“You’re more naked than you think:” Unexpected career threats for academic and other employed physicians in an RVU-driven world

ACADEMIC PHYSICIANS SECTION
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(“If you fail to plan, you plan to fail. Strategy sets the scene for the tale…”)
(from “Mastermind”, lyrics by Taylor Swift and Jack Antonoff, 2022)
Today’s speakers
(Order of appearance)

- Gary M. Gaddis, MD PhD; Delegate, Academic Physicians Section GC
- Stuart Greenstein MD; Member, Academic Physicians Section GC
- Mr. Richard H. Levenstein; Shareholder, Nelson Yeager Gerson Harris and Fumero, P.A., Palm Beach Gardens, FL
- Mr. Dio Tsitouras; Executive Director, AAUP-Biomedical and Health Sciences of New Jersey
- Mr. Dan Bowling; Distinguished Fellow, Duke University School of Law
Part I: Getting started:

- As academic physicians, you may believe that your employment at the academic medical center is secure, unless you commit some outrageous or unethical act.
  - This view overlooks certain facts and factors of which academic physicians may be unaware.
  - We can provide some anonymous examples during small group discussion part of this session, to demonstrate that such faith in one’s “job security” may be woefully misplaced.
Goals:

- Make attendees aware of some tactics used by department chairs and others to move more senior physicians to the side or to decrease their remuneration.
- Make attendees aware of potential job security threats to early-career and mid-career physicians that stem from their status as employees.
- Review some basics of employment laws/practices that are relevant to these matters.
- Discuss potential solutions to this problem.
“You’re more naked than you think”

Objectives:
After attending this session, the attendee will be able to identify potential career threats to:

- **Early-career** employed and academic physicians...
  - Most derive from anything that constrains the physician’s *ability to generate revenue* from provision of clinical care.

- **Mid-career** employed and academic physicians...
  - Most ALSO derive from anything that constrains the physician’s *ability to generate revenue* from provision of clinical care.

- **Late-career** employed and academic physicians...
  - MANY also largely derive from anything that constrains the physician’s *ability to generate revenue* from provision of clinical care.
  - ALSO: The *costs to the employer* for the physician to remain employed.
“You’re more naked than you think”

Other Objectives: To identify:

- **Principal sources of revenue** to the department derived from **patient care activities**
- **Other sources of revenue** to the department or hospital, **not derived from billings for patient care services**, but for underwriting of education-related expenses
- **Applicable** to physicians employed as **academic physicians**, but also to **non-academic employed physicians**.
Background/Rationale:

- Most academic physicians:
  - Are employees
  - Work at a medical school within a clinical department
  - Employer is typically the faculty practice plan of a school of medicine.

- Many other physicians ALSO work for an employer
  - By “organization”, a single specialty or multispecialty self-governing physician group is excluded.
Integration & Physician Issues

74% of physicians are hospital or corporate employees, with pandemic fueling increase

Kelly Gooch - Tuesday, April 19th, 2022

The percentage of U.S. physicians employed by hospitals, health systems or corporate entities grew from 62.2 percent in January 2019 to 73.9 percent as of January 2022, according to new data from Avalere in a study sponsored by the Physicians Advocacy Institute.


This session should also be of interest to non-academic physicians
Some of the challenges in academia:

- **Demands from hospital or department leaders that physicians accept diminished employment status** as a prerequisite for being able to maintain:
  - Employment
  - Academic rank for commensurate with track record of achievement.
    - Especially frequent among “late career” physicians
    - Example from among my friends

- Other career threats are also accruing (More on that from our guest speakers)
  - Unifying theme: Threats center on:
    - Finances/financial issues
    - Contract issues
Other financial considerations/threats:

- **Different challenges confronting doctors in different career phases:**
  - **Early-career:** Challenges developing a referral base & attracting patients (and the income they bring)
  - **Later-career:** Typically have higher salaries commensurate with higher academic rank..which may represent easily identified targets for cost cutting.
    - Especially when a new department chair has been hired.
  - **Any physician:** Educational or administrative roles that constrain ability to generate revenue
    - Subsequently, this decreased revenue generation, due to the physician’s agreeing to be a “team player”, can be held against them by those who would use revenue generation as the sole criterion to support a doctor’s wage
      - Administrative roles have value to the institution
      - Institution could not function without proper administration.
      - Nonetheless, these administrative functions do not directly generate clinical revenue
These career threats are harmful:

