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Implications of CMS RVU Changes on Provider Compensation, Survey Benchmarks, and Compensation Plan Methodologies

MARIA HAYDUK, AURORA YOUNG, AND KATHY BUELL

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Market Dynamics

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Survey Benchmarks Overview: Key Demographics

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Benchmark comparisons in this presentation are derived from ECG's *Physician and APP Compensation Surveys*, as well as a blended benchmark that includes ECG, MGMA, and AMGA.

Key Demographics of 2022 Benchmark Sources

	ECG	MGMA	AMGA
Number of Providers	103,000	192,000	183,000
Physician Specialties	178	220	146
More than 150 Physicians	95%	63%	91%
RVU Calculation Methodology	Calculated from Provider-Level CPT Data	Self-Reported	Self-Reported

ECG and AMGA reported WRVUs and compensation per WRVUs in 2022 under both the 2021 and 2020 MPFS.

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COVID-19 and MPFS Changes

Data collected in the 2022 surveys represents FY 2021 provider performance. Each medical group's COVID-19 experience in 2021 varied depending on internal and external factors, which affected provider performance. As such, compensation and production benchmarks across markets were heavily influenced by recovery from the COVID-19 health emergency. Compounding these events are the release of the 2021 CMS MPFS RVUs.

COVID-19 Health Emergency

The pandemic affected compensation, production, and benefits. Factors such as the prevalence of COVID-19 cases; hospital, medical group, and government actions; and patient fears had an impact on provider performance.

2021 MPFS Changes

The 2021 MPFS, implemented by Medicare on January 1, 2021, brought significant changes to evaluation and management (E&M) RVU values. Most medical groups use RVUs to calculate physician and APP production and earnings. Adopting the 2021 MPFS for physician and APP compensation calculations should be done in conjunction with reviewing market rates to avoid unintended consequences to earnings and medical group financial performance.

Supplemental Benchmarks

As a result of the CMS changes to the MPFS, ECG and AMGA published supplemental WRVU and compensation per WRVU benchmarks to align with survey member incentive methodologies.

It is critical that medical groups refer to industry benchmarks that are calculated consistent with their physician and APP compensation plan calculations.

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2022 Published Benchmarks

In 2022, ECG, MGMA, and AMGA published 2022 benchmarks unadjusted for COVID-19 or the MPFS changes. In addition, ECG and AMGA published supplemental benchmarks using alternative MPFSs for survey member use.

2022 Benchmarks (2021 MPFS)

- Provider compensation and production benchmarks unadjusted for COVID-19 or MPFS changes
- 2022 RVU and RVU rate benchmarks reported utilizing the 2021 MPFS
- ECG, MGMA, and AMGA

2022 Benchmarks (2020 MPFS)

- 2022 RVU and RVU rate benchmarks reported utilizing the 2020 MPFS by ECG and MGMA
- RVU and RVU ratios calculated by ECG by applying the 2020 MPFS to 2021 provider CPT code production data included in the 2022 survey
- AMGA supplemental data; self-reported

2020 Benchmarks (2021 MPFS)

- 2020 RVU and RVU rate benchmarks calculated by ECG by applying the 2021 MFPS to 2019 provider CPT code production data included in the 2020 survey
- ECG only

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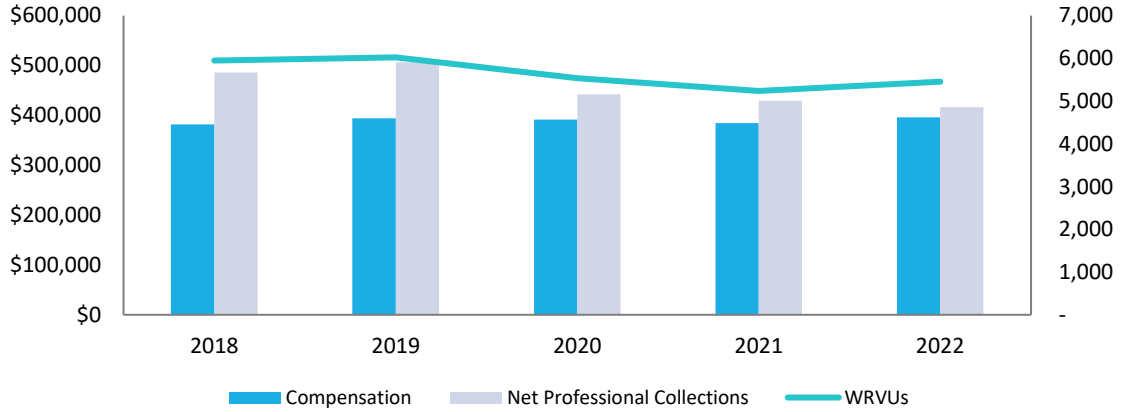
Compensation and Production Trends

Compensation benchmarks, in aggregate, increased from 2021 to 2022 by 3%–4%. Conversely, WRVU-adjusted compensation medians decreased over the same period by 5.1%–5.7%. However, WRVU median changes varied significantly across surveys as a result of reporting methodology differences.

Compensation and Production Median Trends: Physician Adult Specialties Only – Blended Surveys



Source: ECG, MGMA, and AMGA 2018 to 2022 physician compensation surveys and reports for illustrative purposes only.

Change in Medians: Physician Adult Specialties Only – Blended Surveys

Metric	Percentage Change	
	ECG 2022 versus 2021	ECG, MGMA, and AMGA Blend
Compensation	4.2%	3.0%
WRVUs	12.0%	4.2%
Net Professional Collections	12.8%	-3.0%
Compensation per WRVU	-5.7%	-5.1%

Source: ECG, MGMA, and AMGA 2021 to 2022 physician compensation surveys and reports.

