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Healthcare Consulting | Valuation

In December 2020, the Centers for Medicare and Medicaid Services ("CMS") issued the 2021 Medicare Physician Fee Schedule ("PFS") final rule that implemented the most substantial changes in many years. Health systems that employ physicians were left scrambling to understand how the changes would impact both revenue and physician compensation. Part 1 of this series will recap the core issues and the scope of the impact. Subsequent articles will address more specific implications on primary care physicians and office-based medical specialties, surgical specialties, and hospital-based specialties. We will provide practical steps health systems can take to address both the economic and regulatory implications of these drastic PFS changes.

What is the problem?

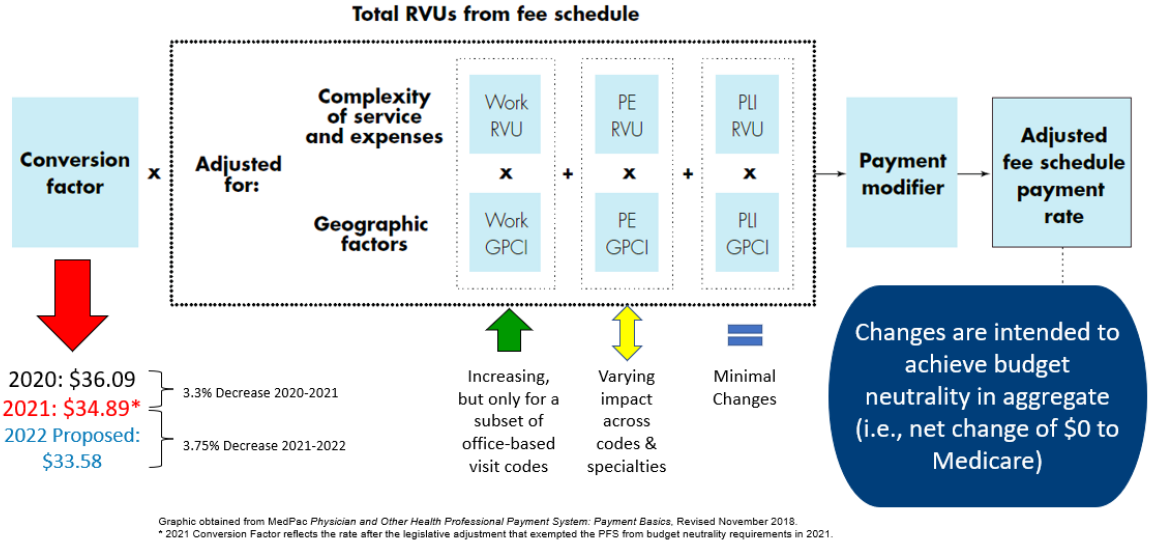
You might be wondering, "why should I care about this?" On the surface, it may not seem like a big deal. CMS releases a new physician fee schedule every year, and even if there are some things that shift, it all washes in the end, right? Since the fee schedule is required to be budget-neutral, it's reasonable to expect that should be the case, and most years that's true. However, as we'll discuss in more detail, there are two big reasons why the 2021 change is different and why health system executives need to be concerned.

Economic Viability

Regulatory Compliance

Background

Before we launch into these concerns, let's provide a quick refresher on how physician services are reimbursed by Medicare. The CPT code for each service is assigned Relative Value Units (RVUs) that are comprised of three parts: Work RVUs that are intended to reflect the time and complexity to perform the service by the licensed provider, Practice Expense ("PE") RVUs intended to reflect the expenses (supplies, equipment, clinical support staff, overhead, etc.) associated with providing the service, and a Professional Liability Insurance ("PLI") component to capture the cost of malpractice insurance connected with the service. Medicare reimbursement for professional services is generally determined by multiplying the applicable RVU amounts for billed services by the Conversion Factor in place on the date the service was rendered (adjusted for the Geographic Pricing Cost Index "GPCI" for the specific locality), as illustrated in the chart below.



