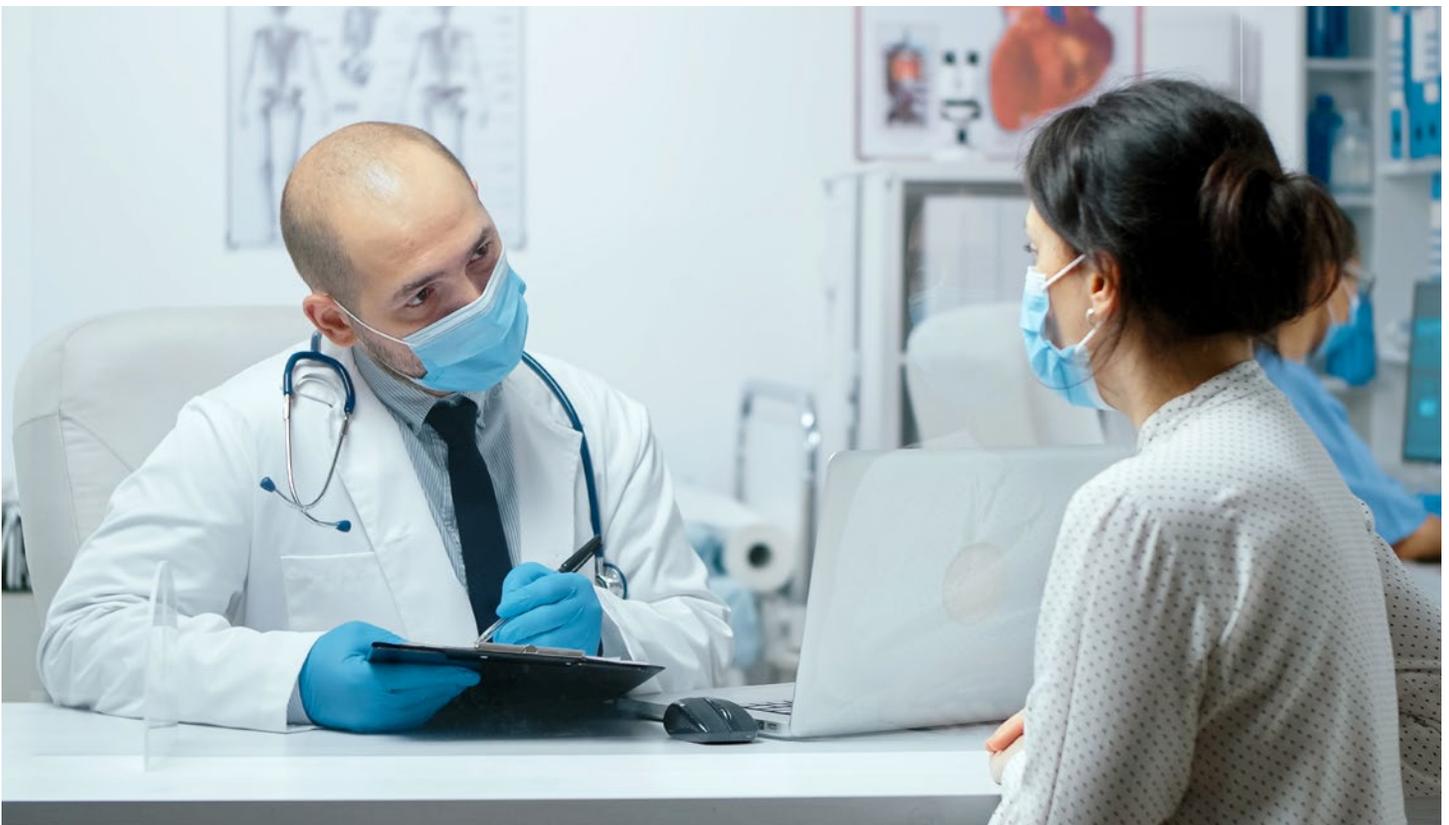




An Executive Briefing on the 2021 MPFS and Its Impact on Hospital Employed Physician wRVU Productivity Models





