>98%</b>
<b>Source: CMS Public Use Files</b>									



# Select Utilization Rates

	2011	Performance Year					Change ('11-'20)	
		2013	2015	2017	2019	2020	#	%
Hospitalizations	318	270	248	244	247	225	(93)	-29%
ED Visits	620	560	568	574	530	427	(193)	-31%
Notes:								
(1) Rates computed by CMS.								
(2) 2011 figures based on previous retrospective alignment model.								
(3) Per 1,000 Person Years.								



# Compensation Principles

- Compensate Providers in a Manner Consistent with how Organization Earns Revenue
- Downside Risk is Born by all Owners (PCP and SCP)
- Operational Costs are Paid by All Owners (PCP and SCP)
- Modifications to Plan will be Necessary

# Historic ACO Budgets and Costs



Year	Per Pt Budget	# of Pt. Yrs	Total Budget	Total Spending	Savings/(Loss)		Due	Repay	Received
					\$	%			
<b>2nd Contract</b>									
2016	9,772	11,277	110,199,957	105,569,651	4,630,306	4.20%	2,236,944	(2,236,944)	-
2017	9,760	12,306	120,113,738	112,822,164	7,291,574	6.07%	3,370,647	(847,048)	2,523,599
2018	10,573	11,348	119,984,942	112,934,785	7,050,157	5.88%	3,297,943	-	3,297,943
2019 (1)	10,984	11,436	62,799,792	57,902,181	4,897,611	7.80%	2,403,808	-	2,403,808
			<b>413,098,429</b>	<b>389,228,781</b>	<b>23,869,648</b>	<b>6.13%</b>	<b>11,309,342</b>	<b>(3,083,992)</b>	<b>8,225,350</b>
<b>3rd Contract</b>									
2019A (1)	10,924	11,464	62,614,921	58,109,946	4,504,975	7.19%	3,316,647	-	3,316,647
2020	10,308	11,190	115,346,341	104,644,867	10,701,474	9.28%	7,975,943		7,975,943
			<b>177,961,262</b>	<b>162,754,813</b>	<b>15,206,449</b>	<b>8.54%</b>	<b>11,292,590</b>	<b>-</b>	<b>11,292,590</b>
						<b>Totals</b>	<b>22,601,932</b>	<b>(3,083,992)</b>	<b>19,517,940</b>
(1) Track 1+ was extended through 6/30/2019 and Enhanced Track Started 7/1/2019.									

# ACO and Total Cost of Care Contracts Distribution Categories and Weights

					Amount	Percent
	I. Repay Corporate for Costs				2,000,000	33.3%
	II. Equal Share Per FTE Placeholder				2,000,000	33.3%
	III. Risk Adjusted Budget				1,000,000	16.7%
	IV. Risk Adjusted Performance				1,000,000	16.7%
	Total Shared Savings				6,000,000	100.0%

# Risk Adjusted Budget and Performance Categories

	# of Bene Yrs (1)	CMS Normalized Risk Score	Budget per Bene	Aggregate Budget (2)	Per Bene Cost	Total Cost	PMPY Variance	Aggregate Variance
Provider A	691	0.89	\$ 8,327	\$ 5,752,446	\$ 9,811	\$ 6,778,106	\$ (1,485)	\$ (1,025,660)
Provider B	526	1.00	\$ 9,109	\$ 4,789,204	\$ 9,196	\$ 4,835,048	\$ (87)	\$ (45,844)
Provider C	573	0.99	\$ 9,222	\$ 5,281,191	\$ 8,638	\$ 4,946,648	\$ 584	\$ 334,543
Provider D	362	1.13	\$ 10,559	\$ 3,820,736	\$ 8,608	\$ 3,114,636	\$ 1,951	\$ 706,100
Provider E	397	1.29	\$ 11,840	\$ 4,702,418	\$11,219	\$ 4,455,627	\$ 621	\$ 246,790
Provider F	3	0.55	\$ 5,764	\$ 17,292	\$ 2,449	\$ 7,347	\$ 3,315	\$ 9,945
<b>Total</b>	<b>2,551</b>	<b>1.03</b>		<b>\$ 24,363,287</b>		<b>\$ 24,137,413</b>		<b>\$ 225,874</b>
(1) Beneficiaries by member months								
(2) Aggregate Budget = 2016 final attribution with 2015 risk scores								

# Using Departments and Incorporating Quality

		Distributable	Quality Score	Keep	Amount Redist.	Total	FTE Shares	Per FTE Share
Primary Care								
	Depart A	700,662	96.34%	675,012	45,210	720,222	2.0	360,111
	Depart B	841,928	96.70%	814,114	54,526	868,641	4.0	217,160
	Depart C	1,798,642	92.41%	1,662,138	111,324	1,773,462	5.0	354,692
	Depart D	1,326,145	92.23%	1,223,132	81,921	1,305,052	5.0	261,010
		<b>4,667,377</b>		<b>4,374,397</b>	<b>292,980</b>	<b>4,667,377</b>	<b>16.0</b>	<b>291,711</b>
Specialty Care								
	Depart A	499,916				499,916	3.0	166,639
	Depart B	344,257				344,257	3.0	114,752
	Depart C	488,451				488,451	3.0	162,817
		<b>1,332,623</b>				<b>1,332,623</b>	<b>9.0</b>	<b>148,069</b>
		<b>6,000,000</b>				<b>6,000,000</b>	<b>25.0</b>	<b>240,000</b>

