AAMC
Tomorrow's Doctors, Tomorrow's Cures

An Update on Physician Compensation Methodologies in Academic Medical Centers

Learn
Serve
Lead

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February 8, 2021

VCU Health
SullivanCotter

Association of American Medical Colleges

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Agenda

Part One
AAMC/SullivanCotter

Physician Compensation Methodologies in Academic Medical Centers: A National Perspective

- Recap: COVID-19 and other factors impacting 2021 compensation planning
- Summary of results from the AAMC/SullivanCotter *2020 Physician Compensation Methodologies in Academic Medical Centers Survey*

To Be Released to AAMC Members Next Week

Part Two
VCU Health

Designing a Physician Compensation Strategy for the Future of Health Care: Lessons Learned

- Organizational overview
- Overview of current compensation models
- Challenges and responses
- Clinical work effort methodology

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Part One

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Previous Webinar: COVID-19 Impact

November 12, 2020: Impact of COVID-19 on Physician Compensation

The global pandemic continues to drive fundamental change and uncertainty with respect to health care organization budgets, reimbursement, processes and operations

Financial Sustainability

- Decreases in volume/revenue
- Increases in expense

Population Health

- Flexibility to adapt to traditional and non-traditional access to care
- Increased focus on care coordination

Patient Access

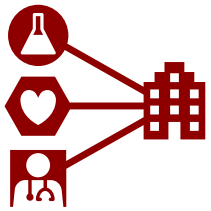
- Constraints on in-person patient consults due to COVID-19 protocol
- Requires expanded in-office hours

Clinical Workforce Optimization

- Physician/APP redeployment
- Expanding APP scope

Virtual Medicine

- Development/expansion of non-traditional patient access
- Long-term uncertainty in virtual care reimbursement



Pandemic-driven change and organizational response may have long-term impact and requires aligned leadership

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Other Factors Impacting Compensation

2021 Compensation Planning

2021 CMS Final Physician Fee Schedule Changes

- Impact on physician productivity (wRVUs) and reimbursement

Final Updates to Federal Physician Self-Referral Law ("Stark") and Anti-Kickback Statute Regulations

- Uncertainty and potential policy changes
- Provides increased flexibility

Expansion of Virtual Health and Emerging Providers

- Temporary vs. permanent reimbursement
- Demand and commercialization
- Competition
- Walmart, Walgreens