Introduction

On December 27, 2020, the Consolidated Appropriations Act (CAA) modified the calendar year [2021 MPFS Final Rule](#) released earlier that month by the Centers for Medicare & Medicaid Services (CMS). There are several changes from the CAA and the 2021 MPFS that hospitals and health systems who employ physicians and use a compensation methodology based on wRVUs should carefully consider. Two of the more impactful changes include:

1

WRVUs for the Office and Other Outpatient Services Evaluation and Management (O/O E/M) and certain other relevant services increased on January 1, 2021. For example, the wRVU values for E/M codes 99202 through 99205 (new office visits) increased by a range of 7% to 13%. Perhaps more notably, the wRVU values for E/M codes 99212 through 99215 (established office visits) increased by a range of 28% to 46%.

2

These MPFS changes cumulatively result in overall positive total relative value units for which CMS, by law, created an offsetting adjustment to remain budget neutral. As finalized, the Medicare conversion factor decreased by 3.3% (from \$36.0896 in 2020 to \$34.8931 in 2021) to accomplish the budget neutrality required associated with the wRVU and other fee schedule changes. This decline in the conversion factor impacts all codes in the MPFS. Further, if commercial payer contracts or state Medicaid payer reimbursement models are tied to the current MPFS, changes to the fees or rates for these payers may change too.



Case Study

These changes, as well as others in the MPFS, have the potential to create compliance issues or be very costly for hospitals and health systems that employ physicians. PYA recently helped evaluate the financial impact of these changes for several clients. One was a health system that pays most of their employed physicians based on the number of wRVUs they generate. The analysis for this client was performed on a physician-by-physician basis using individual Current Procedural Terminology (CPT) code utilization for the prior year and then comparing wRVUs and professional collections under the 2021 MPFS (versus the 2020 MPFS). The analysis did not consider any change in Commercial or Medicaid reimbursement, as these contracts were not based on the MPFS.

The analysis revealed three key results:

1

With no change to the current physician compensation methodology, and by using the 2021 MPFS to calculate physician wRVUs, the hospital will incur an incremental loss of approximately \$20,000 per physician this calendar year.

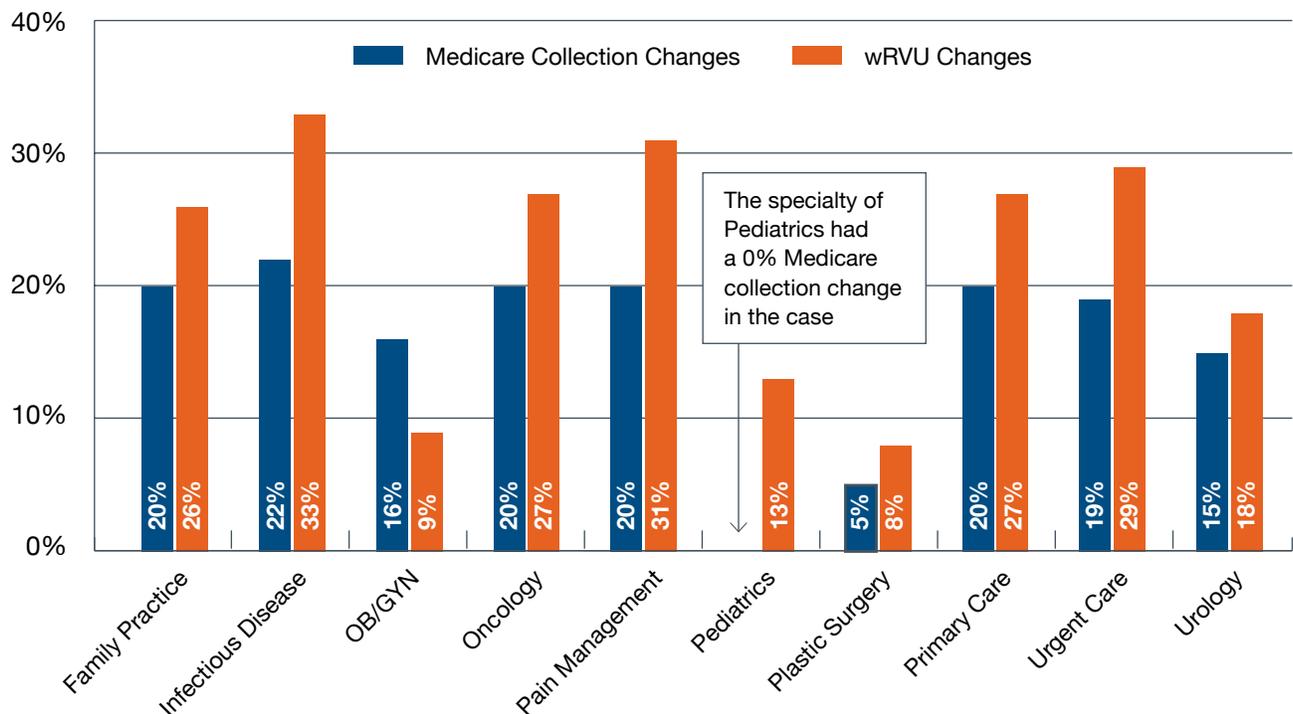
This unbudgeted loss includes the incremental average increase in compensation the hospital will pay to physicians using the wRVUs in the 2021 MPFS less the incremental average increase in Medicare professional collections.