Changes in the WRVU and net professional collections medians between 2021 and 2022 fluctuated across the various surveys.

Compensation and Production Trends by Specialty Category

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2022 compensation per work RVU medians declined over 2021 survey medians across each specialty category except for hospital-based physicians. When adjusted for the 2021 MPFS, rates increased except within primary care.

2022 Survey (2021 MPFS) versus 2021 Survey (2020 MPFS)

ECG Adult Specialties Weighted Medians

2022 Standard versus 2021 (2021 MPFS)	Hospital Based	Medicine	Primary Care	Surgery	All
Clinical Compensation	3.6%	3.9%	2.9%	3.4%	4.2%
Clinical Compensation per WRVU	2.4%	-7.4%	-15.4%	-1.2%	-5.7%
WRVUs	6.5%	9.7%	24.4%	7.1%	12.0%

2022 Survey (2021 MPFS) versus 2021 Survey (2021 MPFS)

ECG Adult Specialties Weighted Medians

2022 Standard versus 2021 (2021 MPFS)	Hospital Based	Medicine	Primary Care	Surgery	All
Clinical Compensation	3.6%	3.9%	2.9%	3.4%	4.2%
Clinical Compensation per WRVU	3.8%	3.0%	-0.3%	3.8%	3.3%
WRVUs	5.2%	0.0%	5.0%	1.6%	2.4%

Compensation and Production Trends by Specialty Category *(continued)*

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2022 compensation medians across each specialty category lag behind 2020 survey results. In addition, WRVU medians remain below 2020 (prepandemic levels) except within primary care.

2022 Survey (2021 MPFS) versus 2020 Survey (2021 MPFS)

ECG Adult Specialties Weighted Medians

2022 Standard versus 2020 (2021 MPFS)	Hospital Based	Medicine	Primary Care	Surgery	All
Clinical Compensation	-3.8%	-3.3%	-0.8%	-1.9%	-1.4%
Clinical Compensation per WRVU	15.8%	9.0%	1.1%	11.9%	10.6%
WRVUs	-8.1%	-4.8%	0.3%	-4.5%	-3.6%

MPFS Change Impact on WRVU Benchmarks

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Calculating 2022 WRVU survey medians under the 2020, 2021, and 2022 MPFS applied to CPT code production results in median variances across each specialty category. While medians calculated under the 2021 and 2022 MPFS are similar, there is a measurable difference when using the 2020 MPFS.

2022 WRVUs under the 2020, 2021, and 2022 MPFSs by Specialty Category

Specialty Category	2022 ECG Median WRVUs		
	2020 MPFS	2021 MPFS	2022 MPFS
Hospital Based	5,025	5,101	5,101
Medicine	5,087	5,772	5,771
Primary Care	4,720	5,547	5,549
Surgery	6,981	7,414	7,411
All	5,165	5,781	5,781

Source ECG benchmarks based on 2021 CPT production data from the ECG *2022 Physician and APP Compensation Survey*. Calculated by ECG from provider-level CPT production data.

Specialty Category	2022 AMGA Median WRVUs	
	2020 MPFS	2021 MPFS
Hospital Based	5,115	5,170
Medicine	6,245	6,768
Primary Care	4,525	5,293
Surgery	7,976	8,267
All	5,813	6,200

Source AMGA benchmarks based on the *2022 Medical Group Compensation and Productivity Survey*. Self-reported.

Across all specialty categories, physicians are able to generate more WRVUs under the 2021 MPFS and the 2022 MPFS than they are under the 2020 MPFS without changing practice patterns or volumes.

MPFS Change Impact on Compensation per WRVU Benchmarks

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Compensation per WRVU medians calculated under the 2021 and 2022 MPFS are similar; however, rates calculated under the 2020 MPFS are higher. Applying compensation per WRVU rates to provider WRVUs calculated under an inconsistent MPFS may result in unintended compensation payments.

2022 Compensation per WRVUs under the 2020, 2021 and 2022 MPFSs by Specialty Category

Specialty Category	2022 ECG Median Compensation per WRVUs		
	2020 MPFS	2021 MPFS	2022 MPFS
Hospital Based	$69.85	$68.97	$68.97
Medicine	$76.02	$68.39	$68.48
Primary Care	$58.59	$49.65	$49.65
Surgery	$72.23	$68.57	$68.57
All	$68.40	$62.56	$62.56

Source: ECG benchmarks based on 2021 CPT production data from the ECG *2022 Physician and APP Compensation Survey*. Calculated by ECG from provider-level CPT production data.

Specialty Category	2022 AMGA Median Compensation per WRVUs	
	2020 MPFS	2021 MPFS
Hospital Based	$87.77	$87.26
Medicine	$73.71	$68.23
Primary Care	$66.27	$57.15
Surgery	$78.83	$76.63
All	$80.09	$75.38

Source: AMGA benchmarks based on the *2022 Medical Group Compensation and Productivity Survey*. Self-reported.

To avoid unintended compensation changes, medical groups are adjusting compensation plan rates when they adopt the 2021–2023 MPFS.

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APP Compensation and Production

APP 2022 WRVU survey medians increased by between 9.1% and 16.7% due to the 2021 MPFS implementation. As a result, APP compensation per WRVU medians declined by between -8.7% and -14.1%.