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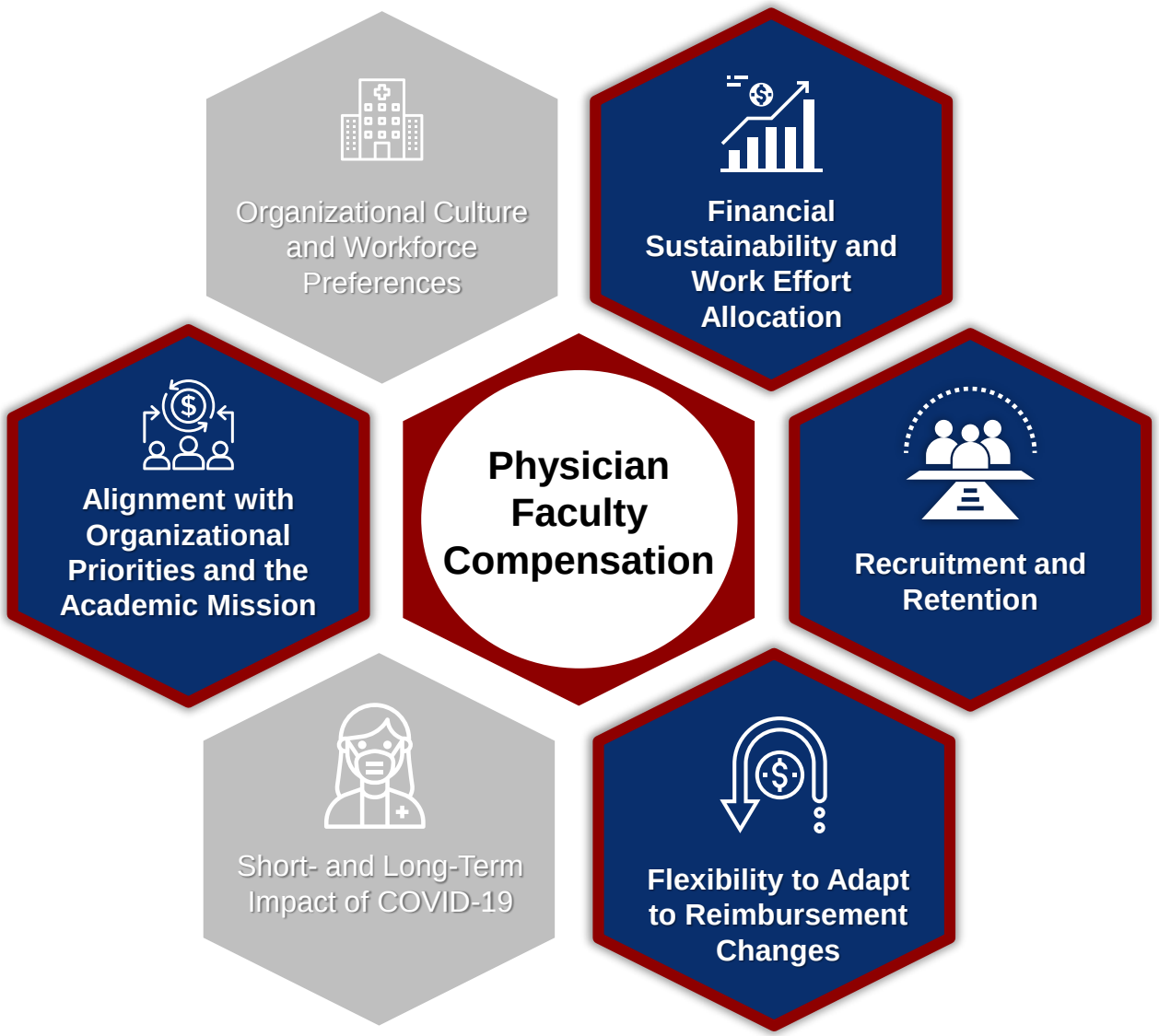
Physician Faculty Compensation
Considerations



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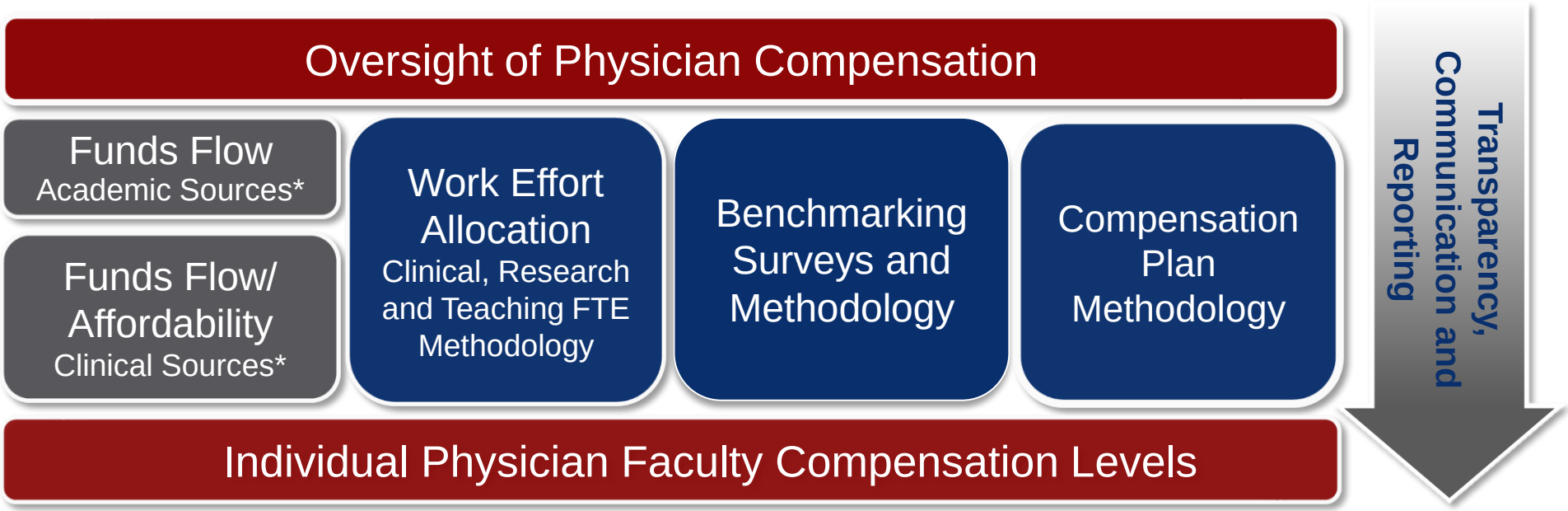
AAMC/SullivanCotter Research