Graphic obtained from MedPac *Physician and Other Health Professional Payment System: Payment Basics*, Revised November 2018.
* 2021 Conversion Factor reflects the rate after the legislative adjustment that exempted the PFS from budget neutrality requirements in 2021.

The 2021 PFS significantly increased the value attributed to office evaluation and management (E&M) visits by increasing the Work RVUs assigned to those codes. The most commonly used E&M codes increased from 7% to as much as 46%[i]. However, to achieve this shift and still stay within the bounds of budget neutrality, there was a corresponding decrease in the conversion factor used to determine reimbursement. The reduced conversion factor is applied to **all** physician services. This mitigates the reimbursement impact of the increased value of office E&M visits, and actually reduces reimbursement for other services. If health systems don't assess the impact of the changes on the expected reimbursement stream and continue to pay physicians at historical levels, they risk incurring losses that could be substantial.

The conversion factor for 2021 was ultimately adjusted as a result of legislation enacted December 27, 2020. This law[ii] exempts the PFS from budget neutrality requirements for 2021 in response to providers' concerns about a decrease in reimbursement as they continue to deal with repercussions of COVID-19. The adjustment resulted in a net reduction of only 3.3% from the 2020 conversion factor rather than the more than 10% reduction reflected in the final rule. However, while the adjustment helps to mitigate the revenue impact of 2021 PFS changes this year, it does not eliminate the economic viability and regulatory compliance concerns. Further, the legislation explicitly states that the waiver applies only for 2021, and that the adjustment should NOT be taken into account when payment amounts are established for services furnished after 2021. Accordingly, the CY 2022 PFS Proposed Rule released by CMS in July 2021 includes a proposed conversion factor of $33.58, which reflects a 3.75% decrease from the 2021 conversion factor. Additionally, the 2% Medicare sequester is scheduled to resume in 2022 after being suspended during the pandemic, which will reduce Medicare reimbursement rates even further.

Economic Viability

So back to the initial question – why should you care? Whether you employ physicians or are a physician yourself, it is critical for you to understand how your practice will be impacted financially by the PFS changes.

For starters, some specialties are likely experiencing an overall reduction in revenue for services provided to Medicare patients. This is particularly true for specialties that tend to have relatively few office visits. However, even physicians who are expected to see an increase in Medicare revenue likely won't have enough of an increase to offset the increase in compensation that will be paid if contract terms are not adjusted. Why? Because most employed physicians have a significant production-based component to their compensation. Due to the significant increase in RVUs attributed to office E&M visits, a physician who performs exactly the same amount of work as in the prior year could end up with considerably more compensation if they are paid a fixed dollar amount per Work RVU, which is quite common. Additionally, even if Medicare reimbursement increases, commercial payers won't necessarily follow. All this has a compounding effect that can result in significant losses if left unchecked. Let's illustrate:

	Current	Impact Based on Proposed 2021 CMS Changes	Increase (Decrease)	% Increase (Decrease)
wRVUs	**10,250**	**12,162**	**1,912**	**18.65%**
Fee for Service Revenue	$ 683,130	$ 742,905	$ 59,775	8.75%
Other Revenue	-	-		
Revenue	**$ 683,130**	**$ 742,905**	**$ 59,775**	**8.75%**
Provider Compensation	**$ 543,652**	**$ 664,081**	**$ 120,428**	**22.15%**
Net Income (Loss) before Provider Benefits & Non-Provider Expenses	**$ 139,478**	**$ 78,824**	**$ (60,654)**	**(43.49%)**

Impact to work RVUs for primary care specialties will vary based on service mix.

Impact to reimbursement for primary care specialties will vary based on service mix and payer mix.

Impact to provider compensation is dependent on portion of compensation tied to Work RVUs and structure of Work RVU-based compensation.