2

Many physicians will earn additional compensation that exceeds their incremental Medicare collections, adding to losses this hospital experiences on their employed physicians. Supplemental losses from implementing the 2021 MPFS ranged from \$0 (for physicians whose compensation was not based on wRVUs) to approximately \$200,000 per physician.

3

Significant percent increases in both wRVUs and total Medicare collections are expected in most specialties. In the majority of instances, the percent change in wRVUs will exceed the Medicare collection changes (or the Medicare collection change may be nominal, or 0%, as was the case for pediatrics in the case study). However, when interpreting this data, it is important to remember that 1) any increase in collections is specific to Medicare only, while this client's compensation methodology (like most other clients) pay physicians based on wRVUs for seeing all patients (i.e. regardless of the payer classification). Thus, there is a gap between collection changes based on Medicare patients only and wRVU changes which are paid for all patients; and 2) what appears to be a significant percent increase in collections across some specialties may not be that large of a dollar increase in collections because of a low percentage of Medicare patients.





What are Our Clients Doing About this Situation?

Although each hospital and/or health system will have its own set of facts and circumstances (e.g., a physician's CPT code frequency and use even in a specific specialty may yield different results, and potentially materially different results), the key takeaways from the client example described above are not unique. ***In fact, PYA has helped and/or held discussions with other hospital and health system clients across the country that indicate implementing the 2021 (vs. 2020) MPFS to calculate wRVUs and then paying employed physicians using that fee schedule will create aggregate losses ranging from a few million dollars to tens of millions of dollars annually.***

Given these results, it is not surprising that we are often asked, “What are your clients doing about this situation?” In response, we offer the following steps and thoughts.

1

If not already completed, perform an analysis comparing the change in Medicare collections to the change in physician compensation under a physician's compensation formula and the use of 2021 (vs. 2020) MPFS wRVUs.

Some physicians, such as those that work on a salary or are hospital-based specialties that work shifts (e.g., hospitalists) may not have any change to their compensation. Alternatively, this type of analysis may lead to potentially six-digit changes in physician compensation for highly productive physicians. These latter results have left many of our clients surprised by their enormity.



2

If the results of the aforementioned analysis are affordable to the hospital or health system, consider any impact on fair market value compensation and commercial reasonableness. For example, suppose there is a hospital employed physician who has historically been paid \$55 per wRVU and is expected to earn another 2,500 wRVUs under the 2021 MPFS (versus the 2020 MPFS). The hospital is incurring a loss on the physician before implementing the 2021 MPFS, and Medicare collections are not expected to change considerably because there is little to no Medicare in the physician's payer mix. In this case, it is important to consider whether paying the physician another \$137,500 annually would be fair market value and commercially reasonable.