Over the last six years, the AAMC and SullivanCotter have collaborated on research topics important to academic medical centers (AMCs)



* Areas not covered by the study

Recent 2018/2020 Studies: Identify work effort allocation approaches and contemporary pay practices used by AMCs to compensate faculty and community-based physicians

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Characteristics of Survey Participants

Overall Responses | Organizational Structure

The 2020 survey results reflect the following characteristics:

24

Overall Responses

Fully Integrated	**25%**
Academic Integration	**42%**
Clinical Integration	17%
Independent Structures	12%
Independent FPP Structure	4%

71%

of AMCs indicated community-based physicians are included in their workforce

Responses were collected from December 2019 to June 2020 and reflect pre-pandemic results

Source: *2020 AAMC/SullivanCotter Faculty and Community-Based Physician Compensation Methodologies in Academic Medical Centers*

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Characteristics of Survey Participants, cont.

Physician and APP Staffing | Percentage Change from 2018

Growth in the advanced practice providers (APP) workforce is vastly outpacing physician growth

Physician and APP Full-Time Equivalent (FTE)[1]

FTE	Physicians *Faculty and Community* *n = 22*	APPs *n = 18*	MD/APP Ratio *n = 18*
Median	1,003	353	3:1
Percentage Change from 2018[2]	3.4%	**25.1%**	3:1
Average	**1,111**	**355**	**6:1**
Percentage Change from 2018[2]	2.0%	**21.2%**	4:1

[1] Provider staffing from the 2018 report indicated median figures as follows: 775 physician FTEs, 188 APPs and a 3:1 MD/APP ratio

[2] Percentage change reflects the same participants from the 2018 survey; ratios reflect calculated ratios, not percentage change; n = 18

n = 21

Source: *2020 AAMC/SullivanCotter Faculty and Community-Based Physician Compensation Methodologies in Academic Medical Centers*

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Physician Projected Staffing Levels

Recruitment/Retention Challenges

Participants project significant growth in physician staffing levels as reported in the following **growth goals** over the next year[1]

Projected % Growth[2]	Total		Community-Based[3]	
	2020 (n=15)	2018 (n=9)	2020 (n=8)	2018 (n=7)
Median	3.0%	4.3%	16.2%	7.7%
Average	11.1%	3.3%	22.2%	12.4%

[1] Data normalized as organizations reported a range of time periods
[2] Reflects information collected prior to COVID-19
[3] Growth percentage based on participants with community-based physicians (68%) and could be influenced by potential acquisition targets in the community being served

Specialties Experiencing Most Growth[1]

Family Medicine
Internal Medicine
Pediatrics

Specialties Experiencing Retention Challenges[1]

Cardiology
Neurology

[1] Of the nineteen that responded, 6 or more selected primary care specialties; cardiology and neurology were selected by 4 and 3 respondents, respectively. Cardiothoracic surgery mentioned in both categories above

Source: *2020 AAMC/SullivanCotter Faculty and Community-Based Physician Compensation Methodologies in Academic Medical Centers*

