While You Were Sleeping….

Proposed Rule Positioned to Significantly Impact Physician Compensation

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Education Partners for Florida Hospitals

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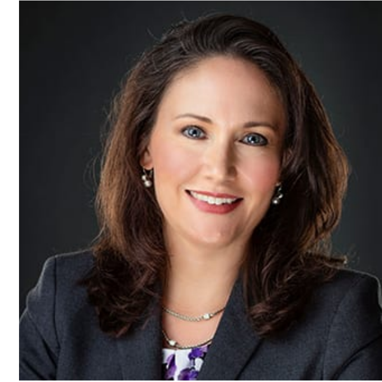

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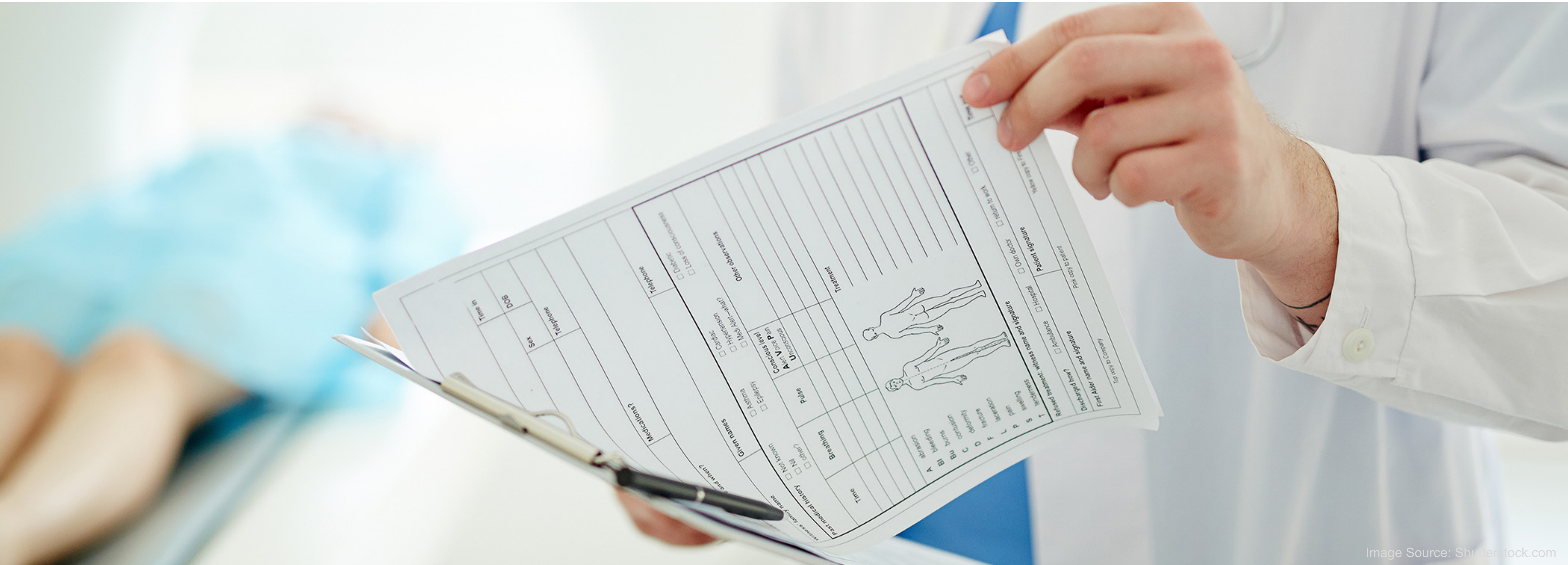
Agenda

Re-Valuing Outpatient E/M Services

Physician Compensation Impact

New E/M Guidelines

1. Re-Valuing Outpatient E/M Services



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Medicare Physician Fee Schedule

- Fee schedule payments established under Section 1848 of the Social Security Act
  - Relative value for the service
    - Work
    - Practice expense
    - Malpractice expense
  - Conversion factor (RVU x CF = national payment rate)
    - Dollar amount based on statutory cap on MPFS spending
    - Sustainable Growth Rate replaced in 2015 by MACRA annual adjustment factor
  - Geographic adjustment factor
    - Reflects variation in practice costs between metropolitan and non-metropolitan areas between and regions
    - Specific RVU adjustment for each MSA and non-MSA area of state
      - Average = 1 (i.e., if Region A = 1.2, then Region B = 0.8)

