Step 1: Calculate Risk Adjusted Panel Size (RAPS)

PCP A

1. Each patient → HHS-HCC risk score: bounded [0.5 – 5.0]
2. Average risk score * PCP's panel size = RAPS (raw)
3. Prorate RAPS by FTE → RAPS (standardized)

Step 2: Set Risk Adjusted Panel Size (RAPS) Targets

PCP A  → RAPS = 3,416

PCP B  → RAPS = 2,851

PCP C  → RAPS = 3,279

For all PCPs in a stratum, the median RAPS = Target

Step 3: Set RAPS Targets Strata and Adjustments

Non-Health Center MDs:
3,279 RAPS
~1,650 patients

Health Center MDs:
2,911 RAPS
~1,450 patients

Med/Peds MDs:
2,446 RAPS
~1,500 patients

NP/PA Adjustment: +650-800 RAPS per FTE to target

Step 4: Compensation → Set Base Salary

Non-Health Center MDs:
3,279 RAPS
~1,650 patients

Health Center MDs:
2,911 RAPS
~1,450 patients

Med/Peds MDs:
2,446 RAPS
~1,500 patients

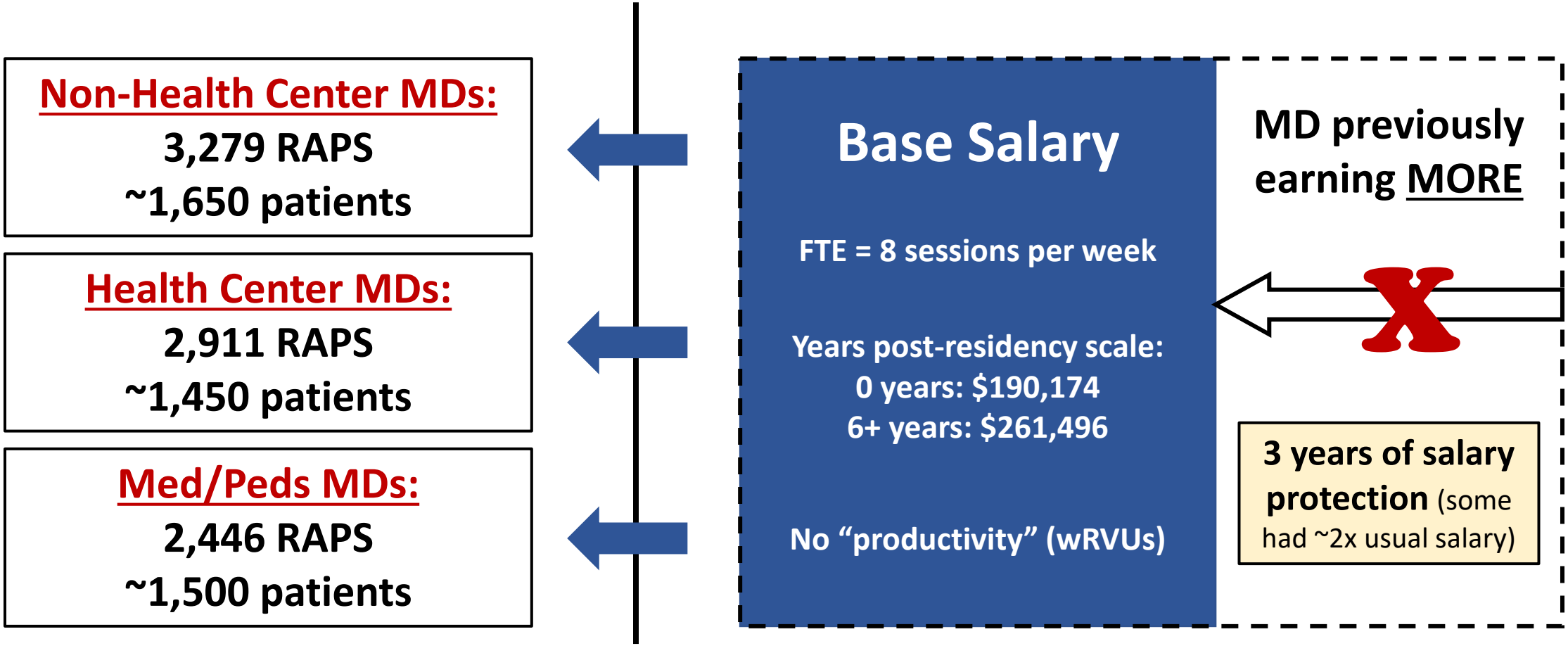
Base Salary

FTE = 8 sessions per week

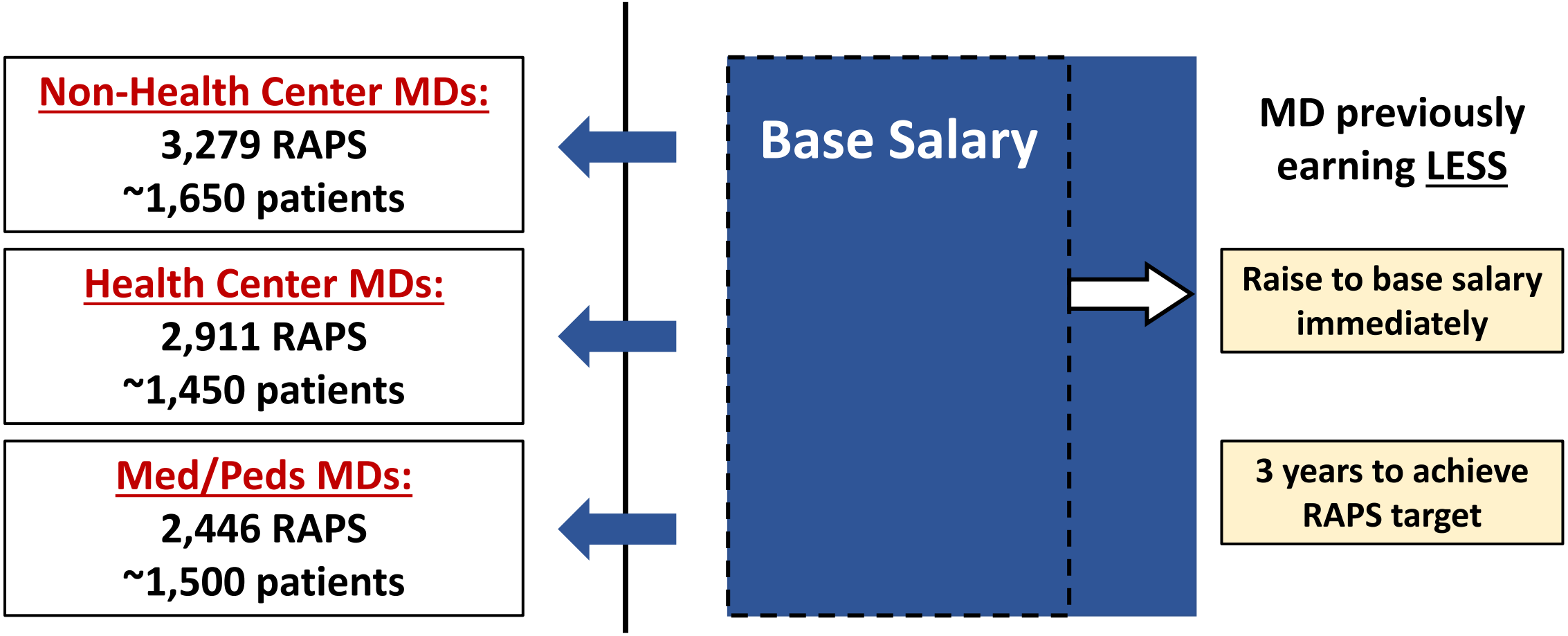
Years post-residency scale:
0 years: $190,174
6+ years: $261,496

No "productivity" (wRVUs)