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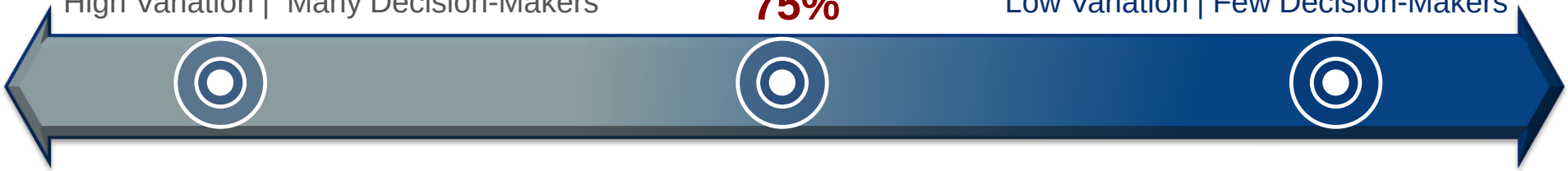
Physician Compensation Oversight

Due to significant growth and other environmental factors, AMCs continue to seek better alignment between their compensation programs and organizational strategy

Departmental | 17%
High Variation | Many Decision-Makers

Blended 75%

Institutional | 8%
Low Variation | Few Decision-Makers



- Higher levels of **autonomy** promote **departmental decision-making** resulting in:
  - **Barriers to care coordination** and collaboration for traditional and non-traditional patient care
  - **Retention and/or recruitment risk** (e.g., low pay, high productivity) due to differences in pay structure between specialty groups (e.g., percentage of base/variable compensation)
  - High levels of **administrative burden**; strong budget process required to support **financial sustainability**
  - More potential for regulatory risk and gender inequity
  - Faculty may perceive and prefer higher levels of autonomy

- Higher levels of institutional decision-making results in:
  - Risk **lower levels of physician engagement** due to less local control and input on key decisions
  - More **consistent and strategic reward structure**, including decision-making related to mission support
  - Greater ability to respond to **reimbursement changes**; typically, a more **flexible** compensation program that aligns faculty expectations with the future of health care
  - Fewer compensation approaches may not **recognize the differences between practice settings** and **physician phenotypes**

Source: *2020 AAMC/SullivanCotter Faculty and Community-Based Physician Compensation Methodologies in Academic Medical Centers*

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Polling Question

Physician Compensation Oversight

Select the option that best describes your academic medical center's oversight of physician compensation

Departmental
High Variation | Many Decision-Makers

Blended

Institutional
Low Variation | Few Decision-Makers

A **B** **C** **D** **E**

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Definitions

Work effort allocation is managed by department chairs in **95%** of organizations (n=22)
***27%** of organizations indicate the allocation is also reviewed by an Oversight Committee*

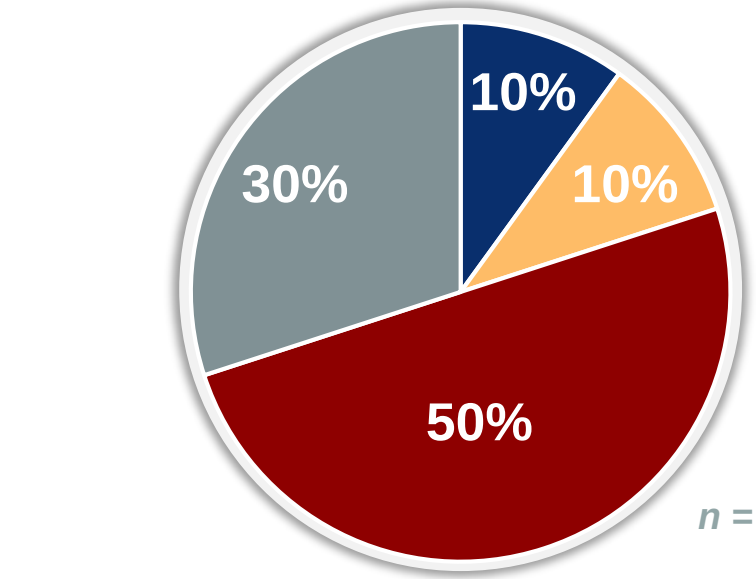
Session
(excluding hospital-based)