- **To Everyone:**
  - When academic physicians and employed physicians are “moved on”, their departure from the institution and from the group disrupts “institutional memory”
These career threats are harmful:

- **To Patients:**
  - **Patients often seek out** more senior or more distinguished physicians due to their *experience and/or “track record”*
    - When more senior docs are moved aside, continuity of care is disrupted.
  - Other early-career and mid-career physicians can develop their own excellence
    - Patients can also seek these physicians for medical care.
These career threats are harmful:

- **To Residents and Students:**
  - Experienced later career physicians are a source of long-term experience & valuable for teaching of trainees.
  - Early-career and mid-career physicians are closer in time to trainees’ own education.
    - Therefore, they can bring valued insights to the educational processes that later-career physicians may be less likely to recognize or articulate.
  - “Institutional memory” is valuable to provide to encapsulate lessons and principles, not only within the institution, but also outside of the institution (such as re threats and interactions from regulators, etc.)
    - Example: What if the E.H.R. fails?
“Why” and “What”:

- We suspect that many early-career, mid-career and late-career academic and employed physicians are not well acquainted with the various threats against and possible protections for their ongoing employment and academic appointments.
- We shall provide an overview to the problem
- We will offer potential remedies
Part II: Show (and explain) the $$

- Revenue from reimbursements for the provision of clinical care is the chief source of any department’s revenue.
  - Obtained from those entities that pay for that care:
    - Commercial health insurers
    - Medicare
    - Medicaid
    - Patients:
      - To fulfill health insurance “deductibles”
      - As “self-pay” payment by the uninsured
CODING: The first step toward revenues:

- This revenue accrues after FIRST coding and billing for those services:
  - Billing is NOT done by diagnosis
  - All medical and surgical diagnoses have a code to be assigned
    - Defined by the International Classification of Diseases, 10th Edition (ICD-10)
  - Revenues are generated for clinical services that fit the description of one of six possibilities, as defined within the Current Procedural Terminology (CPT) resource.
    - (CPT was originated by the AMA in 1966)
The six sections of CPT codes:

- **Evaluation & Management** (99202–99499)
- Anesthesia (00100–01999)
- Surgery (10021–69990) — further broken into smaller groups by body area or system, within this range of codes.
- Radiology Procedures (70010–79999)
- Pathology and Laboratory Procedures (80047–89398)
- **Medicine Services and Procedures** (90281–99607)
Converting codes into $$

- Values for services captured by all types of these service codes are embedded within a scheme that applies a value to all services, for "Evaluation and Management", "Anesthesia", "Surgery", " Procedures" of any type (Radiology, Pathology, Lab or Medicine).
  - The work unit value is quantified in terms of Relative Value Units (RVUs)
RVUs?

Hsiao et al. developed a methodology to quantify the amount of “effort” (preparation plus execution) to deliver any medical service.
Quantitating “Resource-Based Relative Values”

- RBRV = (TW) * (1+RPC)*(1+AST), where:
  - RBRV = Resource-based relative value (Relative Value Units, or “RVU”)
  - TW = Total work input by the physician
  - RPC = Relative Specialty Practice Costs
  - AST = Amortized value of opportunity costs encountered to obtaining the necessary specialized training.
    - AST is important and valuable to anyone who has been required to complete a lengthy residency.
      - The longer the training required, the greater the AST

- Meaning: Any procedure that take a specific amount of time to deliver (Such as 1 hour) will have more RVU for a cardiothoracic surgeon with 7 years of residency training than for a family physician or emergency physician with 3 years of residency training.
If only....

- One COULD look up the RVUs for each and everything you do....
  - ...but this is impractical
  - Who has the time?
- Do know that the RVUs you generate are an index of your “work output”, imperfections of the RBRVS notwithstanding?
Commercial insurers utilize RVUs to quantify the clinical work provided.