APP WRVU Medians under 2021 versus 2020 MPFS

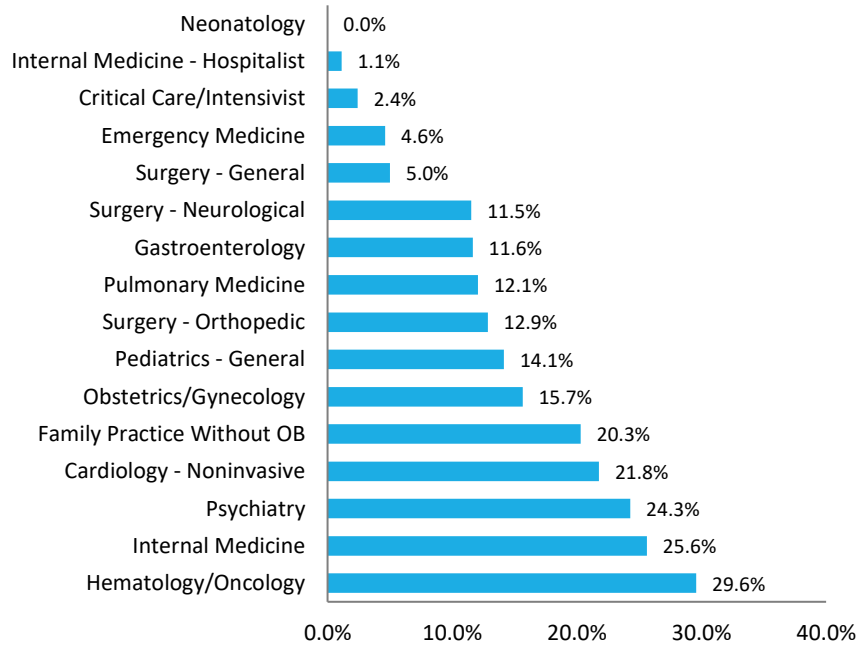
Provider Type	2022 Survey (2021 MPFS)	2022 Survey (2020 MPFS)	% Variance
NP	2,479	2,126	16.6%
PA–Nonsurgical	2,482	2,127	16.7%
PA–Surgical	1,469	1,347	9.1%
APP (NP, PA)	2,347	2,011	16.7%

APP Compensation per WRVU Medians under 2021 versus 2022 MPFS

Provider Type	2022 Survey (2021 MPFS)	2022 Survey (2020 MPFS)	Percentage Variance
NP	$49.15	$57.22	-14.1%
PA–Nonsurgical	$51.85	$58.10	-10.8%
PA–Surgical	$86.89	$95.18	-8.7%
APP (NP, PA)	$53.16	$61.54	-13.6%

Source: ECG *2022 Physician and APP Compensation Survey*.

APP by Specialty WRVU Median % Change: 2020 versus 2021 MPFS



APP WRVU benchmarks are highly dependent on each APP's utilization, roles, and responsibilities.

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CMS 2023 MPFS Final Rule

On November 1, 2022, CMS released the final rule for the MPFS rates in CY 2023. This final rule reflects changes from the proposed rule published in July 2022.

Reduction of the Conversion Factor

- CMS finalized a conversion factor of $33.89, representing a decrease of $0.72 from the CY 2022 MPFS conversion factor of $34.61.

E&M Visits

- Finalized and adopted most of the American Medical Association (AMA) CPT changes in coding and documentation for other E&M visits (hospital inpatient, hospital observation, emergency department, nursing facility, home or residence services, and cognitive impairment assessment)
- Finalized the creation of Medicare-specific coding for payment of other E&M prolonged services (will be reported with three separate Medicare-specific G codes)

Split (or shared) Visits

- Finalized a one-year delay of the split (or shared) visits policy for E&M visits
- Clinicians who furnish split (or shared) visits to continue to have a choice of history, physical exam, or medical decision-making, or more than half of the total practitioner time spent to define the “substantive portion” instead of using total time to determine the substantive portion

Telehealth Services

- Finalized proposal to extend the duration of time that services are temporarily included on the telehealth services list during the Public Health Emergency (PHE) for at least a period of 151 days following the end of the PHE
- Finalized the proposal to allow physicians and practitioners to continue to bill with the place-of-service indicator that would have been reported had the service been furnished in person

MPFS Change Impact on Benchmarks: 2023 MPFS

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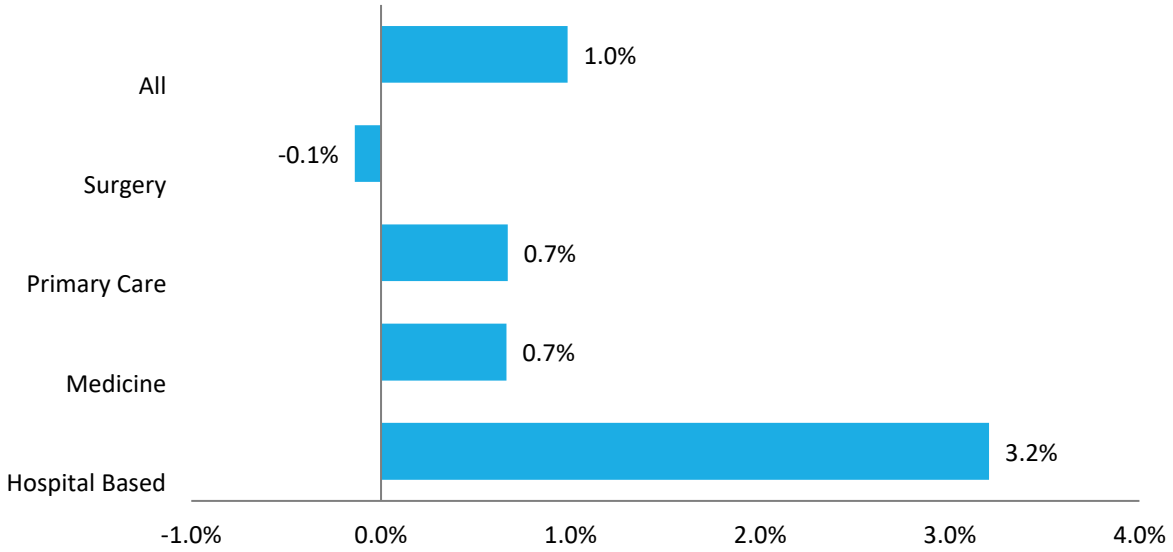
The 2023 PFS changes are projected to deliver another material impact in WRVUs, particularly for specialties for which production is driven by inpatient E&M codes.