91%

define a session as a
half day or **four hours**

n = 11

Number of Weekly Sessions for 1.0 FTE



n = 10

Source: *2020 AAMC/SullivanCotter Faculty and Community-Based Physician Compensation Methodologies in Academic Medical Centers*

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Hospital-Based Specialties

Work Effort Definitions

70% of organizations indicated that hours per shift vary by hospital-based specialty and **82%** indicated that shifts per FTE per year also vary by specialty

Specialty Group	Hours Per Shift		Annual Shifts		Annual Hours		
	Average	Median	Average	Median	Average	Median	Median % Δ from 2018
Critical Care *n = 11*	11.0	12.0	169	168	1,822	1,800	n/a
Emergency Medicine *n = 12*	9.5	10.0	177	168	1,658	1,584	3.1%
Anesthesiology *n = 13*	10.3	10.0	194	188	1,956	1,888	(6.8%)
Hospitalist *n = 14*	10.8	10.5	188	182	1,972	2,028	(6.1%)
Radiology *n = 14*	9.1	8.5	200	184	1,801	1,835	9.2%

Source: *2020 AAMC/SullivanCotter Faculty and Community-Based Physician Compensation Methodologies in Academic Medical Centers*

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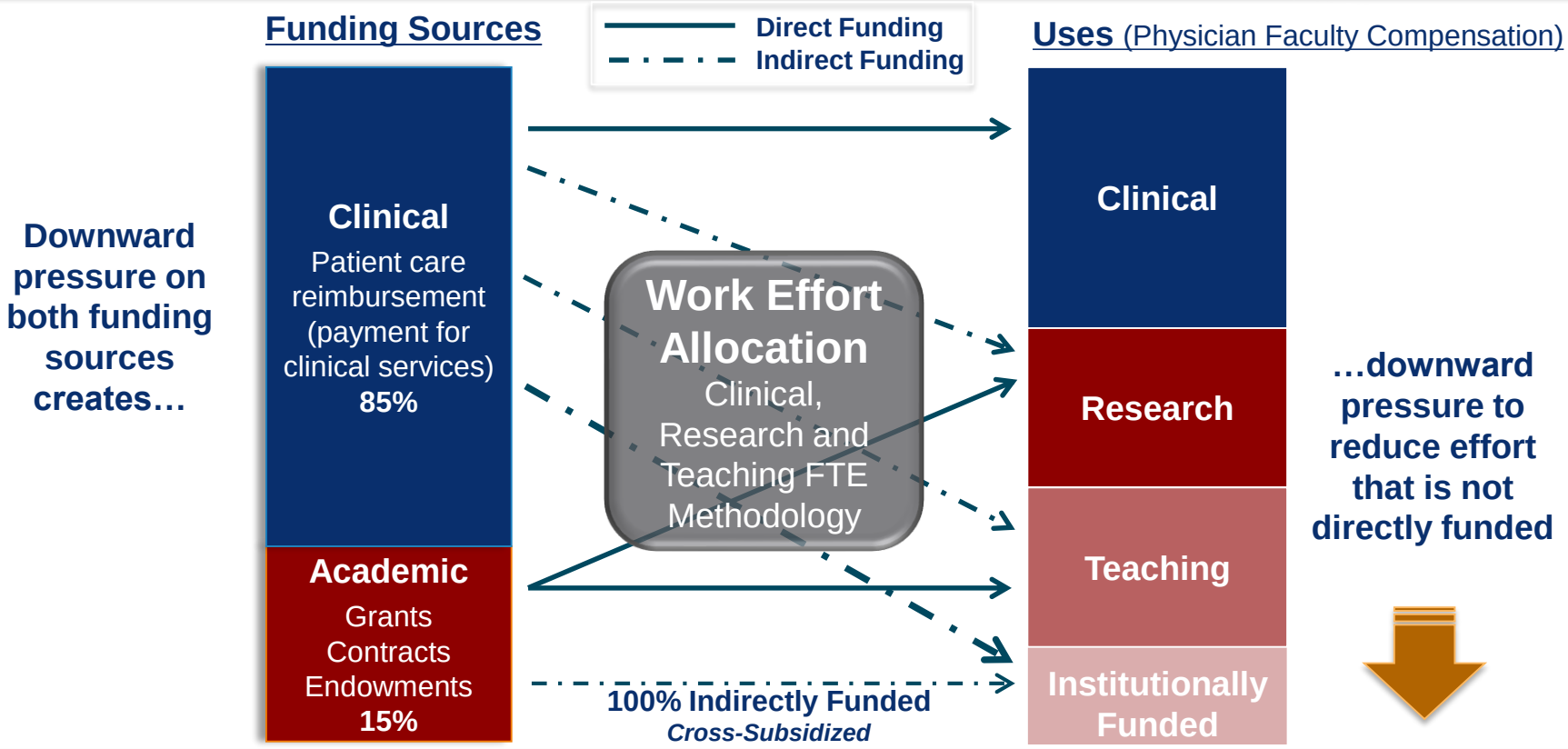
Sources and Uses