# Calculating Quality Scores

		Dept 1	Dept 2	Dept 3	Dept 4	Dept 5	Dept 6
<b>Patient Satisfaction Domain</b>							
	Patient Satisfaction	4.69	4.67	4.82	4.49	4.54	4.70
	Points Earned	1.85	1.85	2.00	1.55	1.70	1.85
	Total Points Earned	1.85	1.85	2.00	1.55	1.70	1.85
	Domain Score	92.50%	92.50%	100.00%	77.50%	85.00%	92.50%
<b>Care Coordination/Patient Safety Domain</b>							
	Doc of Medications	100%	100%	100%	100%	100%	100%
	Points Earned	2.00	2.00	2.00	2.00	2.00	2.00
	Fall Risk Screening	89.77	84.23	89.07	82.42	84.80	81.37
	Points Earned	2.00	2.00	2.00	2.00	2.00	1.85
	Total Points Earned	4.00	4.00	4.00	4.00	4.00	3.85
	Domain Score	100.00%	100.00%	100.00%	100.00%	100.00%	96.25%

# Sample HCC Gap Report

	# Pts W/HCC	07/31/2015			07/31/2014			06/30/2015		
		RAF			RAF			RAF		
		Per Chart Dx	Per Chart	Per Claims	Gap	Per Chart	Per Claims	Gap	Per Chart	Per Claims
<b>PCP 1</b>										
A	430	1.37	1.03	0.34	1.28	0.87	0.41	1.43	1.03	0.40
B	488	1.26	0.83	0.43	1.22	0.71	0.51	1.31	0.83	0.48
C	555	1.13	0.81	0.32	1.10	0.76	0.34	1.14	0.79	0.35
D	42	1.17	0.86	0.31	1.14	0.79	0.35	1.21	0.89	0.33
E	436	1.44	1.11	0.33	1.38	0.93	0.45	1.47	1.08	0.40
F	453	1.17	0.88	0.29	1.11	0.69	0.42	1.24	0.85	0.39
	2,404	1.26	0.92	0.34	1.20	0.79	0.41	1.31	0.91	0.40
<b>PCP 2</b>										
A	390	1.24	0.89	0.35	1.18	0.82	0.36	1.27	0.90	0.37
B	10	0.89	0.53	0.36	0.91	0.66	0.25	1.10	0.52	0.58
C	695	1.22	0.90	0.33	1.16	0.75	0.41	1.26	0.88	0.38
D	56	1.09	0.56	0.53	1.00	0.57	0.43	1.15	0.55	0.60
E	671	1.23	0.89	0.34	1.14	0.74	0.40	1.26	0.88	0.38
I	599	1.44	0.97	0.47	1.29	0.86	0.43	1.45	0.93	0.52
J	552	1.26	0.98	0.28	1.21	0.91	0.31	1.31	0.99	0.31
	2,973	1.27	0.91	0.36	1.12	0.76	0.36	1.30	0.91	0.39
<b>Tot</b>	<b>5,377</b>	<b>1.26</b>	<b>0.89</b>	<b>0.37</b>	<b>1.14</b>	<b>0.70</b>	<b>0.44</b>	<b>1.30</b>	<b>0.91</b>	<b>0.39</b>