WRVU Median Impact by Specialty Category



WRVU Median Impact: Select Hospital-Based Specialties

Select Specialty	Projected WRVU % Change
Internal Medicine–Hospitalist	8.4%
Emergency Medicine	0.0%
Neonatology	0.2%
Pulmonary Medicine–Critical Care	2.8%
Critical Care/Intensivist	2.0%
Family Medicine–Hospitalist	8.7%

For organizations with productivity-based models, a review of current compensation models and structures is imperative to plan for the projected impact to WRVUs in 2023.

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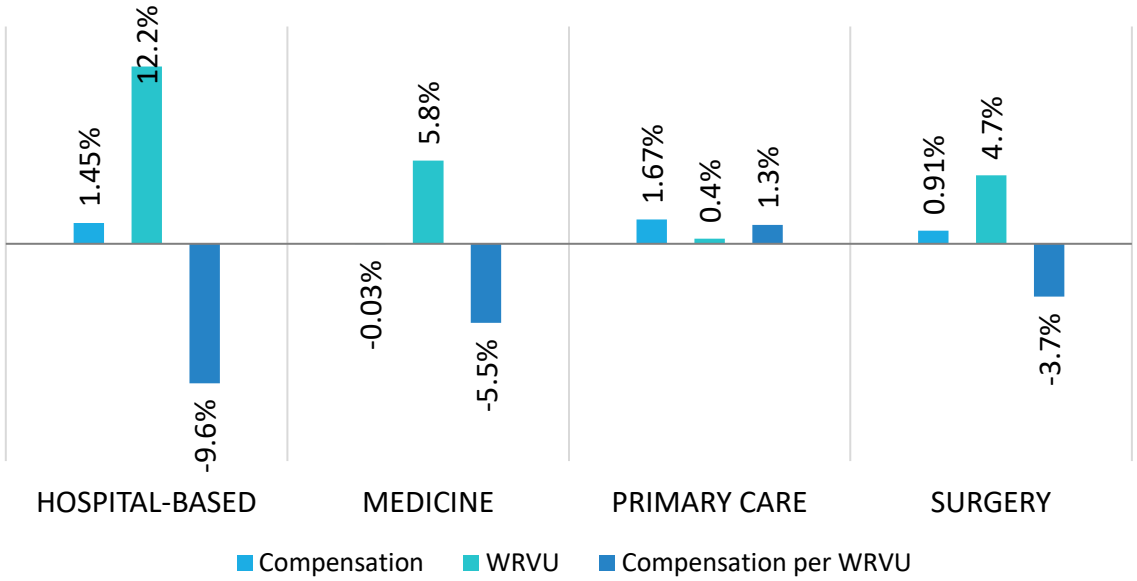
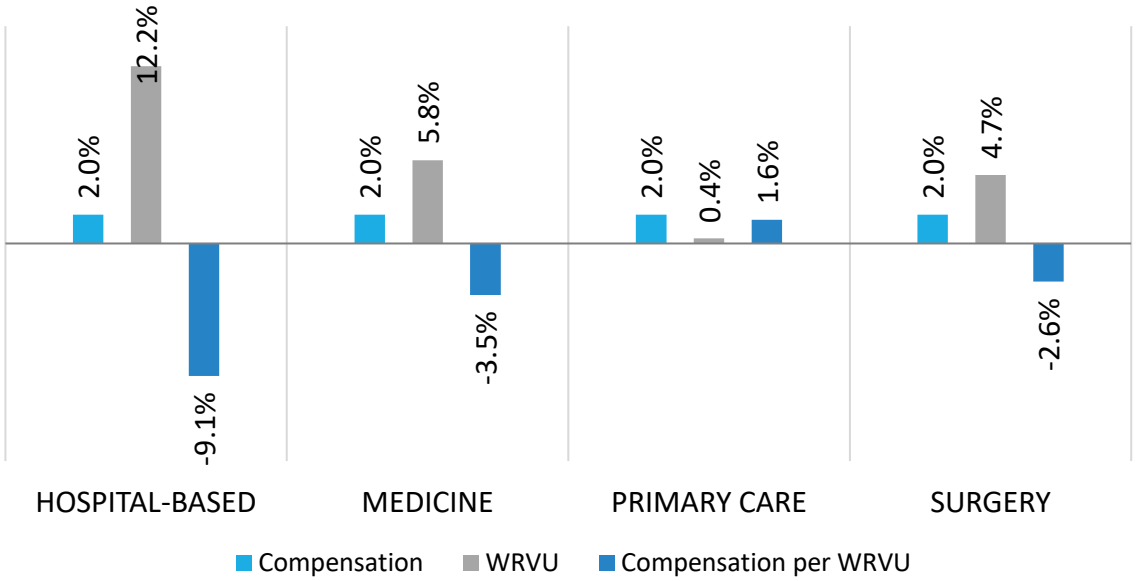
2023 Survey Projections

Compensation and WRVU benchmarks are increasing at varying rates.

