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White Paper

The Primary Care Compensation Paradigm Shift That Was Meant to Be

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By Kelsi O'Brien, M.H.S.A.

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In 2020, the RVS Update Committee (RUC) made a recommendation that would spur a significant paradigm shift in the way we view and value primary care services. Facilitated by the American Medical Association (AMA), the RUC establishes relative value unit (RVU) values for new CPT codes, reviews existing code values every five years, and provides RVU recommendations to the Centers for Medicare & Medicaid Services (CMS), among other tasks. The committee consists of 32 members who represent major national medical specialty societies of all types. Recommendations are ultimately made to CMS when the committee achieves a two-thirds vote from its members regarding any given issue. The final decision regarding recommendations ultimately lies with CMS, but the RUC holds substantial influence.

Ultimately the RUC recommended, and CMS implemented, RVU and documentation requirement changes for outpatient evaluation and management (E/M) codes that will have a lasting impact on medical groups nationwide. Let's breakdown the key changes and the goals behind them.

The Recommendations

Figure 1 shows the change in work RVUs (wRVUs) associated with each outpatient E/M code. Established patient visits, which largely compromise outpatient office billings, saw the greatest increase. In terms of documentation, the focus has moved from the arduous history and examination documentation requirements to medical decision making (MDM) or the time spent performing the service on the day of the visit when selecting the level of service.

Figure 1

CMS 2021 Outpatient E/M wRVU Changes			
Code	**2020**	**2021**	**% Increase**
New Patient			
Visit	**wRVUs**		**Percent**
99201	0.48		0%
99202	0.93	0.93	0%
99203	1.42	1.60	13%
99204	2.43	2.60	7%
99205	3.17	3.50	10%
Established Patient			
Visit	**wRVUs**		**Percent**
99211	0.18	0.18	0%
99212	0.48	0.70	46%
99213	0.97	1.30	34%
99214	1.50	1.92	28%
99215	2.11	2.80	33%

The RUC outlined the objectives for the changes noted (see sidebar below). The fourth objective is key when considering the intention of the changes as they relate

RUC Objectives

To decrease the administrative burden of documentation and coding and align CPT and CMS whenever possible

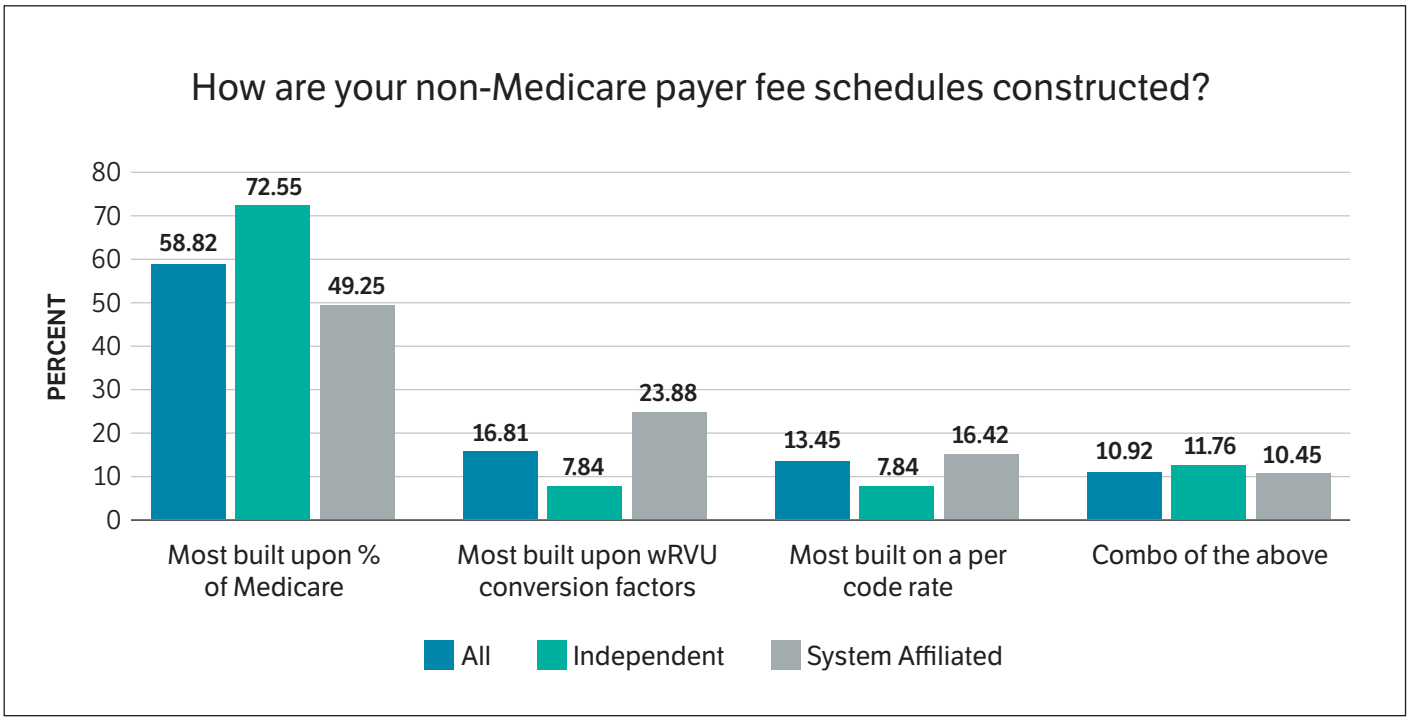
To decrease the need for audits, through the addition and expansion of key definitions and guidelines