Rulemaking

- Each summer, CMS publishes proposed rule detailing payments for upcoming calendar year
  - RVU changes, new reimbursement, projected utilization
  - Adjust conversion factor based on budget neutrality
- Following required comment period, CMS publishes final rule effective January 1
- 2021 MPFS proposed rule published August 17, 2020 (572 pages + 25 related downloads)
  - Telehealth, care management services, MSSP, QPP, OUD services, FQHC PPS, NCDs, infusion therapy, Part B drugs, MDPP
  - Comment period closes October 5

2020 Final Rule: RVU Changes + New Reimbursement Effective 01/01/21

Increase wRVUs for Outpatient E/M

HCPCS Code	2019 Work RVU	2021 Work RVU
New Patient Office Visit		
99201	0.48	N/A
99202	0.93	0.93
99203	1.42	1.60
99204	2.43	2.60
99205	3.17	3.50
Established Patient Office Visit		
99211	0.18	0.18
99212	0.48	0.70
99213	0.97	1.30
99214	1.50	1.92
99215	2.11	2.80

New Codes Relating to Outpatient E/M

1. **GPC1X**: Add-on code for established patient outpatient E/M to account for complexity inherent to those services (0.33 wRVU)
2. **99xxx:** Prolonged outpatient E/M beyond the total time of the primary procedure; each 15 minutes (replacing 99358 & 99359) (0.61 wRVU)

“Redistributive Impact”

- “As these office/outpatient E/M visit codes make up around 20 percent of total PFS expenditures, we understand… the magnitude of the redistributive adjustment necessary to budget neutralize the increased values.”
  - Paying more to manage beneficiaries means paying less to do things to beneficiaries
  - Physicians who primarily perform office visits will generate more revenue; physicians who are hospital-based or who primarily perform procedures will generate less
- Options
  - Longer phase-in period
  - Cap increases/decreases
  - Offset with wRVU reduction for specific services
  - Appeal to Congress

2021 Proposed Rule

- No offset to reduce redistributive impact of outpatient E/M changes
- Conversion factor impact
  - 2019 to 2020: 5¢ increase ($36.04 to $36.09) = 0.14% increase
  - 2020 to 2021: $2.83 reduction ($36.09 to $32.26) = **10.61% reduction**
    - If performed same number of RVUs in 2020 and 2021, would receive 10.61% less in reimbursement in 2021

Disparate Impact

2020

- Greatest increase = 4% (clinical social worker)
- Greatest reduction = 4% (ophthalmology)
- Only 9 specialties saw more than a 1% change

2021

- Practitioners in 18 specialties would see 2% or more increase
- Those in 34 specialties would receive 2% or more reduction
- Practitioners in 5 specialties would see a 0 to 1% change in their reimbursement

Biggest Winners	Medicare Reimbursement Increase	Biggest Losers	Medicare Reimbursement Decrease
Endocrinology	17%	Radiology	-11%
Rheumatology	16%	Cardiac Surgery	-10%
Hematology/ Oncology	14%	Interventional Radiology	-9%
Family Practice	13%	Pathology	-9%
Allergy/ Immunology	9%	Anesthesiology	-8%
OB/GYN	8%	Critical Care	-8%
Psychiatry	8%	General Surgery	-7%

2. Physician Compensation Impact

Impact - Independent Medical Specialists

- Direct impact to bottom line
- Increase in Medicare reimbursement if primarily an E/M practice
- Potential increase in other payer reimbursement, if other payers utilize reference pricing
- Additional reimbursement could help expand capacity for high risk and rising risk patients, thus increasing ability to participate in value-based models

Impact - Independent Proceduralists

- Direct impact to bottom line
- Decrease in Medicare reimbursement
- Potential decrease in other payer reimbursement, if other payers utilize reference pricing
- 3 options:
  1. Do more procedures / grow market share
  2. Reduce expenses
  3. Pursue value-based payments

Impact - Employed or Contracted Physicians

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Contractual conversion factor <u>does not change</u> (unless contract subsequently amended or renegotiated)

- Medical specialists –
  - Increased Medicare reimbursement for the physician's E/M services
  - The same amount of work now will produce more wRVUs
  - Employer will pay the physician more compensation for the same amount of work
  - The incremental financial loss is limited to the amount the contracted conversion factor exceeds the actual reimbursement per wRVU received

Impact - Employed or Contracted Physicians

- Proceduralists –
  - Overall decreased Medicare reimbursement
  - Some increase in total wRVUs due to increase in the RVUs for office/outpatient E/M codes (but far less than medical specialists who provide these services more regularly)
  - Compensation would not be dramatically impacted, as wRVUs will marginally increase and contracted conversion factor will remain the same
- Don’t forget anesthesia –
  - Proposed conversion factor will decline from $22.20 per ASA unit to $19.96 per ASA unit
  - Impact to financial assistance subsidies caused by potentially lower collections

