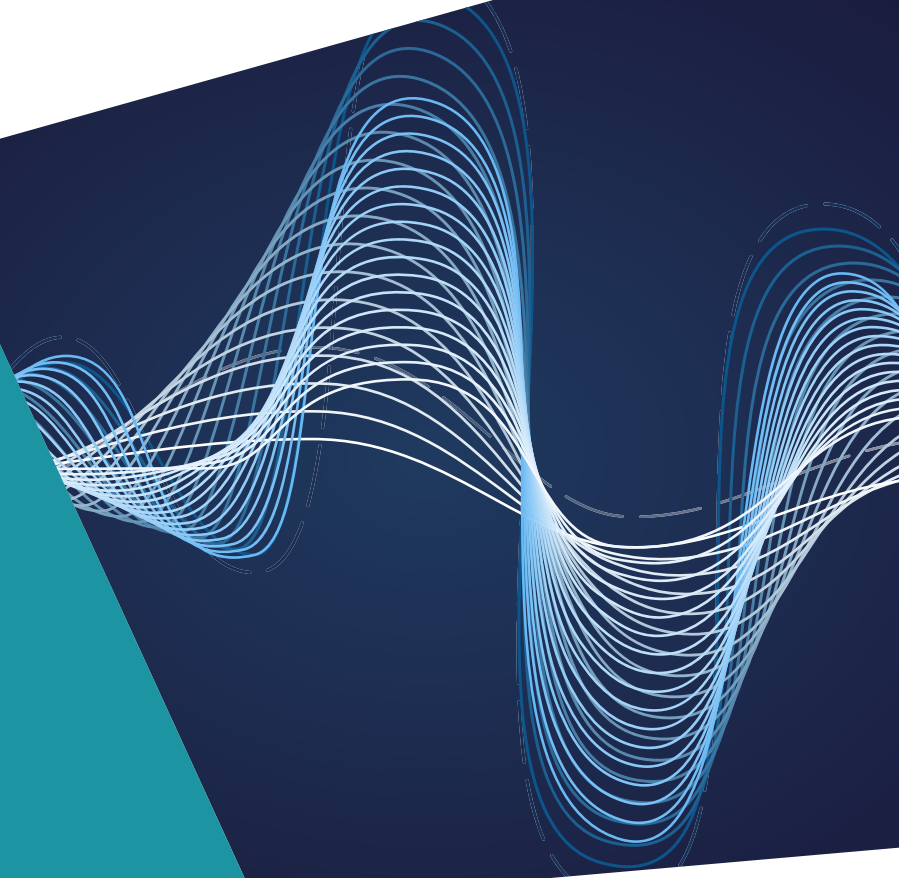




Advancing High Performance Health

White Paper

Making Sense of the Seismic Shifts Affecting Provider Compensation



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

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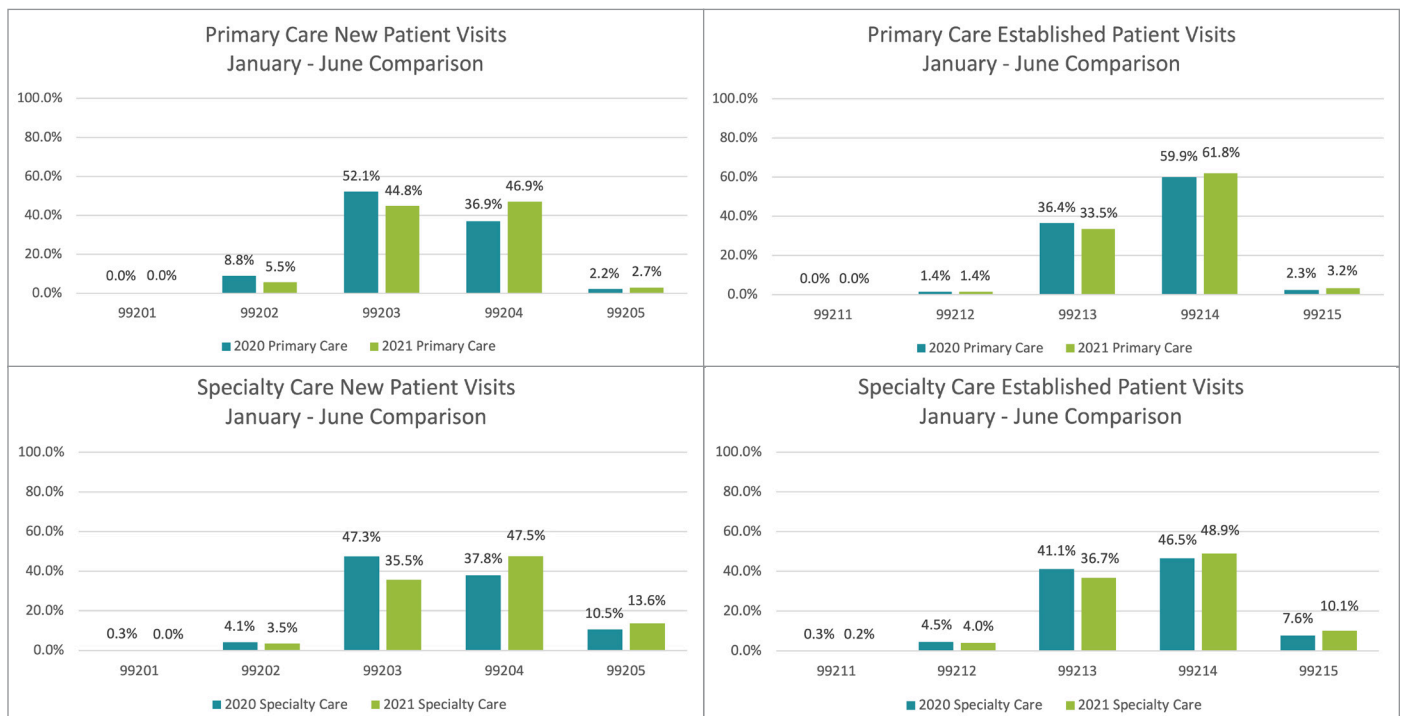