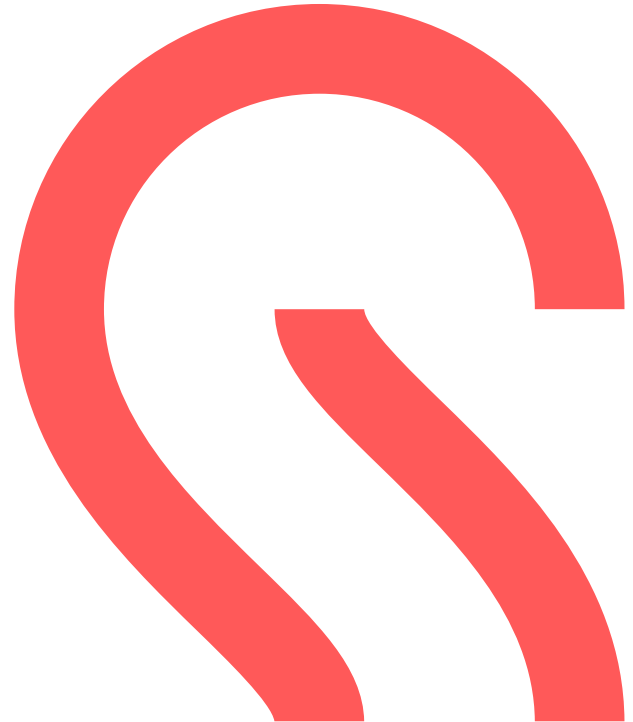
# Compensation Model

NAACOS Annual Conference

October 1, 2021

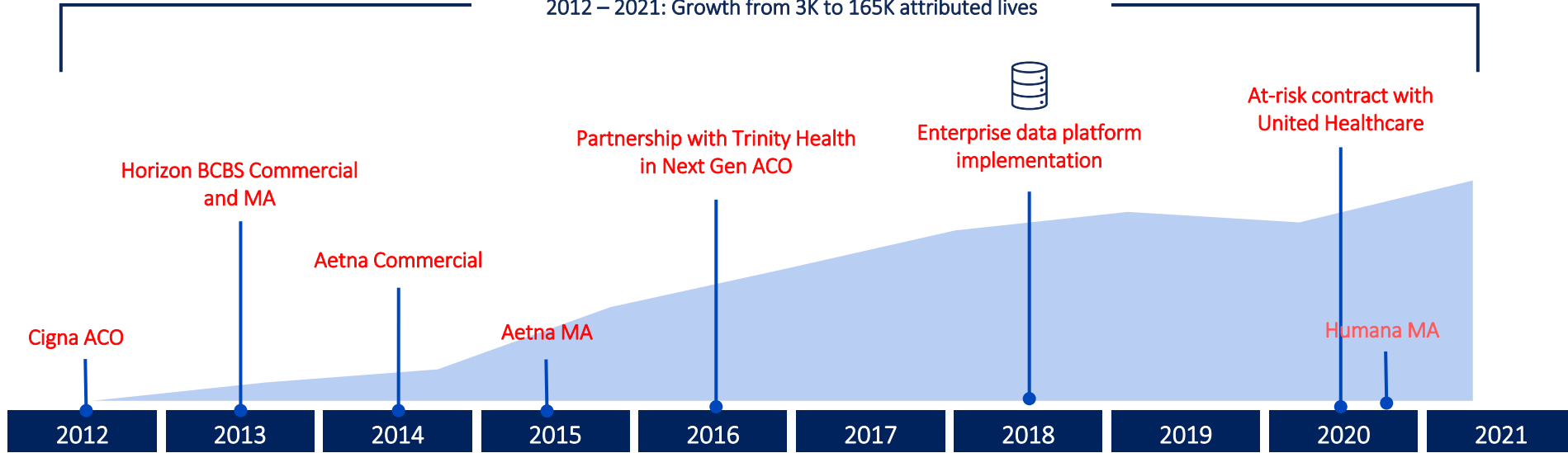
Ashish Parikh, MD

Chief Quality Officer



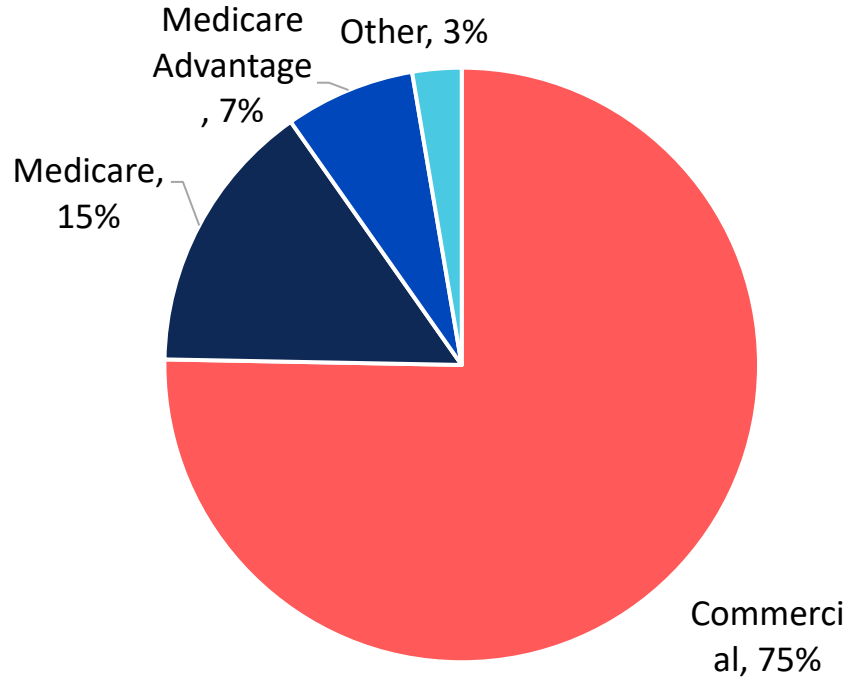
# Our Strategy: Progressive Increases in Risk

2012 – 2021: Growth from 3K to 165K attributed lives

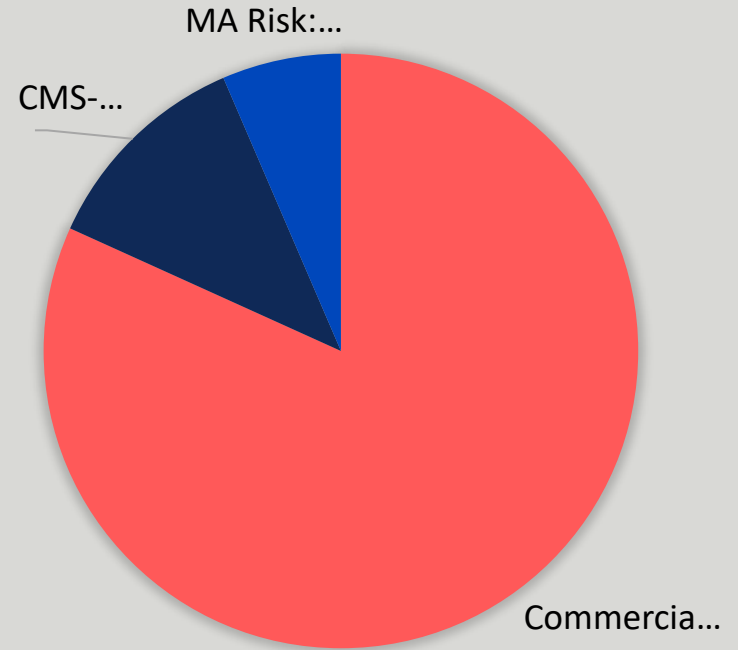


We strategically increased our VBC risk progressively and in parallel with growth in providers, services, and population health management infrastructure