Work Effort Allocation and Rewarding Effort

Typical AMC Funding Sources and Uses



Downward pressure on funding sources combined with a high level of indirectly funded effort dilutes the value that can be placed on individual clinical performance

Result: ***10%*** *of participants are considering either reducing or eliminating standard for academic time*

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Polling Question
Clinical FTE Approaches

Which approach best describes your organization's clinical FTE methodology?

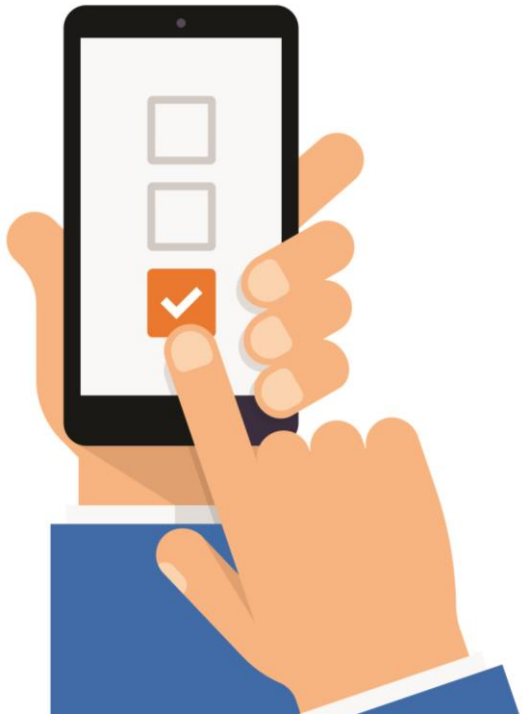
A. 1.0 FTE minus teaching, research and administrative time

B. Number of clinical sessions per week

C. 1.0 FTE minus funded effort

D. 1.0 FTE minus blend of funded academic work effort/time

E. Other



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Polling Question

Standard Half-Day Clinical Sessions per Week in an Ambulatory Setting

How many total weekly hours define a 1.0 cFTE at your organization?