While the determination of what is, or how to determine fair market value and commercial reasonableness is outside the scope of this briefing, part of the answer to this question may be in [the new Stark regulations that became effective January 19, 2021](#). In those regulations CMS emphasized, *“a hospital may not value a physician’s services at a higher rate than a private equity investor or another physician practice... Put another way, the value of a physician’s services should be the same regardless of the identity of the purchaser of those services.”* This guidance may help one begin to analyze the incremental impact of the wRVU and reimbursement changes under the 2021 MPFS on physician compensation. In other words, and as a starting point for considering the incremental impact of the 2021 MPFS on a hospital-employed physician’s compensation (where the compensation for this physician is based on a wRVU productivity model), it may be worthwhile to evaluate how the 2021 MPFS changes will impact physician compensation in a private practice. In the example cited above, if this physician was in private practice, because collections did not materially change, one might expect little to no change to the physician’s total compensation, all other factors being equal.

3

Consider the tactics below to help mitigate any potential financial or compliance issues that may arise.

- a. *Maintain the use of the 2020 wRVU values in 2021* — Many PYA clients are pursuing this strategy, some without choice simply because they cannot afford the financial impact on their hospital or health system. Those that find themselves in this situation have begun comprehensive physician educational programs and/or are sharing data with the physicians regarding the financial impact of the 2021 MPFS to their hospital/ health system. These clients have also begun tracking wRVUs using the 2021 MPFS so a comparison can be made to the 2020 wRVU values using the CPT code utilization in 2021. They believe such data will be helpful in preparing for any potential implementation of the 2021 MPFS later. In addition, they have also cited the importance of tracking this data for evaluating other issues such as potential changes in physician coding behavior under the 2021 MPFS, which may be difficult to model at this time.
- b. *Implement the 2021 MPFS wRVU values and address individual physician agreements which may be problematic.* Some employment agreements contractually require the use of the most recent MPFS. In this scenario, a hospital or health system may not have a choice whether to pay physicians using the wRVUs in the 2020 versus 2021 MPFS. If this situation occurs, it may be helpful to perform an impact analysis (as described earlier) and then re-evaluate fair market value compensation and commercial reasonableness for physicians who stand to have changes (and, in some instances, a material change) in their compensation.

For those physicians whose fair market value and commercial reasonableness analysis identify a potential problem, our clients have generally been addressing this subject by using one of two tactics, all other factors besides the change in 2021 MPFS remaining constant. These tactics include:

- i. *Decrease the compensation per wRVU conversion factor in the physician's current employment agreement.* With results such as those previously described, 2021 physician wRVUs may increase more than 2021 physician compensation. When this occurs, physicians may experience a decrease in compensation per wRVU compared to prior periods. And, while it would be helpful to have comprehensive data on this subject now, unfortunately such a potential change will likely not be seen in salary surveys until 2022 (based on 2021 data) or beyond. Regardless, it may be helpful to

explain to a physician that while their compensation per wRVU is decreasing, absent any change in work effort on their part, their total compensation may stay the same as in the prior year, only calculated differently. Said another way, a compensation per wRVU physician compensation methodology is a “means to an end.” And, absent changes (such as a change to the physician’s full-time equivalent status or extended leaves of absence) besides implementing the 2021 MPFS, a physician’s 2021 total compensation may be the same as his/ her total compensation under the 2020 MPFS.

- ii. *Increase the wRVU threshold in physician contracts where one exists.* Many hospital-employed physicians are on a base salary plus productivity model when they meet a certain wRVU threshold. With several CPT codes (such as new and established office visits) experiencing an increase in wRVUs under the 2021 MPFS, some physicians are likely to meet their productivity threshold faster, thus earning additional compensation for which they were ineligible in 2020. Accordingly, some clients are considering an increase in the wRVU threshold associated with current physician compensation formulas to mitigate the impact of implementing the 2021 MPFS in their compensation formula.

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Conclusion

PYA has reviewed the impact from the 2021 MPFS for several clients across the country and is helping many of them navigate this challenge. We also have extensive experience in physician compensation planning, fair market value compensation, and commercial reasonableness.

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