In this example, a physician is expected to see a **19% increase in wRVUs** based on historical volume and service mix. However, this translates to only a **9% increase in revenue** due to the payer mix. Due to the physician's compensation structure, which actually pays increasing dollar amounts for increasing tiers of production, the compensation under the 2021 PFS, for exactly the same volume and mix of services as performed historically, would increase by **22%**. Accordingly, the employer would incur a loss of over $60,000 by paying out more in additional compensation than they received in additional revenue. Multiply this by the hundreds of physicians that many health systems employ, and you can begin to appreciate the magnitude of the issue. While the example above is fictitious, it is based on realistic numbers and is reflective of what we are actually seeing as we work with our own clients on what the impact would be if left unchecked.

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Regulatory Compliance

Another important factor to consider is whether physician compensation will be considered fair market value (FMV) and commercially reasonable, as required by the Stark Law exception for employment relationships[iii], if no changes are made to the compensation structure or rates. Physicians on a Work RVU-based production model stand to make considerably more under the 2021 PFS for performing exactly the same volume and mix of services as they performed historically. Remember, the example in the previous section showed the physician would receive more than a 22% increase in compensation without performing any additional work or changing the complexity of the service mix. If the compensation increase outpaces the revenue increase, that calls into question whether it's a "sensible" arrangement as commercial reasonability requires[iv].

Because of all the changes, FMV assessments will become more and more complex for the next few years. Often, compensation and production surveys are utilized to demonstrate that a particular arrangement is representative of FMV. For example, valuators look for alignment in a physician's production (i.e., Work RVU) levels to see if that percentile correlates with the percentile for the compensation that would result from the terms of the compensation agreement. Another option is to look at surveys to see whether the aggregate compensation per Work RVU resulting from the terms of the compensation agreement correlate to market norms as reflected in surveys. However, the surveys are expected to be unreliable for at least the next two to three years. The 2021 surveys are based on 2020 data, which is distorted as a result of COVID-related factors that impacted both productivity and compensation levels. For example, production volumes were suppressed due to stay-at-home orders and suspension of elective procedures, which impacted various parts of the country at varying magnitudes and for varying lengths of time. Some employed physicians continued to receive fixed compensation during the public health emergency, while others were furloughed, and many independent physicians suffered significant losses as they continued to incur expenses while revenue drastically declined. This all makes the 2021 surveys fairly unreliable as a reference point for FMV, even without the PFS change. When 2022 surveys (based on 2021 data) are released, we expect to find similar distortion given the different tactics provider organizations utilized in 2021 in connection with the 2021 PFS. Many systems delayed the adoption of the 2021 PFS for purchases of calculating physician compensation in 2021, and instead maintained the 2020 PFS, so reported production and revenue will be based on the 2021 PFS while physician compensation will be reflective of 2020 Work RVUs for the services performed. This will be mixed in with practices that chose to adopt the 2021 PFS, either with or without changes to physician compensation terms. We expect 2023 surveys based on 2022 data to be the next reliable survey information.

Now What?

To help you better understand the implications for your organization, JTaylor will be publishing a series of articles to take a closer look at how various specialties are expected to be impacted by the 2021 PFS. The series will include:

- ***Part 2*** – The "Winners"
- ***Part 3*** – Surgical Specialties
- ***Part 4*** – Hospital-Based Specialties.

Each of these categories encompasses physician specialties with similar characteristics. Using data analytics applied to an extensive database of historical utilization data from physician practices of various sizes throughout the country, we will provide examples of the expected impact of the 2021 PFS on revenue. Once we identify the revenue impact, we can address practical considerations for physician compensation as you contemplate necessary modifications for your physician contracts to remain both financially viable and in compliance with regulatory requirements.

If you need assistance analyzing your physician employment arrangements or developing a strategy for responding to the 2021 PFS changes, JTaylor's dedicated physician compensation team can help.

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[i] For further information regarding specific changes, refer to *2021 Physician Fee Schedule Changes* published by JTaylor on December 3, 2020.
[ii] "Text - H.R.1865 - 116th Congress (2019-2020): Further Consolidated Appropriations Act, 2020." *Congress.gov*, Library of Congress, 20 December 2019, https://www.congress.gov/bill/116th-congress/house-bill/1865/text.
[iii] 42 CFR § 411.357(c)
[iv] 42 CFR § 411.351