Step 5: Compensation → Transition Period



Step 5: Compensation → Transition Period



Early Experience at MGH

Q: How did visit volume change in year 1?	
A)	Increased 10-15%
B)	Increased 5-10%
C)	Increased 0-5%
D)	Decreased 0-5%
E)	Decreased 5-10%
F)	Decreased 10-15%

Revenues across PC ↓ by $10+ million

Base Salary

FTE = 8 sessions per week

Years post-residency scale:
0 years: $190,174
6+ years: $261,496

Floor: minimum of 7 visits per session

Improve patient scheduling

Coding and co-pays

RVU based annual incentive $
- At most 5-10% of total comp
- Much smaller or $0 for most

(1) RAPS > target
(2) wRVUs > expected
[7 visits/session * average weight per visit across PC]

Rewards PCPs who pitch in and see extra urgent visits

Lessons Learned at MGH Primary Care

Year 1: Behind revenue target as revenue fell. Costs roughly at similar level as prior.

Year 2: Started to build back (previous slide).

Year 3: More revenue than projected for the first time in 10+ years due to **visit** and some **panel growth** (not +margin, as hospital subsidies still needed)

3X ↑ in Epic Gateway Calls/Requests

- 300 patient advice requests/mo./FTE
- Amount of work has likely ~"doubled"
- Joy and burnout: worse today vs. 2019

Vision – a true "steady state"

- PCPs use care teams → **panel growth**
- **Panel growth** → ↑ volume & revenue
- Patient and provider health (↓burnout)

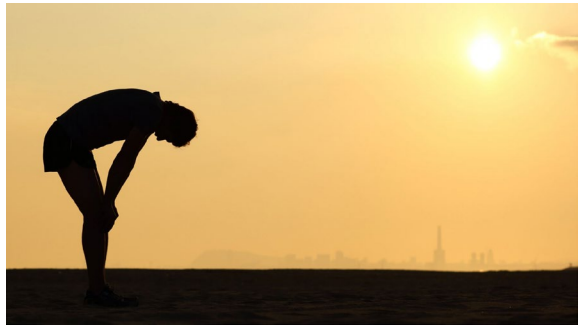
Pandemic

Credit: Josh Metlay, Evan Porter (MGH DGIM)

Lessons Learned at MGH Primary Care

Simplicity

Essential for communicating new model to MDs.
Missteps in trying complicated RAPS targets.



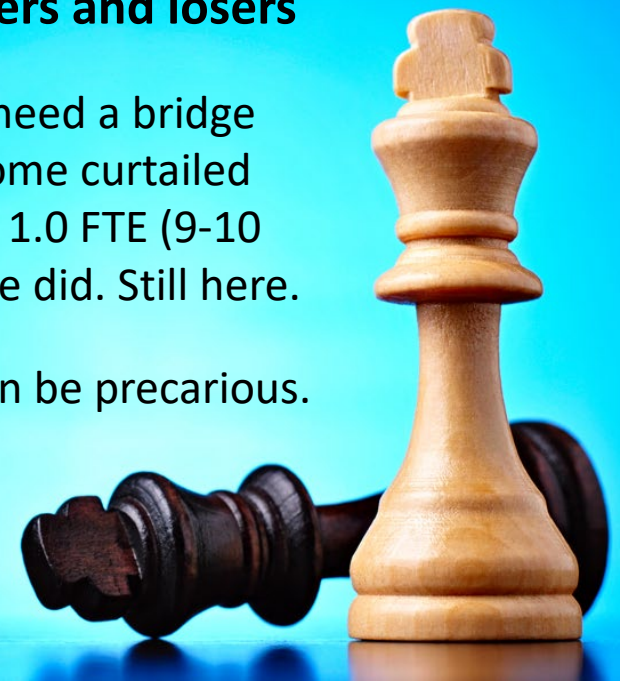
Easier to code.
Harder to take on more pts.

There are PC winners and losers

High FFS earners → need a bridge

- But ultimately income curtailed
- Allowed to exceed 1.0 FTE (9-10 sessions/wk). Some did. Still here.

Healthy panels → can be precarious.



Credit: Josh Metlay, Evan Porter (MGH DGIM)