Scenario One
Compensation Increase Based on Five-Year CAGR



Scenario Two
Compensation Increase Flat 2%



Compensation per WRVU median benchmarks in 2023 may decrease by between 3% and 9% across nonprimary care physician specialties as a result of production gains and the impact of 2023 MPFS.

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PSJH
Case Study

KATHY BUELL

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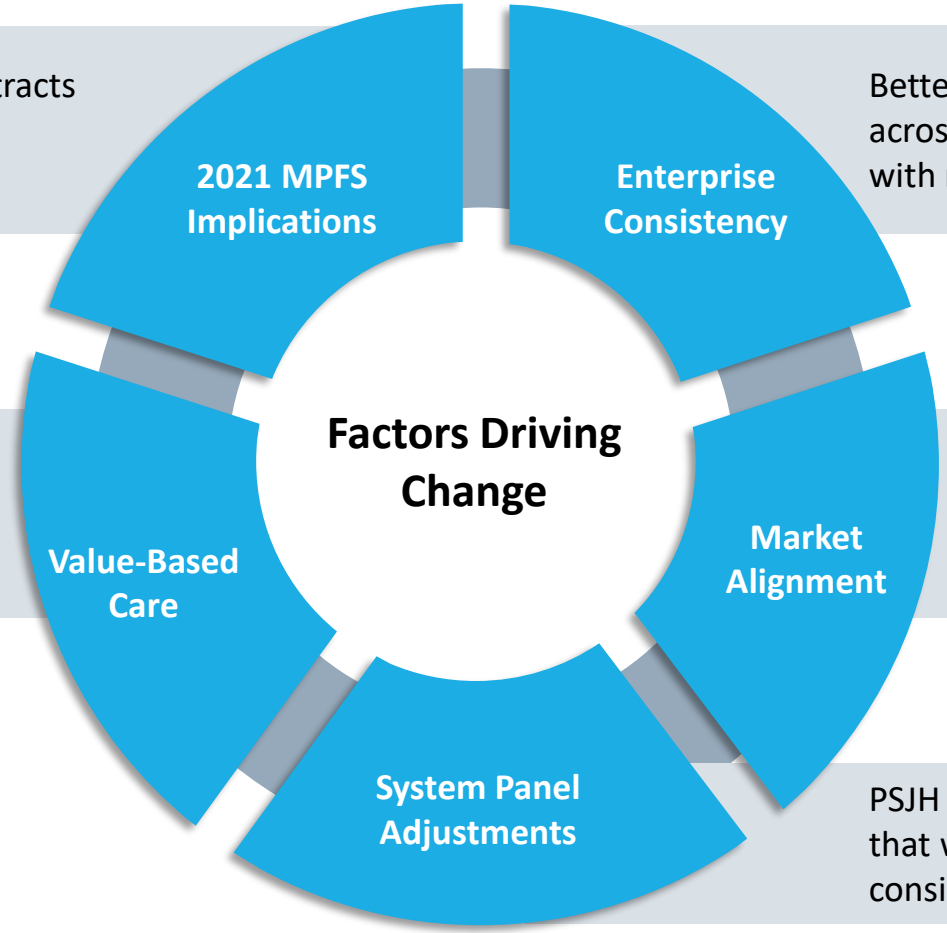
Why now?

Many organizations are adjusting provider contracts to ensure continued alignment with CMS and benchmark surveys.

With recent Stark law updates, many organizations are reprioritizing value-based contracting and aligning provider contracts accordingly.



Better aligning provider compensation models across PSJH would balance enterprise imperatives with regional and individual factors.

It would ensure the utilization of best practice design components that offer competitive compensation and can easily adapt to market disruptors.

PSJH is altering primary care contract components that will warrant future compensation considerations.

There are immediate major implications for medical group revenue and provider compensation.

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Medical Group Revenue

- The conversion factor change will affect Medicare revenue, and unbalanced groups will not be net neutral.
- Commercial payers are likely to seek renegotiations that balance their medical spending budgets.
- The revenue shifts due to the other final changes (e.g., telehealth) are more challenging to predict.

Provider Compensation

- PSA and compensation plans based on dollars per WRVU values need to be reviewed and adjusted, if possible, to avoid budget implications.
- Benchmark WRVU values will not be representative of the market due to the 2021 WRVU changes.
- Provider compensation targets (i.e., total cash compensation) will likely be unchanged in 2021 but begin to shift in 2022 due to revenue changes.

Estimated Medicare Revenue Impact—Specialty Category

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ECG estimated the Medicare reimbursement changes, assuming all payers' fee schedules were based on 100% of Medicare.

Estimated Medicare Revenue Impact by Specialty Category					
Primary Care	**Medicine**	**Surgery**	**Hospital Based**	**APPs**	**Urgent Care**
Increase	Increase	n/a	Increase	Increase	Increase
10.5%	**11.8%**	**n/a**	**18.2%**	**9.2%**	**0.5%**

Estimated Medicare Revenue Impact by Specialty Category (payer mix adjusted)					
Primary Care	**Medicine**	**Surgery**	**Hospital Based**	**APPs**	**Urgent Care**
Increase	Increase	n/a	Increase	Increase	Increase
3.4%	**3.9%**	**n/a**	**6.0%**	**3.0%**	**0.2%**

Considerations

- The change in TRVUs will be affected by the **14.9%** increases in the MPFS change.
- For the specialties provided, the overall estimated payer mix–adjusted impact on revenue is a **3.6%** increase.
- This analysis does not include a GPCI adjustment.