Contract Review Challenges

- Benchmark survey data tied to the compensation conversion factor will not fully reflect these impacts for another 2-3 years given normal timing lags in survey data and the varied rate with which contract modifications occur
  - It may be 2023 (based on 2022 data) before benchmark surveys have stabilized from the impact.
- Documentation surrounding commercial reasonableness
- Consider compensation structure alternatives
  - Incentivize for managing high-risk and rising-risk patients
  - Reduce healthcare costs
  - Improve patient outcomes

Specialty Impact Analysis – Example "Medical Specialists"

Assumptions

- Productivity-based compensation model
- Top 10 CPT codes by specialty
- Median benchmark data (4 surveys)
- Estimated Medicare payer mix using data from 2020 MGMA *Cost Survey*
- No reference pricing for other payers

Takeaways

- Collections increase is not enough to offset compensation increase.
- How does the compensation increase impact your FMV/CR analysis?

	Family Practice	Internal Medicine	Neurology	Psychiatry	Urology
Estimated Collections Increase	$10,323	$1,021	$3,898	$1,922	$2,603
	2.28%	0.24%	1.06%	0.93%	0.38%
Estimated Compensation Increase	$53,660	$31,928	$44,692	$39,476	$42,463
	20.56%	11.70%	14.44%	14.58%	8.81%
Calculated Compensation to Collections Ratio - Current	57.63%	63.20%	83.86%	130.39%	69.53%
Calculated Compensation to Collections Ratio - Proposed Rule	67.93%	70.43%	94.96%	148.03%	75.37%
Variance of Unadjusted and Adjusted Ratios	-10.30%	-7.23%	-11.10%	-17.64%	-5.84%

Specialty Impact Analysis – Example "Proceduralists"

Assumptions

- Productivity-based compensation model
- Top 10 CPT codes by specialty
- Median benchmark data (4 surveys)
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- No reference pricing for other payers

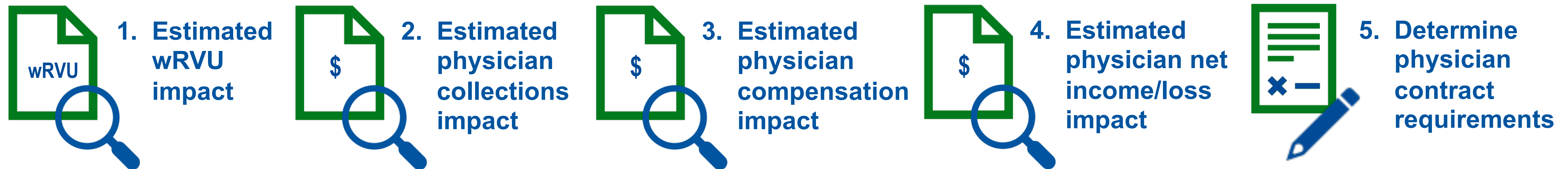
Takeaways

- Collections decreases coupled with compensation increases reduce margin available for overhead expenses.
- How does this change impact your FMV/CR analysis?

	Cardiology	Diagnostic Radiology	Gastroenterology	General Surgery	Interventional Radiology	Opthalmology	Orthopedic Surgery
Estimated Collections Decrease	-$3,794	-$28,687	-$14,311	-$10,056	-$35,831	-$34,060	-$28,182
	-0.68%	-4.29%	-2.12%	-1.99%	-5.45%	-4.39%	-3.63%
Compensation Difference	$46,075	$0	$20,373	$16,207	$0	$1,626	-$10,409
	8.95%	0.00%	3.95%	3.61%	0.00%	0.40%	-1.60%
Calculated Compensation to Collections Ratio - Current	91.76%	78.74%	76.58%	88.85%	84.82%	52.85%	83.55%
Calculated Compensation to Collections Ratio - Proposed Rule	100.65%	82.27%	81.33%	93.92%	89.71%	55.50%	85.30%
Variance of Unadjusted and Adjusted Ratios	-8.89%	-3.53%	-4.75%	-5.07%	-4.89%	-2.65%	-1.75%

Physician Compensation: Next Steps

Focus on physician specialties with greater risk of material impact, if necessary, and assess the following:



Using this data, determine:

- ✓ Do any agreements require adjustment to ensure compensation is fair market value?
- ✓ Do any agreements require adjustment to ensure compensation is commercially reasonable?
- ✓ Are operational losses sustainable?
- ✓ Plan for modifications, if any.