Provider groups across the country have weathered yet another year of turmoil with the presence of the COVID-19 Delta variant, regulatory changes intended to prompt a shift in the value of primary versus specialty care, and unprecedented shortages in staffing. With complete benchmarking data now available from 2021¹, many groups may feel at an impasse when it comes to the application and utilization of this data, given the dramatic impact of COVID-19 coupled with new evaluation and management (E/M) codes with increased work RVU (wRVU) weights. Numerous factors need to be considered as you execute your compensation plan given these variables. While organizations have utilized the 2019 metrics and the 2020 E/M codes as a stop gap, they will need to determine a more appropriate plan going forward, as simply utilizing 2019 metrics with old wRVU weights will not be sufficient or sustainable in the coming year when determining provider compensation.

What We Know

Because of the CMS coding changes that occurred in 2021, outpatient visit documentation requirements evolved this year in a positive way, reducing the burden on medical providers and providing a clearer, more relevant method of assigning medical decision making. A change in the distribution of new and established office visits was inevitable, but to what degree? Figure 1 shows a 10% increase in level 4 new patient visits in both primary and

Figure 1: Visit Distribution Over Six Months — 2020 Compared to 2021



specialty care. This evolution, combined with the new outpatient E/M weights that went into effect January 2021, means primary care wRVUs are up 27% and specialty care up 24%, but not because of an increase in actual visits.

Last, but certainly not least, we saw the physician fee schedule conversion factor (PFS CF) drop from \$36.09 to \$34.89, which decreased reimbursement across all CPT codes except for outpatient E/M services. Their increased weights, even with the reduced PFS CF, translated to increased reimbursement for outpatient office visits at levels of 18% for primary care and 15% for specialty care.

What Does It All Mean?

If you found the changes a lot to digest, you are not alone. The lack of data and short notice that accompanied many of these changes has left provider groups scrambling. The key takeaway, especially when considering provider compensation, is patient visit volume has not increased, but wRVUs associated with those same visits has increased dramatically. Given that more than 80% of compensation plans nationwide are based on production (wRVUs), providers will be receiving a pay increase that is not matched by reimbursement rates, even if they have a large book of Medicare. The shift in outpatient E/M weights was intended to upset the longstanding paradigm that specialty care commands greater reimbursement than primary care; however, benchmark data will not begin to reflect that shift for another year or more, as preliminary information shows many organizations elected not to adopt the new weights, especially when it came to their compensation plans.

A Way Forward

Primary care providers are predictably anxious to reap the benefits of the increased reimbursement for their core billings. Meanwhile, specialty care providers are not likely to embrace a decrease in compensation. The good news is there are ways to account for the changes in your total cash compensation (TCC) and begin a transition that considers both parties. The following is an example of how organizations could choose to address the issue. The formulaic approach below starts with 2019 group-level data and the assumption that the annual escalation rate for compensation is 2.5%. This methodology allows for an annual increase in compensation that we have typically seen from year to year, while at the same time not inadvertently applying market metrics in a manner that would result in overpayment and threaten an organization’s financial well-being.

Step 1: Calculation of the Dollar per Unit

$$\frac{2019 \text{ TCC paid escalated X2 years} / 2019 \text{ wRVUs} = \mathbf{2019 \$ per unit}}{2019 \text{ TCC paid escalated X2 years} / 2020 \text{ wRVUs (new weights)} = \mathbf{2020 \$ per unit}}$$

When determining the 2020 wRVUs, we utilized the calculated increase weights of 27% for primary care and 24% for specialty care and then applied that to the percentage of codes that were outpatient E/M services in place of the exact numbers.

Step 2: Calculation of the % Adjustment Factor

$$\frac{2019: \$ per unit}{2020: \$ per unit} = \% \text{ Adjustment Factor}$$

For the next two steps, it is important that it is done in the order noted at the *specialty level*.