Phase One

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PSJH implemented a two-phased approach to determine the long-term impact on provider compensation.

Phase One
2021 MPFS Response Planning

Calculated Impact	Immediate Response Development
Identify potential issues with: • Compensation. • Operations. • Compliance.	Implementation + Communication

Key Deliverables

- Impact assessment on WRVUs/TRVUs and revenue by medical group (provider and specialty level)
- Initial compensation and financial stabilization recommendations
- Near-term tactical implementation plan

November to January

Phase Two
Strategies for Future Compensation

Operation and Compensation Adjustments	Medical Group Region Adjustments
Articulate Philosophy and Design Principles	Perform Financial Analysis and Model Refinement

Key Deliverables

- Evaluation and selection of preferred compensation plan benchmarks
- Compensation plan principles
- Operational assessment and recommendations
- Future compensation plan structural recommendations
- Transition plan

January to July

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Phase One:
Range of Models—For Illustrative Purposes

100% Fee for Service (FFS) → **100% At Risk**

FFS Model

Straight Salary

Compensation Percentile	Payout Rate (% of Median)
0th–49th	90%
50th–75th	100%
75th–90th	110%
>90th	100%

Value Component

- 10% at risk based on the achievement of organizational metrics

Production Component

WRVU Percentile Threshold	Payout Rate (% of Median)
0th–49th	90%
50th–75th	100%
75th–90th	110%
>90th	100%

At-Risk Payer Contract Model

Production and Value Component

Panel Metric	PMPM Value
Production	$0.50
HCC Recap	$0.75
CEI Quality	$0.50
Access	$0.50
Maximum	**$2.25**

Fixed Component

- 40th percentile base compensation
- Adjusted based on achievement of median WRVUs

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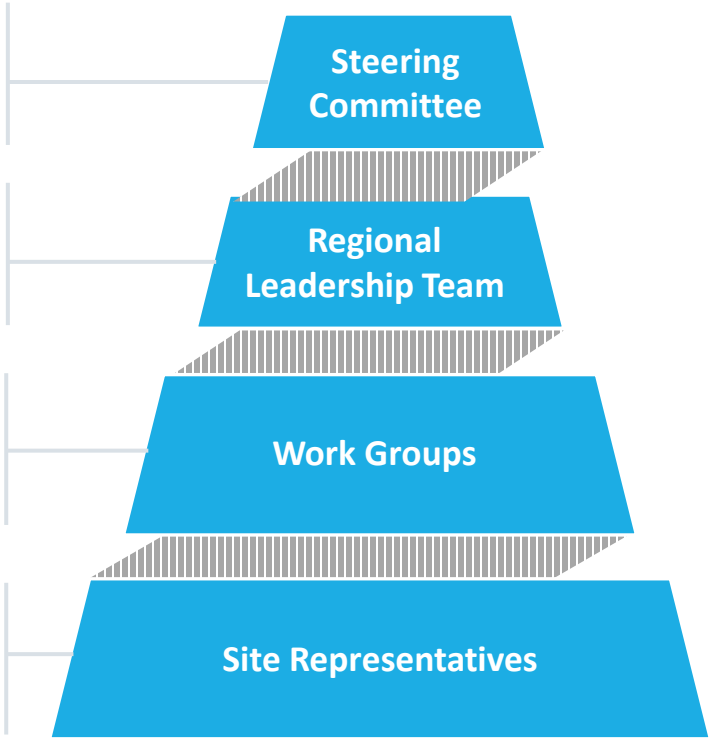
Phase One:
PSJH-Defined Work Groups

Including in a diverse range of stakeholders is pivotal to the success of the compensation assessment and design processes.

- Directly lead the assessment, design, and implementation of the model design process.
- Provide direction on the policy development, parameter definitions, and defining regional autonomy.
- Gather specialty-specific feedback and context considerations from already defined work groups.
- Utilize site representation to provide context on the current state of provider compensation design and individualized considerations.



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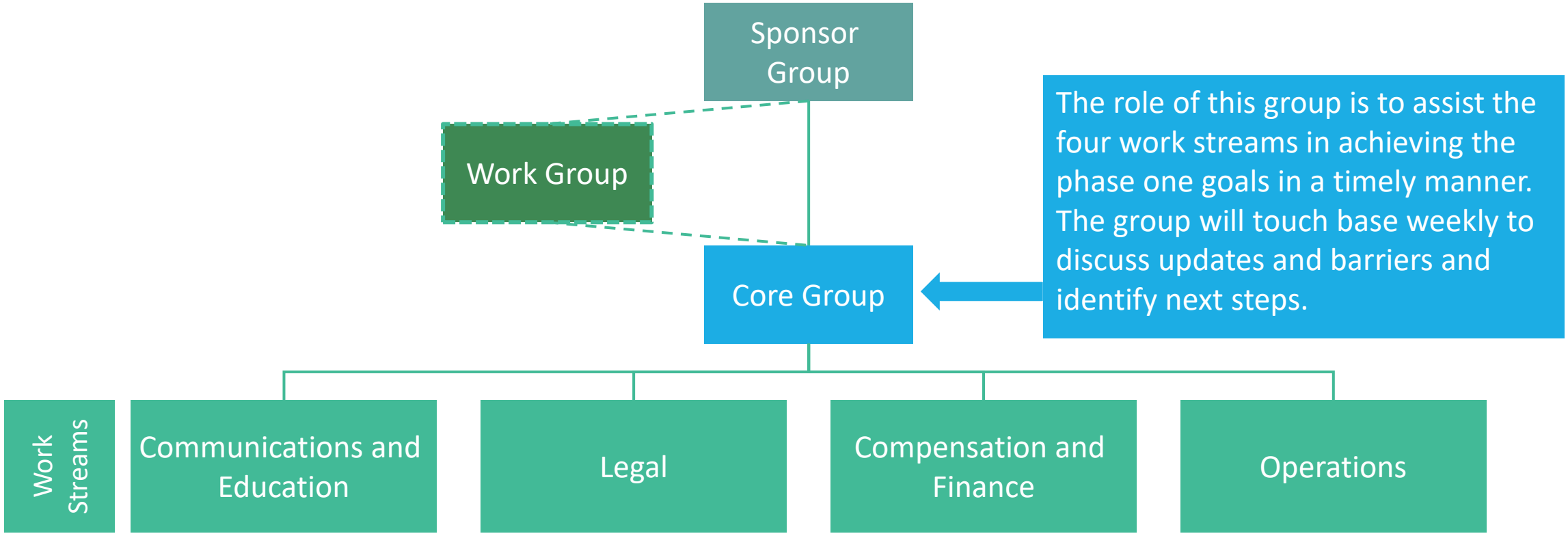
Phase One:
Work Stream Reporting Structure