To decrease unnecessary documentation in the medical record that is not needed for patient care

To ensure that payment for E/M is resource-based and that there is no direct goal for payment redistribution between specialties

to reimbursement for services. The objective clearly states that *redistribution* is not the goal, but rather to ensure appropriate allocation of resources. This is important when evaluating potential changes to provider compensation plans to reflect the increased wRVUs. There was no intention to devalue any providers, whether they are specialists or not.

Figure 2

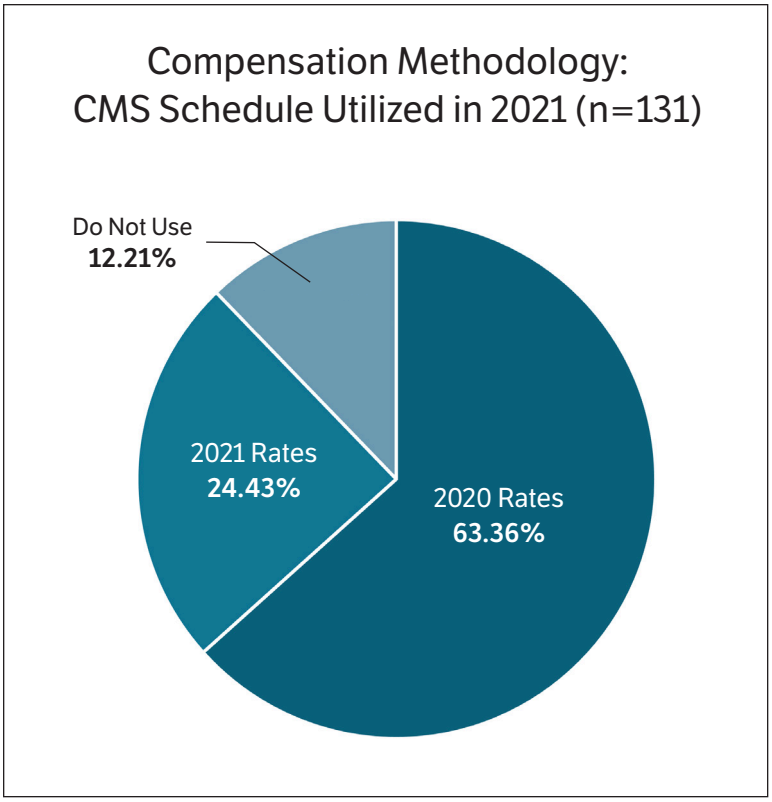


Making the Connection

In 2021, a survey of 120 AMGA medical groups found that the majority of respondents were receiving non-Medicare reimbursement based on fee schedules that were derived from a percent of Medicare, indicating that medical groups saw an increase in revenue as a result of the wRVU changes if they had a certain payer mix (Figure 2).