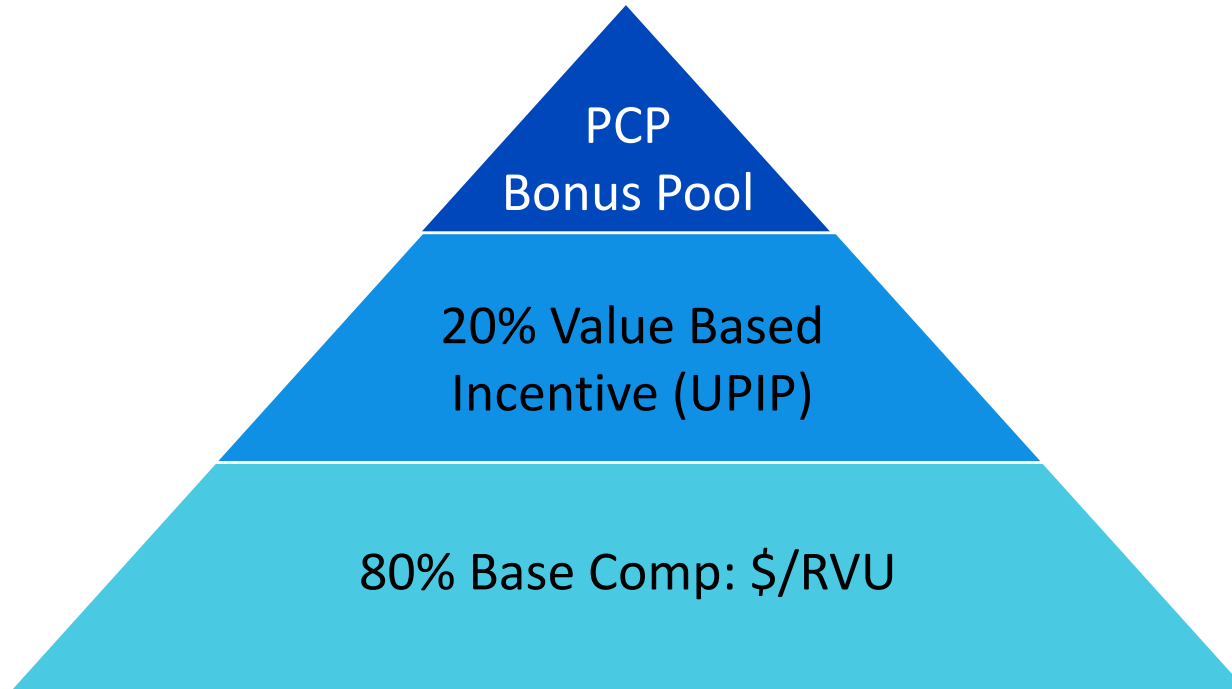
# Revenue by Health Plan Type



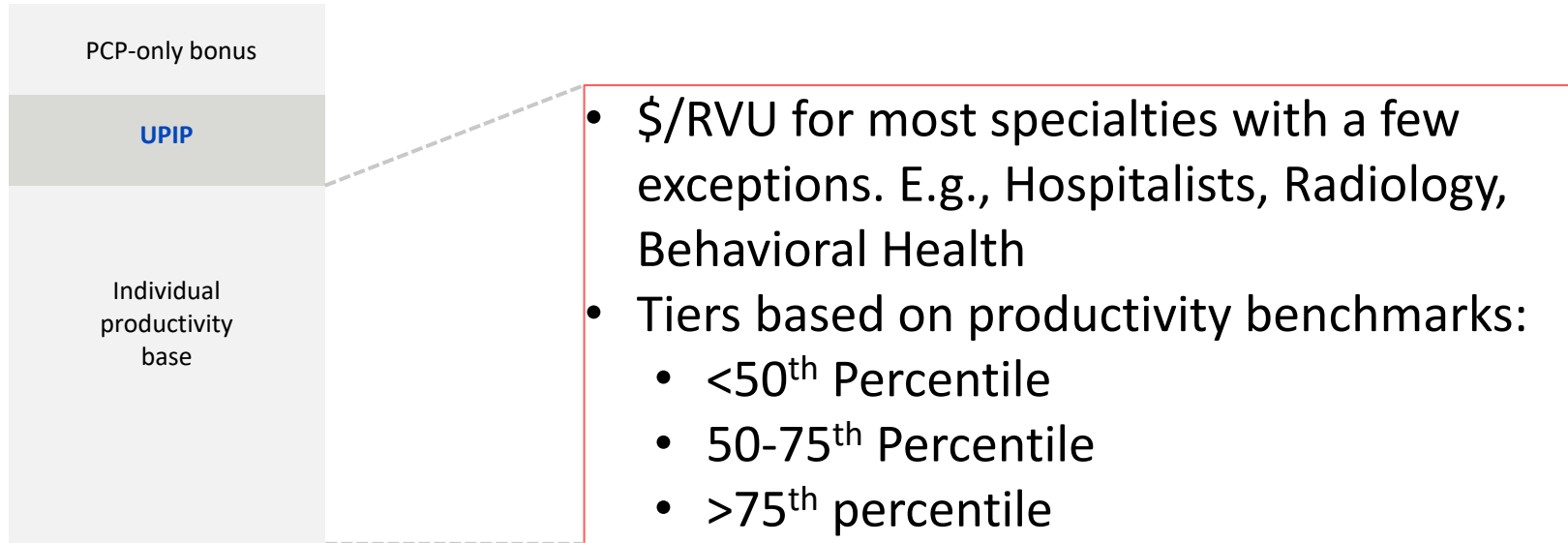
# Attributed Lives by Plan Type



# Summit Health Physician Compensation Model

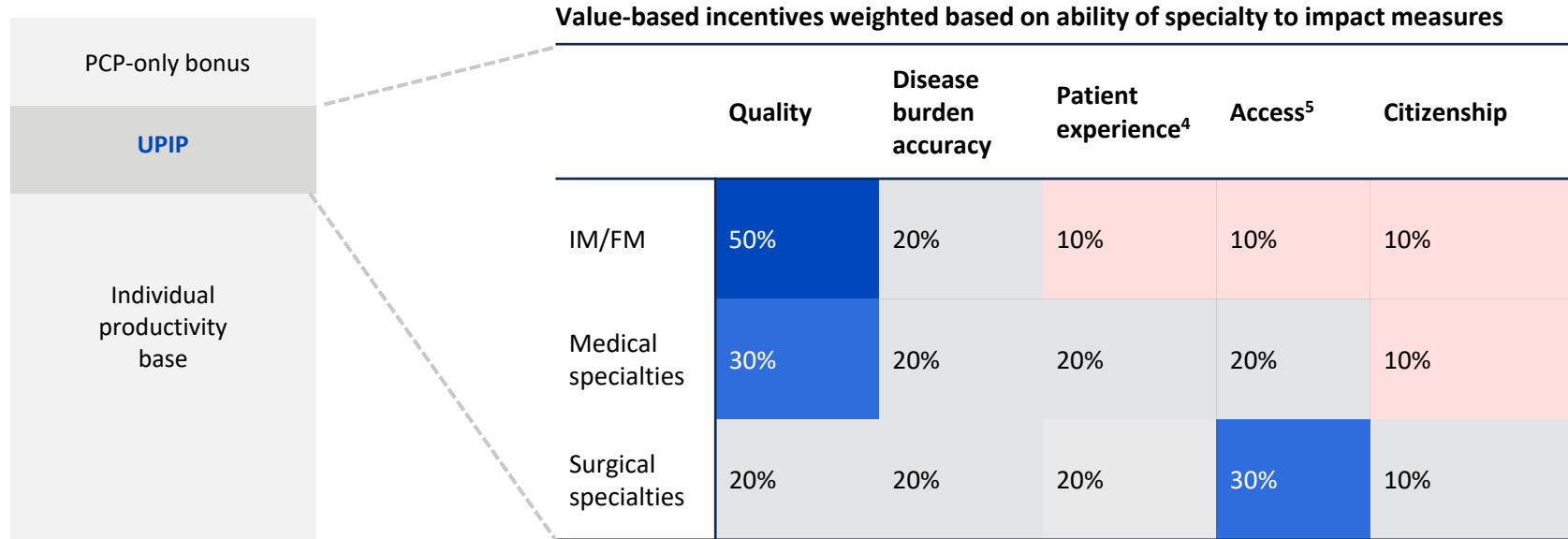


# Base Compensation



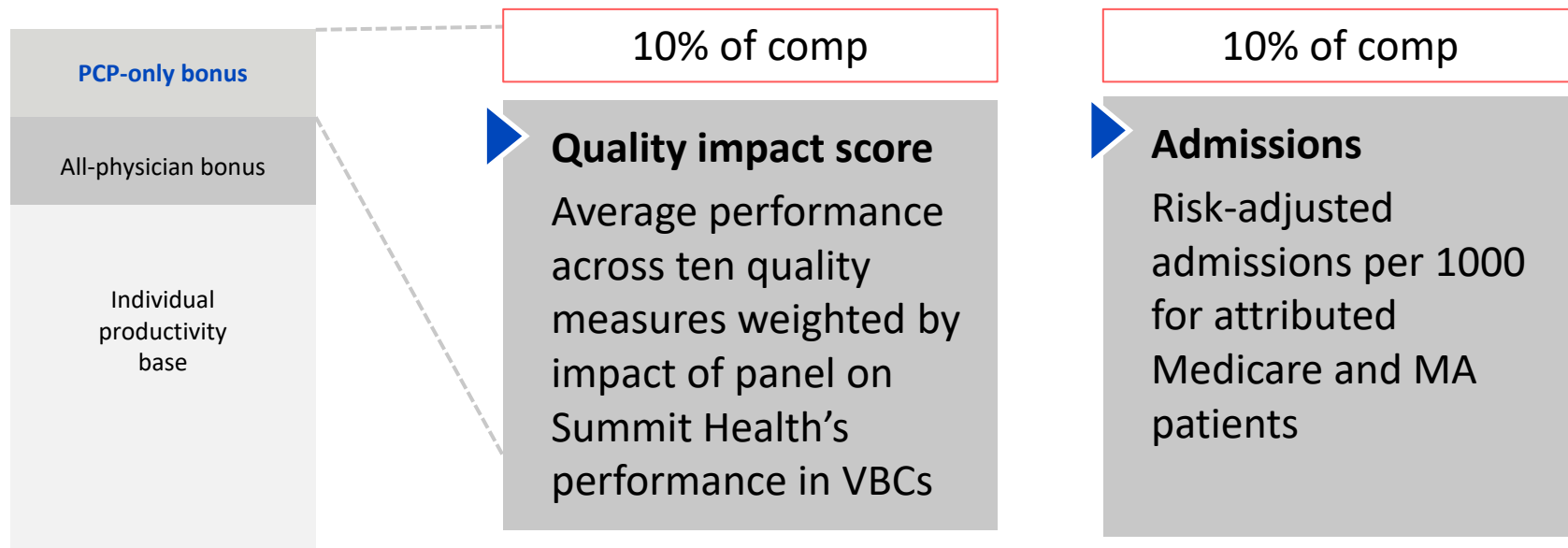
Measures within each attribute vary by specialty

# Creating a Universal Value-Based Bonus Framework



Measures within each attribute vary by specialty

# PCP Bonus Based on Impact of Panel on Group's Performance



# Timing of Payouts

- Biweekly draw based on historic productivity
- 85% place holder for UPIP in first quarter of the year, then true score used
- Mid-year settlement and draw adjustment if needed
- Year-end settlement
- PCP bonus paid out as lump-sum at end of the year

# Provider Reporting

- **DOMO data visualization tool used to push monthly reports**
  - Productivity-based compensation
  - Monthly personal report
- **Value-Based UPIP dashboards**
  - Transparent performance reported across entire specialty
  - Drill down capability to go from attribute score to measure specific performance to patient level details where applicable
- **PCP Bonus reports**
  - Transparent performance compared to peers with drill-down to patient level details
  - Performance can be viewed at individual physician and at pod level