Confirm the role of the work group and members of each work stream.

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Phase One: Components of the Impact Study

The reliance on WRVUs as a measure of provider productivity is virtually ubiquitous across healthcare, and the 2021 MPFS changes will affect nearly all physician contracts.

Assessment Components

Calculate the expected variance between actual WRVUs and the 2021 MPFS projected WRVUs.[1]

Compare the specialty variance based on historical data and market variances.[2] This comparison is performed with and without add-on code application.

Facilitate a discussion regarding the organization's vulnerabilities and impacts.

1 Actual WRVUs are calculated based on submitted CPT codes (e.g., CY 2019, FY 2020) applied to the 2019 MPFS to ensure consistent adjudication of the codes and avoid issues due to year-over-year adjustments in the MPFS.

2 The analysis calculates the client CPT code volume under the respective fee schedules for a direct comparison and compares the results to the ECG *2021 Physician Compensation Survey* results for the same projection.

Phase Two

PSJH implemented a two-phased approach to determine the long-term impact on provider compensation.

Phase One
2021 MPFS Response Planning

Calculated Impact	Immediate Response Development
Identify potential issues with: • Compensation. • Operations. • Compliance.	Implementation + Communication

Key Deliverables

- Impact assessment on WRVUs/TRVUs and revenue by medical group (provider and specialty level)
- Initial compensation and financial stabilization recommendations
- Near-term tactical implementation plan

November to January

Phase Two
Strategies for Future Compensation

Operation and Compensation Adjustments	Medical Group Region Adjustments
Articulate Philosophy and Design Principles	Perform Financial Analysis and Model Refinement

Key Deliverables

- Evaluation and selection of preferred compensation plan benchmarks
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- Future compensation plan structural recommendations
- Transition plan

January to July

Phase Two: Key Model Input Design

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	Regional Variation	Regionally Defined with System Guidelines	Identical
Total Compensation Philosophy			X
Benchmark Surveys			X
WRVU Tier Thresholds			X
Payment Rates		X	
Percentage of Compensation Tied to Value	X		
Value-Based Domains		X	
Value-Based Metrics		X	
Compensation for APP Supervision		X	
Employment Obligations/FTE Definitions		X	
Performance Thresholds (panel size, WRVUs, etc.)		X	
Panel Size Attribution and Risk-Adjustment Methodology		X	

Phase Two: Physician Benchmark Selection Process (production-based plans)

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Existing Plan Benchmarks

2020 Total Cash Compensation (Trend Adjusted[1])		WRVU Production (no adjustment)	Dollars per WRVU
2020 Median Survey Benchmarks			Calculated/Imputed
Primary Care	+3.1%	2020 Median WRVUs	2020 Median Compensation ÷ 2020 Median WRVUs
Adult Non–Primary Care	+2.1%		
Peds Non–Primary Care	+1.6%		
Practice Clinicians	+2.5%		

Proposed Plan Benchmarks

Compensation	WRVU Production (undecided)	Dollars per WRVU
2022 Median Compensation Survey Benchmarks	• Begin with 2020 Median Survey Benchmarks • Adjust for 2021, 2022, or 2023 MPFS	2020 Median Compensation ÷ 2021, 2022, or 2023 Median WRVUs

[1] The percentage adjustment was applied to 2020 compensation survey benchmarks based on 2019 data.

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Summary-Enterprise Assessment

Lessons Learned

	**Cultural Impact** Cultural differences among sites and regions impacted adoption rates.
	**Objectives** Rebasing all provider production was the initial goal. The more important goal is to find a meaningful percentage of difference while abiding by compliance.
	**Benchmarking** Learned to focus on total cash compensation benchmarks when wanting to ensure competitive rates.