Thus, RVUs are the basis for reimbursement insurers (or Medicare) will provide.
  - Each E/M and each Procedure code has a specific assigned RVU value.
  - Those RVUs are occasionally revised by the RVS Update Committee (“RUC”) which meets regularly under the aegis of the AMA:

The RVS Update Committee (RUC) is a volunteer group of 32 physicians and other health care professionals who advise Medicare on how to value a physician's work.
  - For instance, for Emergency Medicine, that has long been Dr. Mike Bishop, a community emergency physician from Bloomington, IN.
Conformers and Exceptions:

- Medicare, some Medicaid, and all commercial insurance use RVU-based E/M or Procedure codes to quantify billable services, toward enabling a reimbursement for services rendered.

  - FYI: Some states’ Medicaid programs have reimbursed physicians at a flat rate for all levels of “Evaluation and Management”, at least for certain categories of physicians.
    - Example: Missouri used to reimburse emergency physicians $15 per patient, regardless of the level of service or complexity of decision-making required.
    - Example: California physicians are reimbursed at ~54% of Medicare rates and have not had an increase from MediCAL for at least 15 years.
RVUs: The Chair’s and Administrator’s “Handmaiden”

- Hospitals’ administrators and department leaders typically utilize RVUs as the chief tool to track physician productivity:
  - RVUs provide an agreed-upon quantification tool to measure work output.
  - RVUs are the basis for reimbursement by most payers.

But, how many RVUs do I get for serving on the IRB or Curriculum Council or P&T Committee?

That number is a whole lot less than the value of your service to the institution!
Linking RVU to $$: \text{PAYMENT} = \left[(\text{RVU}_W \times \text{GPCI}_W) + (\text{RVU}_{PE} \times \text{GPCI}_{PE}) + (\text{RVU}_{MP} \times \text{GPCI}_{MP})\right] \times \text{CF}

- Goal: To understand the formula to convert what we do to RVUs to $$ via CF

- Example: Bronx (Dr. Greenstein) vs St Louis (me) for malpractice and practice expense adjustments

- $\text{RVU}_W$ is the RVU for the work provided, as per Hsaio et al. as may or may not have been modified by the RUC
- $\text{GPCI}_W$ is the “Geographic Practice Cost Index” for the physician’s work.
  - For instance, the GPCIW is:
    - Bronx, NY (Dr. Greenstein) = 1.056
    - St. Louis, MO (Dr. Gaddis) = 1.000
- $\text{RVU}_{PE}$ is the RVU for practice expense.
- $\text{GPCI}_{PE}$ is the Location-adjusted “Cost Index”:
  - Bronx, NY = 1.212
  - St. Louis, MO = 0.964
- $\text{RVU}_{MP}$ is the local adjustment for malpractice coverage expense in that doctor’s specialty.
  - For example, Obstetrics/Gynecology has higher RVU$_{MP}$ than Family Medicine
- $\text{GPCI}_{MP}$ is the correction for location of practice:
  - For example, malpractice coverage costs more in Florida than in North Dakota.
- $\text{CF}$ ($$$ per net RVU) is the “Conversion Factor” which multiplies the other term to yield a dollar figure.
Can anyone spot the correction for “inflation”?  

- Payment = \( [(RVU_w \times GPCI_w) + (RVU_{pe} \times GPCI_{pe}) + (RVU_{mp} \times GPCI_{mp})] \times CF \)

- CMS sets the CF annually

- Does anyone remember how CF had been tied to “budget neutrality”?

- On January 5, 2023, the Centers for Medicare & Medicaid Services (CMS) announced an updated CY 2023 physician conversion factor (CF) of $33.8872. This change reflects a 2.5% positive adjustment from the initial CY 2023 physician CF of $33.0607 announced in the CY 2023 Medicare Physician Fee Schedule (PFS) Final Rule.
Physicians have seen their inflation-adjusted payments drop 26% since 2001 to 2023, and those payments are further eroded by frequent and large payment redistributions statutorily required by budget-neutrality adjustments contained in the annual Medicare physician payment schedule.
This just appeared June 7th!