# Example UPIP Report, Quality Section

Quality - % of Max Points Earned														Minimum	Maximum
	Dec-2016	Jan-2017	Feb-2017	Mar-2017	Apr-2017	May-2017	Jun-2017	Jul-2017	Aug-2017	Sep-2017	Oct-2017	Nov-2017	YTD	Points Goal	Points Goal
Provider 1	0%	70%	73%	80%	75%	86%	90%	86%	0%	0%	0%	0%	86%	50%	75%
Provider 2	0%	63%	63%	67%	75%	79%	81%	85%	0%	0%	0%	0%	85%	50%	75%
Provider 3	0%	73%	82%	82%	85%	92%	94%	94%	0%	0%	0%	0%	94%	50%	75%
See Athena QM tab for details															

## Detailed Quality Metrics, by Individual Provider

Specialty QM		Internal Medicine													
Measure	Satisfied	Not Satisfied	Total	Satisfaction %	Goal	Stretch Goal									
SMG Physician Metrics 2017-Internal Medicine															
Coronary Artery Disease (CAD): ACE/ARB Therapy for Patients with CAD and Diabetes and/or Left Ventricular Systolic Dysfunction (All or nothing measure)	103	51	163	66.88%	75%	91%									
Diabetes: Hemoglobin A1c poor control	16	114	130	12.31%	34%	19%									
Diabetes: Urine protein screening	120	10	130	92.31%	90%	91%									
Documentation of current medications in the medical record	3757	39	3,796	98.97%	58%	83%									
Hypertension: Controlling high blood pressure	484	171	655	73.89%	61%	76%									
Screening for clinical depression and follow-up	2217	636	2,853	77.71%	16%	51%									
Tobacco use: Screening and cessation intervention	3276	50	3,326	98.50%	76%	84%									

# Example of Pod Level Admits/1000 Report

POD	Member Months	Panel RAF	Admits	Admits/1000	Risk Adjusted Admits/1000
Pod 1	5,686	1.184	63	132.96	105.40
Pod 2	1,202	1.065	11	109.82	112.55
Pod 3	7,816	1.068	77	118.22	120.27
Pod 4	25,080	1.209	338	161.72	127.83
Pod 5	17,133	1.050	176	123.27	129.68
Pod 6	3,728	0.910	28	90.13	132.39
Pod 7	10,514	1.083	118	134.68	132.83
Pod 8	10,595	1.082	121	137.05	135.49
Pod 9	3,615	1.165	48	159.34	136.62
Pod 10	17,647	1.070	202	137.36	138.90
Pod 11	16,347	0.964	155	113.78	142.08
Pod 12	954	1.004	10	125.79	144.05
Pod 13	19,321	1.083	235	145.96	144.19
Pod 14	1,835	0.905	16	104.63	148.11
Pod 15	27,824	1.057	345	148.79	153.55
Pod 16	15,914	1.061	203	153.07	156.72
Pod 17	7,989	1.143	118	177.24	160.12
Pod 18	6,137	1.157	93	181.85	161.27
Pod 19	13,555	1.058	179	158.47	162.85
Pod 20	5,662	1.029	72	152.60	164.47
Pod 21	42,061	1.116	625	178.31	168.03
Pod 22	15,936	0.944	179	134.79	168.40
Pod 23	10,950	1.114	167	183.01	173.16
Pod 24	4,089	0.942	51	149.67	183.77
Pod 25	292	0.998	4	164.38	184.13

# Concepts in Physician Compensation

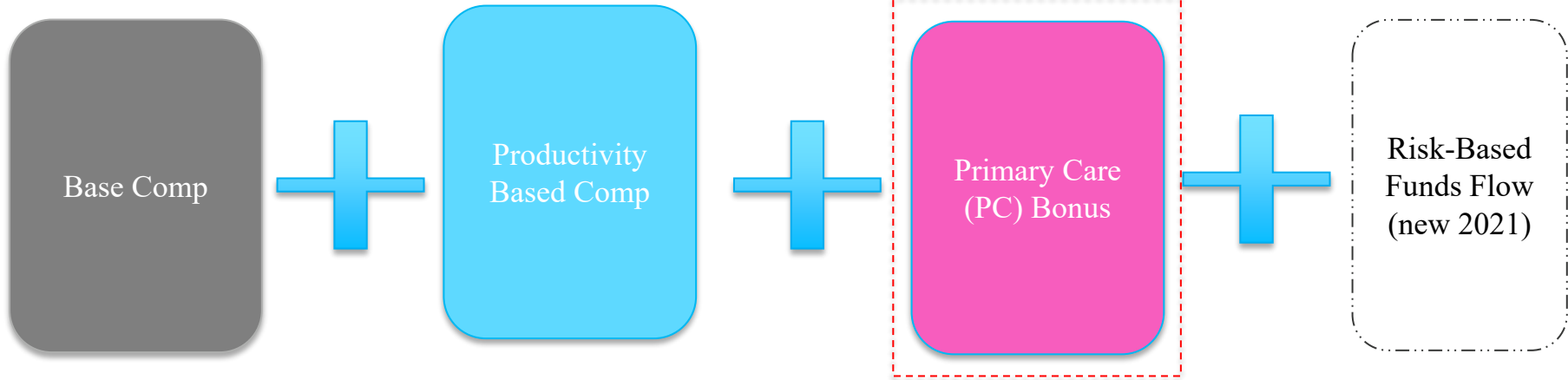
Rob Fields MD MHA  
EVP, Chief Population Health Officer  
Mount Sinai Health System



**Mount  
Sinai  
Health  
Partners**

# Current Structure of Employed Physician Comp

← Compensation Redesign



- Specialty
- FTE Split
- Academic Status

- RVU Performance

- Specialty
- FTE Split
- Academic Status

# 2021 PC Bonus Overview

## Bonus Components

The 2021 PC Bonus will be comprised of Quality, Patient Sat, UM, and Recapture metrics – **the focus of these materials will be on the options for the 2021 UM metric only** –



