Member Survey

Divisional Budgets

Heart Failure Specialty group seem to pose the greatest discrepancies (e.g. higher salaries [and therefore higher wRVU targets] versus wRVU generation capabilities [mostly ambulatory-based, complex – timely care]).

... understand their MAJOR contribution to the Hospital Enterprise and Surgical Department (in and above their value to the CV Division), but given their limited ability to generate wRVU (MedAxion editorializes on this), what are the available options out there to optimally support their practices?

Possible Options

Q. Heavy APP practices supported either independently or within HF provider wRVU's (to drive up RVU productivity)?
Q. Enterprise / Hospital-dollars (not just for the transplant or PH directors, but all HF Faculty) (to drive down targets)?
Q. Some type of CT-Surg shared-model??? (to off-set budget discrepancies)
Q. Other more inventive strategies??? (endowments, philanthropy, etc)

Answers:

1. For us at UCSF, the two areas that don't work well with the RVU funds flow model is ACHD and Heart Failure (as you point out below). We have been successful at negotiating a different $/RVU model for those two specialties with our health system (instead of using median MGMA numbers for non-invasive cardiology). We polled several academic "like institutions" for wRVU productivity and compensation in each ACHD and HF. Then went to our health system to calculate a better (more appropriate) $/RVU payment. This increases every year the same % as the academic MGMA values. We also did need to make the case that there was downstream (significant) revenues for these two areas to help the argument—but that was pretty easy since both are quite lucrative for the hospital.

2. Most of us have negotiated with hospitals or health systems to subsidize the HF/Tx groups work. In our health system, all organ transplant physicians are subsidized in a sort of "advanced organ failure" model, since transplant programs are generally good money makers for the organizations. A helpful resource is the MedAxiom data, available through the ACC – they have a report you can download. The last version I looked at had compensation for most cardiology specialties at ~$50/RVU, where HF/Tx was ~$90/RVU. It gives you a sense of compensation across specialties and is very helpful.

3. One thing I'd caution is the nurse practitioner piece given changes potentially coming in the 2022 CMS physician fee schedule.

   We are proposing to refine our longstanding policies for split (or shared) E/M visits to better reflect the current practice of medicine, the evolving role of non-physician practitioners

   (NPPs) as members of the medical team, and to clarify conditions of payment that must be met to bill Medicare for these services.

   In the CY 2022 PFS proposed rule, we are proposing the following:

   - Definition of split (or shared) E/M visits as evaluation and management (E/M) visits provided in the facility setting by a physician and an NPP in the same group.
   - The practitioner who provides the

substantive portion of the visit (more than half of the total time spent) would bill for the visit.
- Split (or shared) visits could be reported for new as well as established patients, and initial and subsequent visits, as well as prolonged services.
- Requiring reporting of a modifier on the claim to help ensure program integrity.
- Documentation in the medical record that would identify the two individuals who performed the visit. The individual providing the substantive portion must sign and date the medical record.
- Codifying these proposals and revised policies in new regulations at 42 CFR 415.140.

The second and fourth bullet are "major" changes to this process. Currently, the physicians are only required to document that a face-to-face visit took place and an exam component to substantiate the physician in fact had a face-to face visit with the patient. However, as you can see based on the proposed rule, it is the person who conducts more than half of the total time who would bill for the visit. While they have not yet identified the specific modifier, one will be required to ensure truthfulness.

4. Because of the significant hospital spinoff of a cardiac transplant/MCS program, in the 3 programs I have been associated with the hospital supported the physician faculty, and employed the coordinators/advanced practice providers.

5. In addition to the subsidies already mentioned we transitioned all CCU care to our HF faculty. In that role they bill at Critical Care rates.

6. We have used a combined approach. On the hospital side, we have made the case the wRVU alone is a crude measure of productivity as others have outlined below. Also, included in this group is structural heart echocardiographers.Those that fall below the bench mark MGMA or Medaxiom, have explanations as to the why for the administration. In addition, for physician compensation bonus, we "supersize" the E&M codes to even the distribution and more fairly compensate those toiling in the office or seeing the complex CHF or ACHD patients.

7. All of the support for our team was from the hospital, not other physicians. We used a unique identifier in the MRN and were able to demonstrate to the hospital the enormous book of business for a transplant program, despite the fact that the direct revenue from the transplant event was break even. We also had many discussions about the anti-kickback laws. Our legal team concluded the academic exception clause allows such programs to exist between an academic medical center and a medical school without all of the typical Stark III constraints.

8. We were able to negotiate a higher pediatric wRVU rate for ACHD which has helped tremendously for ACHD salary support.

9. We utilize a Program Development Deficit Offset (PDDO) mechanism I negotiated with the hospital/health system. While I hate the term "backstop" – this is a good way to think about it.

10. So I have pulled all HF faculty, APPs, and an expanding disease management nursing pool into this PDDO. Since the HF downstream stays with the hospital, this allows me to establish appropriate salaries etc. and recruit based on need and shared business plans. If the professional charges the HF MDs/APPs recover are not sufficient to support their salary +fringe etc. cost to the section, we are trued up and kept whole. IN this way we all are incentivized to grow. We use wRVUs as one of several productivity measures that we jointly monitor but we do not compensate on $/wRVU basis. This is working reasonably well but not perfect. While it protects us financially from any faculty/APP salary related losses and we can recruit more confidently as the need is established it is not perfect as I am still working on negotiating a financial upside to the section to support non clinical mission…, the process requires active management/establishing shared benchmarking metrics which not everyone always agrees on and trust with hospital and school finance which can be fleeting. I also have to guard against faculty complacency.

11. On a smaller scale to answer # 10, we have done something similar but didn't name it – might have to borrow "PDDO" moving forward - Acronyms are big in Philly and I like that one! By focusing the "PDDO" on areas of interest to the hospital (easy in HF as readmission penalty was something we focused on and could move the needle) we were able to share the reward – but also at risk if it failed. As someone mentioned – the key is close management and clearly defining the goals.

12. Here is how our model works. We receive funds from the health system (funds flow) based on $/wRVU as a group (not individual) + research funding + Medical directorship + GME. We distribute the compensation (compensation plan) based on a formulated mechanism: Base (same for everyone based on % clinical FTE) + specialty market adjustment + academic rank + productivities (percentage of contribution to the group wRVU) + Citizenship (3-5 metrics) + Academic performance (3-5 metrics including grant fundings and teaching awards). The quality performance comes as a bonus (annually distributed with 3-5 metrics). We do have a productivity bonus that only comes to us if we, as a group, produce wRVU above the budgeted amount (predicated on hospital profitability, so at risk).

    It's a complicated model but entirely formulated and transparent. The Specialty market adjustment is where we supply the advanced CHF faculty additional compensation, as pointed out in previous emails, who would never produce comparable wRVU as other subspecialties, yet require compensation similar to others. Our health system eliminated PSA for the Advanced CHF/Transplant group. Since then, We have not been able to negotiate any differential $/wRVU for them. Therefore, the CV division has to pool the funds from everyone to share with the advanced CHF faculty.