It would be a mistake not to mention that the changes in wRVUs were finalized in the midst of a pandemic and 30 days from the end of the year, leaving medical groups scrambling. The *AMGA 2022 Medical Group Compensation and Productivity Survey* shows that in 2021 the majority (63%) of groups compensated providers based on 2020 wRVU weights (Figure 3), which is most likely the result of a lack of time and resources for planning and implementing appropriate adjustments.

Figure 3



Fast forward to the present, and the sharp reality that the market data may not completely reflect the original intentions of the RUC is evident. Some medical groups received increased revenue associated with the increased weights due to their payer mix, but those dollars did not necessarily find their way to primary care providers' compensation. Figure 4 demonstrates that net collections increased in primary care by 4.65%, and our insights tell us that the aforementioned changes are a significant contributing factor.

Figure 4

AMGA National Median Survey Data				
Specialty	Metric	2020 Survey, 2019 Data	2022 Survey, 2021 Data	% Increase from 2020 to 2022
Primary Care	Total Cash Comp	$273,099	$281,810	3.19%
	wRVUs	5,061	5,573	10.12%
	Collections	$480,347	$502,670	4.65%
Surgical Specialties	Total Cash Comp	$446,996	$459,437	2.78%
	wRVUs	7,399	7,275	-1.68%
	Collections	$634,025	$626,424	-1.20%

The upside of this situation is that organizations are armed with the necessary data to adjust their compensation plans and facilitate primary care providers realizing the additional revenue their services are generating. Additionally, AMGA market data were gathered with the assumption that medical groups reported wRVUs with both the 2020 and the 2021 weights. The total cash compensation (TCC) market metric is where additional mitigation must happen. The TCC in the market data does not reflect the increased revenue. Medical groups should evaluate their collections in relation to wRVUs that reflect the 2021 weights.

The Path Forward

Conversations about the worth of primary care providers and their contribution to value-based care initiatives and care management have been taking place for quite some time. CMS elected to act on the recommendations of the RUC, and now that organizations have moved from treating COVID-19 as pandemic to endemic, they should revisit the appropriate allocation of the potential increased revenue generated by primary care providers.

It's important to note the "potential" increase in revenue because, while the RUC recommendation was implemented, CMS also made its own change to the Physician Fee Schedule Conversion Factor (PFS CF), or CMS payment per RVU. The decrease in PFS CF by $1.48 from CY2020 to CY2021 was largely driven by other separate legislation and initiatives. Market data show that primary and surgical care providers' compensation has continued to increase at standard rates (Figure 4), meaning the additional revenue did not make its way to primary care providers. CMS is set to drop the PFS CF by $1.55 again in 2023, leaving even less revenue available to primary and specialty care providers alike. The critical point worth reiterating is there was no intent to devalue specialty care and/or proceduralists, but if there is additional revenue, they are not the intended recipients.

When adapting your compensation plan to distribute the additional wRVUs and/or associated revenue, you will not be able to afford paying on the increased wRVUs at the current published comp per wRVU market rates. The market data in Figure 4 show that the increase in wRVUs far exceeded the actual additional collections (revenue) generated in primary care. It is important to calculate the appropriate adjustment factor (Figure 5) and consider your organization's payer mix and associated payer contracts when projecting the shift in payment for primary care providers.

Figure 5

$$\frac{\text{2021 specialty specific comp per unit (new weights)}}{\text{2019 specialty specific comp per unit (escalated x2 years)}} = \text{\% Adjustment Factor}$$

The RUC had clear intentions when they made the recommendation to modify RVUs for outpatient office visits. Medical groups compensating performance based on the new wRVUs stand to gain a significant advantage in the recruitment and retention of primary care providers. The time to make adjustments is now.

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Disclaimer: The content contained within this article is a summary of events and the associated impact on the market over the last two years. It is not necessarily reflective of the opinions of AMGA Consulting or reflective of our professional opinion regarding how provider compensation should evolve at the specialty level.

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