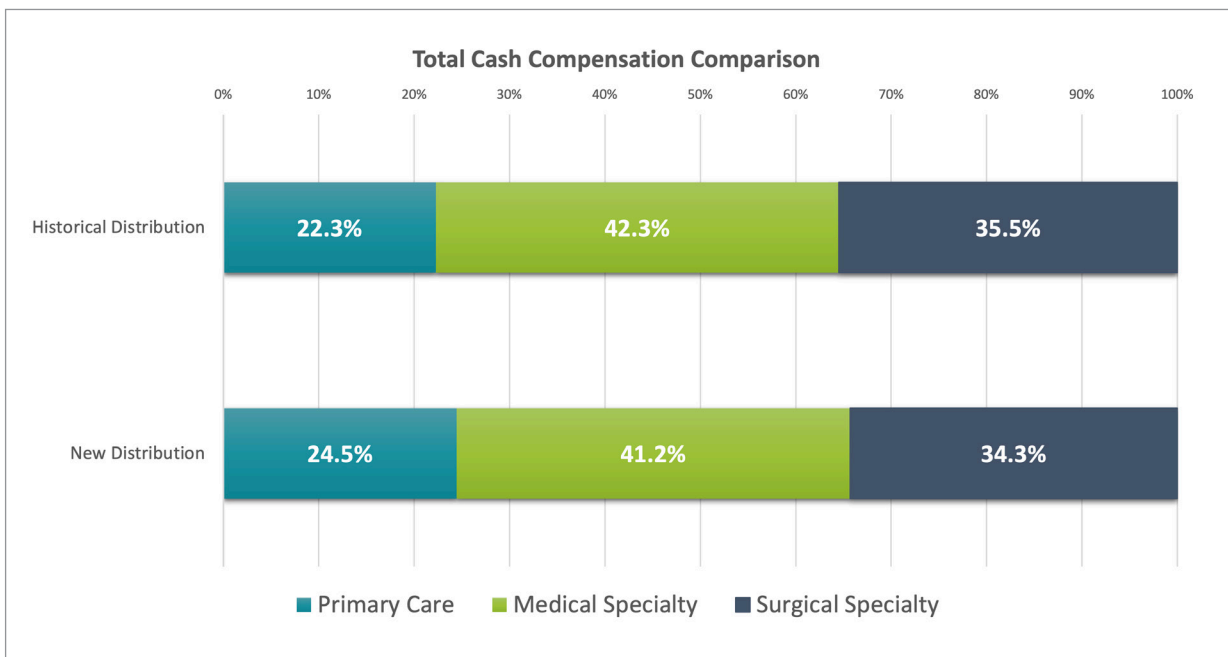
Step 3: Calculation of Compensation Plan Dollar per Unit by Specialty

$$2019 \$ \text{ per unit} * 1.05 = \text{Inflated } \$ \text{ per unit}$$

$$\text{Inflated } \$ \text{ per unit} * \% \text{ Adjustment Factor} = \text{Compensation Plan } \$ \text{ per unit}$$

Step 4: Utilize the newly determined specialty level compensation plan “\$ per unit” as the multiplier against your 2020 wRVUs to arrive at a new TCC. When we applied this approach to sample groups, we saw the type of change in distribution represented in Figure 2, which is a step toward recognizing the paradigm shift CMS intended. This approach also allowed for reasonable and sustainable compensation increases using current market data.

Figure 2: Compensation Shift Under Proposed Methodology



There are certainly other approaches to reworking provider compensation, given the various factors impacting production and reimbursement. Regardless of which approach you take, we strongly recommend engaging your compensation committee from the beginning to assure transparency and foster provider buy-in.

No End in Sight

Every year, the need for CMS to achieve budget neutrality means a variety of possible changes. In 2022, CMS is further reducing the PFS CF by \$1.30. This only reinforces the notion that modeling and evaluating your provider compensation and contracts on an ongoing basis is critical to financial sustainability. Staying one step ahead in today's climate has become essential.

Final Thoughts on Compensation Oversight

In order to manage provider compensation and provide for compensation oversight during these turbulent times, we recommend an organization build and utilize the right approach (toolkit). Without the ability to utilize developed tools and processes, organizations risk paying amounts not aligned to the market, payment amounts that could create financial hardships, or underpayment that will threaten provider recruitment and retention. We suggest developing the tools referenced in the Toolkit box in order to ensure you have the capability to manage this important aspect of your organization.

TOOLKIT

- Key annual surveys
- Charted annual inflation
- Impact by physician by specialty of E/M coding
- Percent of E/M codes by specialty
- Percentile increase from increased weights
- Compensation philosophy
- Compensation committee

References

1. AMGA's *2021 Medical Group Compensation and Productivity Survey* and *2021 Medical Group Operations and Finance Survey*. Visit amga.org/performance-improvement/best-practices/benchmarking-surveys.



Kelsi O'Brien, M.H.S.A., is a director at AMGA Consulting. Her areas of expertise include compensation plan design, operations optimization and improvement, change management and provider utilization. Kelsi brings over 10 years of healthcare experience to the team. She has worked with provider organizations of various sizes and scope from across the country. kobrien@amgaconsulting.com

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One Prince Street
Alexandria, VA 22314-3318

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