The provision was included in the Omnibus Budget Reconciliation Act of 1989, which mandated that any estimated increases of $20 million or more to the Medicare physician payment schedule—created by upward payment adjustments or the addition of new procedures or services—must be offset by cuts elsewhere.

"It’s time to update that number," AMA Senior Vice President of Advocacy Todd Askew said in a recent episode of "AMA Update." "We think $100 million is a reasonably number before Medicare needs to trigger those cuts."

The evidence is clear: The Medicare payment system is on an unsustainable path threatening patient access to physicians.

Along with updating budget-neutrality requirements and triggers, the AMA strategy for reform involves:

- Linking automatic inflation-based annual updates to the Medicare Economic Index.
- Reforming the Medicare Quality Payment Program by making the Merit-based Incentive Payment System (MIPS) more clinically relevant and less burdensome.
- Making more alternative payment models (APMs) available for practices to participate in.

Learn about how you can take part in the fight to fix Medicare on behalf of your patients and practices at the AMA's Fix Medicare Now website.

Leading the charge to reform Medicare pay is a critical component of the AMA Recovery Plan for America's Physicians.

The AMA has challenged Congress to work on systemic reforms and make Medicare work better for you and your patients.
That CF is crucial!
(Does anyone think the AMA was uninvolved?)

- On January 5, 2023, the Centers for Medicare & Medicaid Services (CMS) announced an updated Current Year (CY) 2023 physician conversion factor (CF) of $33.8872.

- This change reflects a 2.5% positive adjustment from the initial CY 2023 physician CF of $33.0607 announced in the CY 2023 Medicare Physician Fee Schedule (PFS) Final Rule.
The E.H.R. informs the billing:

- Billing and coding is typically done utilizing data provided by a patient’s health record as the data base.
  - Think of the health record as providing an “itemized receipt” for the billing submitted to Medicare, Medicaid or the commercial insurer
  - And, most commercial insurers reimburse physicians at a multiple of the Medicare rate for the applicable number of RVU
    - Figures of 105-120% are not unusual.
Give your coders some love!

- Every employed physician who has their reimbursement impacted by the number of RVU they generate is at the mercy of the coder to code correctly
  - Of course, all coders whom I have known are conscientious employees.
  - However, as one can imagine, their job is pretty boring...to THEM.

- What they DO impacts your income and perceived “activity”
Potential sources of error in coding:

- Accurate assigning of and crediting of RVUs can be problematic, especially with patient care “handoffs”:
  - Between physicians at change of shift on a specific date, because only one E/M code can be submitted per calendar date.
  - The relative contribution by each doctor to the provision of services can be difficult for coders to discern.
- Thus, coders typically adopt an “all or none” approach:
  - Only one physician gains credit for provision of services
  - Coders typically try to identify which doctor provided the key portions of the service...
  - ...Or, they use a fixed rule, such as “credit goes to the first (or last) doctor named in the chart.”
Using RVU to track “Productivity”

- Rightly or wrongly, a raw estimate of physician financial productivity can be:
  - Total RVU generated per month.
  - Rate of RVU generation, such as RVU/clinical hour
RVUs alone make an incomplete picture of physician productivity:

- A solely RVU-based measure of productivity overlooks other sources of revenue to the institution and/or to the clinical department.
- That work is crucial to the department and includes:
  - Externally funded research or task-specific grants
  - Education of trainees, as provided by Medicare funding:
    - Medicare reimbursements are made to the hospital that employ the residents in training, toward recognizing the expenses incurred in provision of such training.
Tracing the Medicare dollars: 
(“Back of the envelope”)

- Two sources of Medicare support for medical education:
  - “Indirect”
  - “Direct”
- Much variability per resident, range can be ~$90K to ~$165K per resident from Medicare
  $$$ remain after paying residents’ salary and benefits
Medicare “Indirect”

- Prospective payment hospitals that have residents in an approved graduate medical education (GME) program receive an **additional payment for a Medicare discharge, to reflect the higher patient care costs of teaching hospitals relative to non-teaching hospitals.**
  - The regulations regarding the calculation of this additional payment, known as the indirect medical education (IME) adjustment, are located at 42 CFR §412.105.