3. New E/M Guidelines

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2021 E/M Guidelines History: How Did We Get Here?

- CMS' and the AMA's collaboration has resulted in:
  - Revised Outpatient E/M code descriptions in the 2021 CPT Manual (99202-99215)
  - 2021 E/M Guidelines published in 2021 CPT Manual effective January 1, 2021
    - MDM and Time redefined
  - Omission of CPT Code 99201
  - Revised Work Relative Value Units (wRVUs)
- No other E/M code set guidelines have been changed at this time; however, some other ranges' values have been proposed to increase.
- Since the change is in CPT, impact will be industry-wide.

2021 E/M Changes: Key Elements

Eliminated history and physical exam as elements for code selection

Modified MDM criteria with focus on tasks affecting management of patient conditions

Allows providers to choose to select code based on MDM or Total Time

2021 E/M Changes: Reimbursement

CMS 2020 Final Rule: Changes for E/M Visits 2021[1]

- Maintain separate payment rate for all E/M levels
- Deletion of E/M code 99201
- Addition of add-on codes:
  - 99XXX: Prolonged E/M services (15-minute increments)
  - GPC1X: E/M complexity of care of ongoing complex conditions

TABLE 16: Summary of Codes and Work RVUs Finalized in the CY 2020 PFS Final Rule for CY 2021

HCPCS Code	Current Total Time (mins)	Current Work RVU	CY 2021 Total Time (mins)	CY 2021 Work RVU
99201	17	0.48	N/A	N/A
99202	22	0.93	22	0.93
99203	29	1.42	40	1.6
99204	45	2.43	60	2.6
99205	67	3.17	85	3.5
99211	7	0.18	7	0.18
99212	16	0.48	18	0.7
99213	23	0.97	30	1.3
99214	40	1.5	49	1.92
99215	55	2.11	70	2.8
99XXX	N/A	N/A	15	0.61
GPC1X	N/A	N/A	11	0.33

1. 84 Fed. Reg. 62,568 (Nov. 15, 2019)

CMS G-Code

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- The 2020 MPFS Final Rule adopted an add-on G-code to indicate E/M complexity of primary care and specialty care of ongoing complex conditions.
- The 2021 MPFS Proposed Rule requests comment to help clarify the definition of this code.
  - **GPC1X**: *Visit complexity inherent to E/M associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious, or complex chronic condition.*
    - *Add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established*
    - Not restricted to a specialty
    - Distinct from preventive and care management services

CMS G-Code

"…we believe HCPCS add-on code GPC1X reflects the time, intensity, and PE when practitioners furnish services that enable them to build longitudinal relationships with all patients (that is, not only those patients who have a chronic condition or single high-risk disease) and to address the majority of patients' health care needs with consistency and continuity over longer periods of time."[2]

2. 85 Fed. Reg. 50,138 (Aug. 17, 2020)

2021 E/M Changes: Preparation

Identify project lead

- Assign lead responsible for staff education, review of internal policies/procedures, and financial tracking.

Schedule staff preparation time

- Schedule training.
- Plan in-person/video meetings to discuss changes, implementation, and any provider or staff questions/concerns.

Update protocols

- Update procedures/protocols to correspond to new guidelines.
  - *Note: Do not eliminate references to 1995/1997 guidelines still in effect for other code ranges.*

Consider coding support

- Review and update coding resources to support correct coding.

2021 E/M Changes: Preparation

Be aware of malpractice liability

- Providers should continue to carefully document services being rendered to mitigate malpractice implications.

Guard against fraud and abuse

- Health systems should continue to perform monitoring and auditing to address refund obligations from over-coding.
- Coding auditors should update audit tools to match guidelines.

Update compliance plan

- Compliance officers should update current policies and procedures and include these codes in the audit workplan.

Evaluate EHR

- Administrators should confirm EHR schedule and plans for implementing E/M code changes, if any.

2021 E/M Changes: Preparation

Assess financial impact

- Perform gap analyses to determine whether any financial impact will result from code level selection changes per the new guidelines and the value changes by CMS.
- Consider provider compensation impacts relevant to wRVU and code utilization changes.

Confirm other payer requirements

- Be aware of specific self-funded plan, other governmental, and commercial payer requirements above and beyond the CMS changes and interpretations of the guidelines.

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How can we HELP?

A national healthcare advisory services firm providing consulting, audit, and tax services