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Key Compensation Planning Considerations

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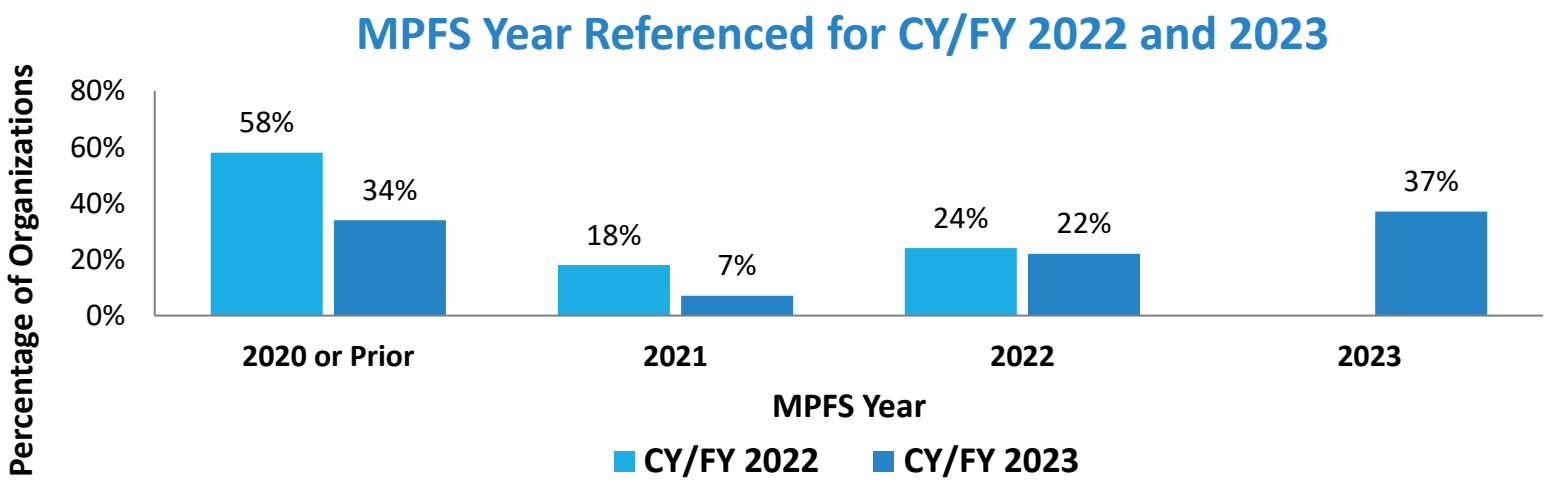
ECG MPFS Rapid Survey Results



- Of more than 100 healthcare organizations surveyed, approximately **40% of organizations will be on the most recent MPFS in 2023**. Of the remaining 60% of organizations, about 27% plan to move to the new MPFS in 2024, but the majority remain undecided.
- **In the 2023 calendar or fiscal year, most organizations will have transitioned away from the 2020 MPFS;** however, approximately 30% of organizations are referencing the 2021 or 2022 MPFS.

* Based on a December 2022 ECG annual MPFS Rapid Survey of more than 100 healthcare organizations, representing over 100,000 physicians and APPs.

Top Reasons for Delaying Transition to new MPFS

- Need a thorough communication and education plan
- Lack of aligned benchmark data
- Updating reporting/budgeting tools
- Affordability concerns

Other Takeaways

- A total of 70% of organizations have made changes to their compensation plan methodologies as a result of MPFS changes.
- Of these organizations, 25% are making their own adjustments to account for the MPFS WRVU changes.

2023 Considerations and Potential Mitigation Strategies

The increase in relative value for E&M codes and decrease in the reimbursement value result in a significant shift of dollars across the specialty spectrum.

- The industry's ability to rely on productivity and revenue benchmarks will be hampered for two to three years.
- Provider compensation will shift over the next two to three years in response to the specialty-specific revenue changes with some variability by market.
- This shift is a clear next step along the path to an industry landscape dominated by value-based payment models.

Evaluate current compensation methodologies for employed and integrated providers to assess the impact related to the change.

Assess the impact on PSAs and other arrangements that are funded and/or distributed on a compensation per WRVU factor.

Consider methodological adjustments to ensure financial sustainability at the organizational level and mitigate volatility at the individual provider compensation level.

Because these changes might also impact the FMV determination of certain arrangements, review and audit your provider arrangements.

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Typical Approach Options

Option	Description	
Option One	Maintain Status Quo	• No change; utilize pre-2023 MPFS to calculate WRVUs and thresholds. • Maintain current conversion factors.
Option Two	Implement 2023 MPFS and Determine Compensation Based on Historical Levels	• Implement 2023 MPFS to calculate WRVUs and thresholds. • Conversion factors and thresholds will be adjusted based to maintain historical compensation levels.
Option Three	Implement 2023 MPFS and Determine Compensation Based on Expected Levels	• Implement 2023 MPFS to calculate WRVUs and thresholds. • Conversion factors and thresholds will be adjusted based to the expected market/reimbursement. • Adjustments (up and down) to specialty-specific conversion factors may occur based on expected increases or decreases in reimbursement.

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Implementation Options

Delay Transition
(immediate 2020 and 2021)

Maintain the Existing Compensation Structure

No Change

- No implementation required
- Net-neutral compensation expense
- Requires detailed communication with providers regarding the long-term direction
- **Not a long-term solution**

No Change with "Protection" or Onetime Spot Bonuses

- Easy to implement
- Difficult to divide in an equitable manner across providers, sites, and specialties
- May be difficult to take away once the transition to MPFS alignment is complete
- **Not a long-term solution**

Adopt MPFS Changes
(next phase 2022 or 2023)

Adjust Compensation Rates and Thresholds

Historic Compensation Methodology

- Can provide a near-net-neutral compensation expense solution
- May require additional specialty-specific considerations
- **Has the potential to add additional adjustments for specialties with an E&M focus (i.e., primary care)**

"Adjusted" Market Data Methodology

- Adjustments made to recognize the following:
  - Anticipated specialty-level changes in reimbursement
  - Changes in hard-to-recruit specialties
- Aligns compensation with market norms
- May subject the organization to survey volatility

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