- The additional payment is based on the IME adjustment factor....and FYI but not discussed today:
  - The IME adjustment factor is calculated using:
    - A hospital's ratio of residents to beds, which is represented as r
    - A multiplier, which is represented as c, in the following equation: \( c \times ((1 + r) \times 0.405 - 1) \).
  - The multiplier c is set by Congress. (Currently, “c” = 1.35)
  - Thus, the amount of IME payment that a hospital receives is dependent upon the number of residents the hospital trains and the current level of the IME multiplier.
Medicare “Direct”
(It’s a bit complex)

- Medicare direct GME payments are calculated by multiplying the PRA times the weighted number of full-time equivalent (FTE) residents working in all areas of the hospital (and non-hospital sites, when applicable), and the hospital's Medicare share of total inpatient days.
- More (Not sufficient time to discuss here and now)
  - “PRA” is hospital-specific, base-period per resident amount (PRA) that is calculated by dividing a hospital's allowable costs of GME for a base period (Defined as FY 1984) by its number of residents in that base period.
  - Numbers of allowed residents: For most hospitals, the limits were the number of allopathic and osteopathic FTE residents training in the hospital's most recent cost reporting period ending on or before December 31, 1996.
Medicare “Direct”

- Medicare DGME payments cover the direct costs of operating a residency program, including:
  - Resident salaries and benefits
  - Medical malpractice insurance premiums
  - Supervisory physician salaries
  - Administrative costs.

- Detail (Not for discussion now)-DGME payments are made as aggregate payments to hospitals based on a statutory formula: multiplying:
  - The hospital’s per resident amount
    - times
  - The weighted number of full-time equivalent (FTE) residents working in all areas of the hospital (and non-hospital sites, when applicable), and the hospital's Medicare share of total inpatient days.
    - Months rotating in a VA do not “count”
Tracing the tuition dollars: (“Back of the envelope”)

- If a medical student pays $30,000 annually for tuition...
- ...And attends 3 lectures per day for 5 days a week for 50 weeks a year...
- Then they pay 30,000/750 or $40/hr
  - Facilities takes their “cut”
  - The Dean takes their “cut”
- But a lecture attended by 10 students brings in a theoretical $400/hr

How much of that accrues to the person leading the discussion?
Teaching role of faculty and $$$

- Medicare revenues that accrue due to the required medical education role are not typically recognized as the “work product” of the academic physician.
  - All academic physicians contribute labor toward the enabling of training....but, if not for the provision of that training, this revenue would not be realized.
  - The contribution toward training of trainee physicians is not equal between faculty members
  - Contributions are not infrequently treated by chairs and administrators as equally derived from all physicians
Selected Administrative Roles:

- Example: Disputing insurance company adjudications re coding:
  - The doctor who serves this administrative role contributes to enhanced departmental revenue
  - But, that contribution is often not specifically credited to the one undergoing the appeal.
  - The RVUs involved are credited to the clinician who provided the services to generate them

- Example: A clinical chair serves numerous tasks that benefit the department:
  - These tasks are typically compensated to the employee at a fixed rate
  - The employed physician’s essential yet indirect contribution to the department’s revenues is not typically credited, even in part, to them.
Some physicians have developed a reputation for expertise and excellence.

Patients seek these doctors out for care...

...even if they are not practicing in the patient’s presumed “catchment area”.

“Finders Fee”???
Interim Summary:

- RVUs are the “coin of the realm”
- You now know how RVUs started as a means to quantify the value of physician work output, and the basics of how they are computed
- You now know the importance of the “Medicare Conversion Factor”
- Many employed physicians perform services of value that do not generate RVUs and thus are at risk for being insufficiently “credited”
- Any work responsibility that detracts from a physician’s ability to generate RVUs places them at potential risk

- Not mentioned: Sometimes new chairs simply don’t want “institutional memory” around…
- More about how to potentially ameliorate that risk from other speakers…
Selected References:

5. Re: Indirect Medicare Payments for education: [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcutInpatientPPS/Indirect-Medical-Education-IME](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcutInpatientPPS/Indirect-Medical-Education-IME) Accessed May 31, 2023
Thank you!

- NEXT: Mr Richard Levenstein
- Questions?

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