PC Bonus Dimensions	Quality	Patient Sat	UM	Re-Capture
2021 (Planned)				
<i>Criteria</i>	6 quality measures	2 patient satisfaction measures	O:E measure (TCOC, IP, or ED); preference for TCOC but depends on noise in the data etc.	2 recapture measures (Heart Failure, Diabetes w/ Complications)
<i>Calculation Method</i>	Points for each measure based on peer-to-peer score or comparison to benchmark	Points for each measure based on peer-to-peer score or comparison to benchmark	TBD; options outlined in these materials	Points per metric performance meets or surpasses target diagnosis recapture rate
<i>Level of reporting</i>	Provider	Provider	Practice	Practice, POD for MSDD

<sup>1</sup> Re-visit in future if we can increase recapture portion to 50% of total bonus and decrease other components (UM & Quality)

<sup>2</sup> Data has 2 month lag so Sept data would only have one month of run-out before metric is calculated; O:E ratio to be calculated using same time period to adjust for this limitation

# ACG – Observed vs. Expected Illustrative Example

- Calculate Expected:
  - For entire population, create average cost/util metric by ACG

Risk Category (ACG Category)	# of Patients in the Reference Population	Total Costs Incurred by Patients in the Risk Category	Reference Average Cost Per Patient (Expected)
0100	124	\$113,832	\$918.00
0200	792	\$289,872	\$366.00
0300	716	\$273,512	\$382.00
0400	89	\$806,340	\$9,060.00
5070	89	\$770,028	\$8,652.00
<b>Total</b>	<b>1,810</b>	<b>\$2,253,584</b>	<b>\$1,245.00</b>

- For each ACG, multiply the number of patients in your cohort by the average cost calculated for the entire population.

Risk Category (ACG Category)	# of Patients in the Provider's Panel	Reference Average Cost Per Patient (Expected)	Total "Expected" Cost for the Provider's Panel
0100	55	\$918.00	\$50,490
0200	432	\$366.00	\$158,112
0300	225	\$382.00	\$85,950
0400	47	\$9,060.00	\$425,820
...			
5070	56	\$8,652.00	\$484,512
<b>Total</b>	<b>815</b>		<b>\$1,204,884</b>

- Observed:
  - For the cohort, sum up the costs for all patients in the ACG category

Risk Category (ACG Category)	# of Patients in the Provider's Panel	Actual Cost Per Patient in the Provider's Panel	Expected Cost Per Patient in the Provider's Panel	O : E
Total	815	\$1,430.91	\$1,478.39	0.968

## “What can I do to impact my performance?”

### ▣ Appropriate Coding

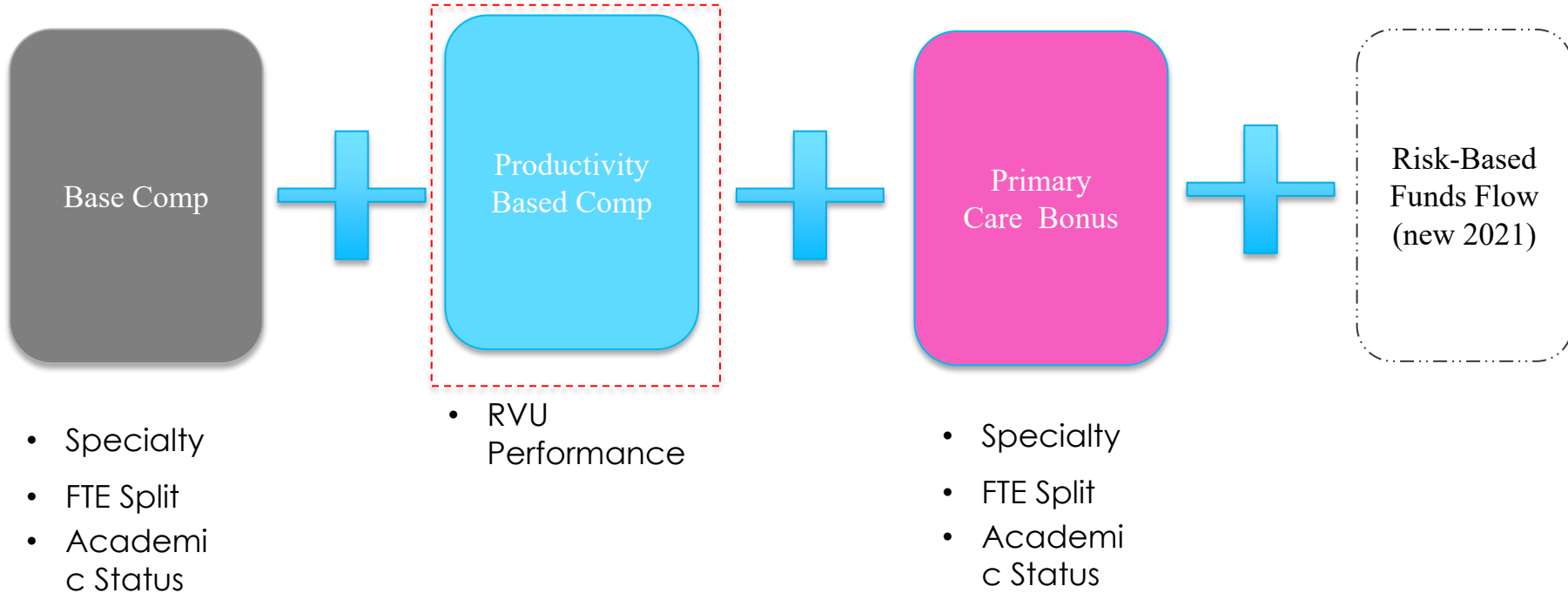
- Diagnosis codes and HCC risk are inputs in the model
- They are effectively increasing the “expected” part of the O:E

### ▣ Avoiding unnecessary expensive care

- Care management
- Condition management
- Post acute work
- Home based care
- Other

## Current Structure of Employed Physician Comp

← Order of Operations



# Measuring Productivity For Risk

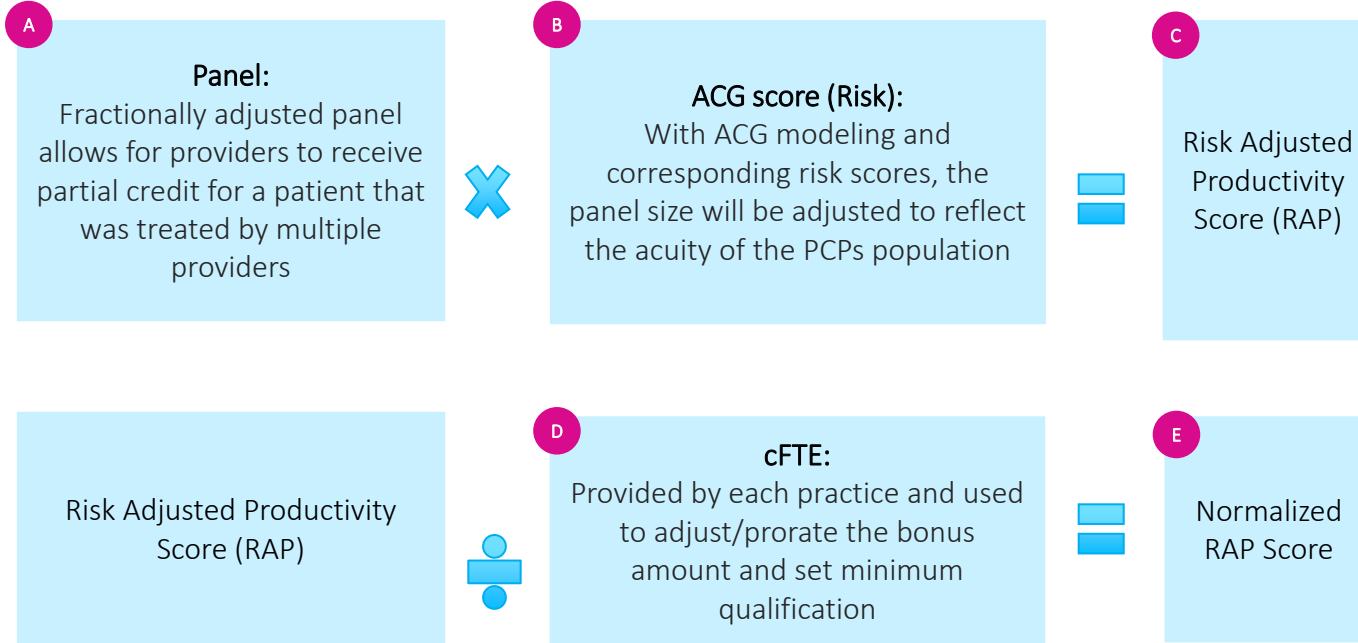
## Hypothesis

Physicians that see a higher % of Medicare and Medicaid have a high needs population and tend not to be as productive in the RVU model.

## Proposed Solution

Measuring productivity by risk adjusted panel is a better measure of productivity for these physicians and aligns well with our downside risk strategy.

# Risk Adjusted Productivity Score Calculation



# Updated Productivity Bonus Methodology Detail

2021 productivity bonus for practices will be calculated via the following methodology –

**Participation Gate**



**Productivity Thresholds**

PCPs who are employed with the practice,  $\geq .2$  cFTE,  $\geq 60^{\text{th}}$  percentile Risk Adjusted Productivity Score (RAP).

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

Achieve productivity benchmarks to receive bonus dollars

	0-60%	60-75%	75-90%	<90%
<b>Bonus Dollars/ RAP Unit</b>	\$1	\$5	\$10	\$0

## Examples:

<p>Providers RAFA panel sizes</p> <ul style="list-style-type: none"> <li>1,000; 20<sup>th</sup> percentile</li> <li>1,400; 40<sup>th</sup> percentile</li> <li>1,800; 60<sup>th</sup> percentile</li> <li>2,200; 80<sup>th</sup> percentile</li> <li>2,600; 100<sup>th</sup> percentile</li> </ul>	x	<div style="border-left: 2px solid blue; border-right: 2px solid blue; padding: 10px; display: inline-block;"> <p>\$1 /RAP score <i>(up to 60<sup>th</sup> percentile)</i></p> <p>\$5 /RAP unit <i>(60<sup>th</sup> – 75<sup>th</sup> percentile)</i></p> <p>\$10 /RAP unit <i>(75<sup>th</sup> – 90<sup>th</sup> percentile)</i></p> <p>\$0 /RAP unit <i>(90<sup>th</sup> percentile+)</i></p> </div>	=	<p>Payout per provider</p> <ul style="list-style-type: none"> <li>\$0; does not qualify</li> <li>\$0; does not qualify</li> <li>\$1,800 = (1800 x 1)</li> <li>\$4,300 (1800 + 300x5 + 100 x 10)</li> <li>\$6,300 = (1800+300x5+ 10x 300)</li> </ul>
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## Summary

- Multi- year phased strategy with a focus on primary care
- Compensation strategy must align with contracting strategy
- Encourage behaviors that are necessary to be successful in value (e.g. accurate coding, panel management, condition management)
- Allow for "ramp up" (shadow reports, "hold harmless" time period)
- Stakeholder input

# The When

When should an organization begin to Align Compensation Model with Organization's Value-Based Goals?



Based on the % of patients in a value-based arrangements?



Based on the % of revenue from value-based arrangements?

# OPEN DISCUSSION

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Choose starting point

Choose destination