A. 35 - 40

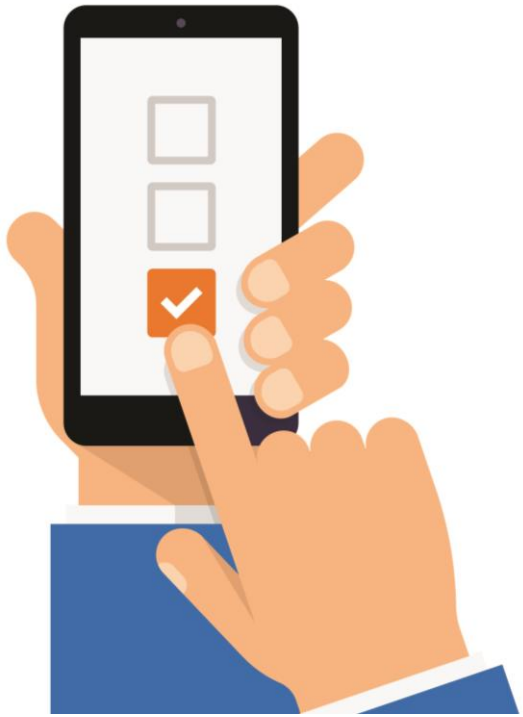
B. 40 - 45

C. 45 - 50

D. 50 - 55

E. >55

F. We don't have a standard definition



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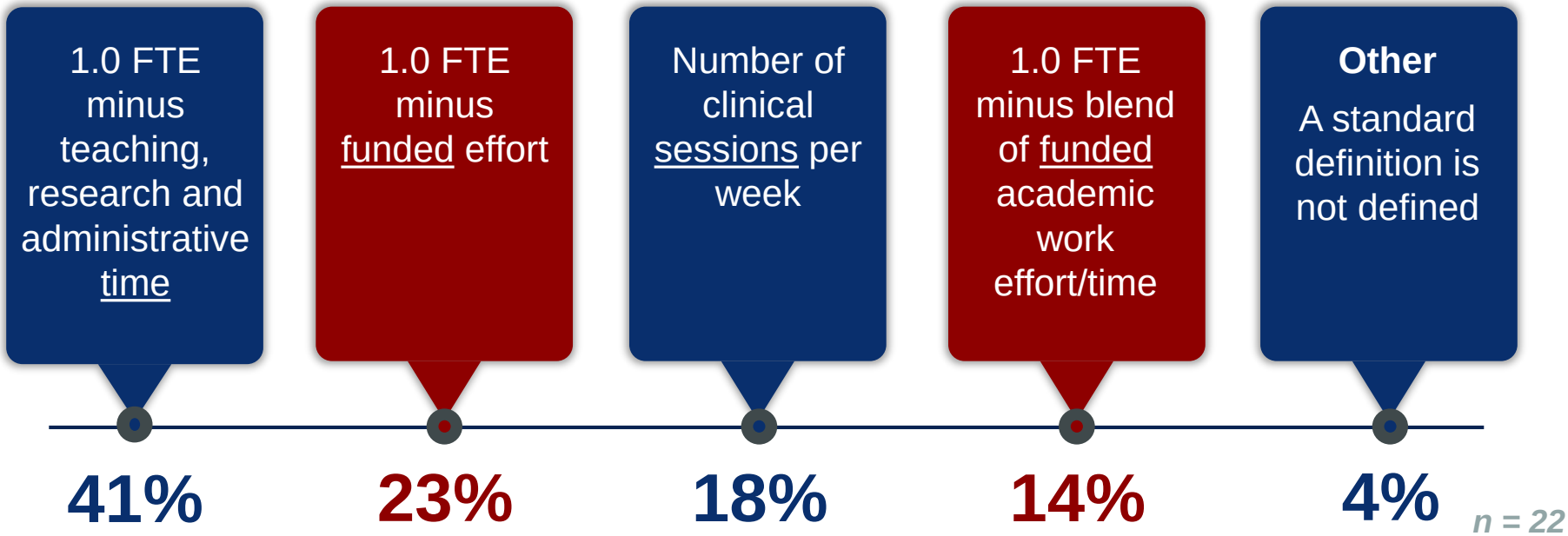
Clinical FTE Approaches

The predominant methodology (**41%**) for determining cFTE is time-based. Relatively consistent from 2018; majority continue to use either time-based or funded approach (**64%** compared to **68%** in 2018).



73% of participants have an organizational standard definition of total hours for a 1.0 cFTE across departments

Source: *2020 AAMC/SullivanCotter Faculty and Community-Based Physician Compensation Methodologies in Academic Medical Centers*

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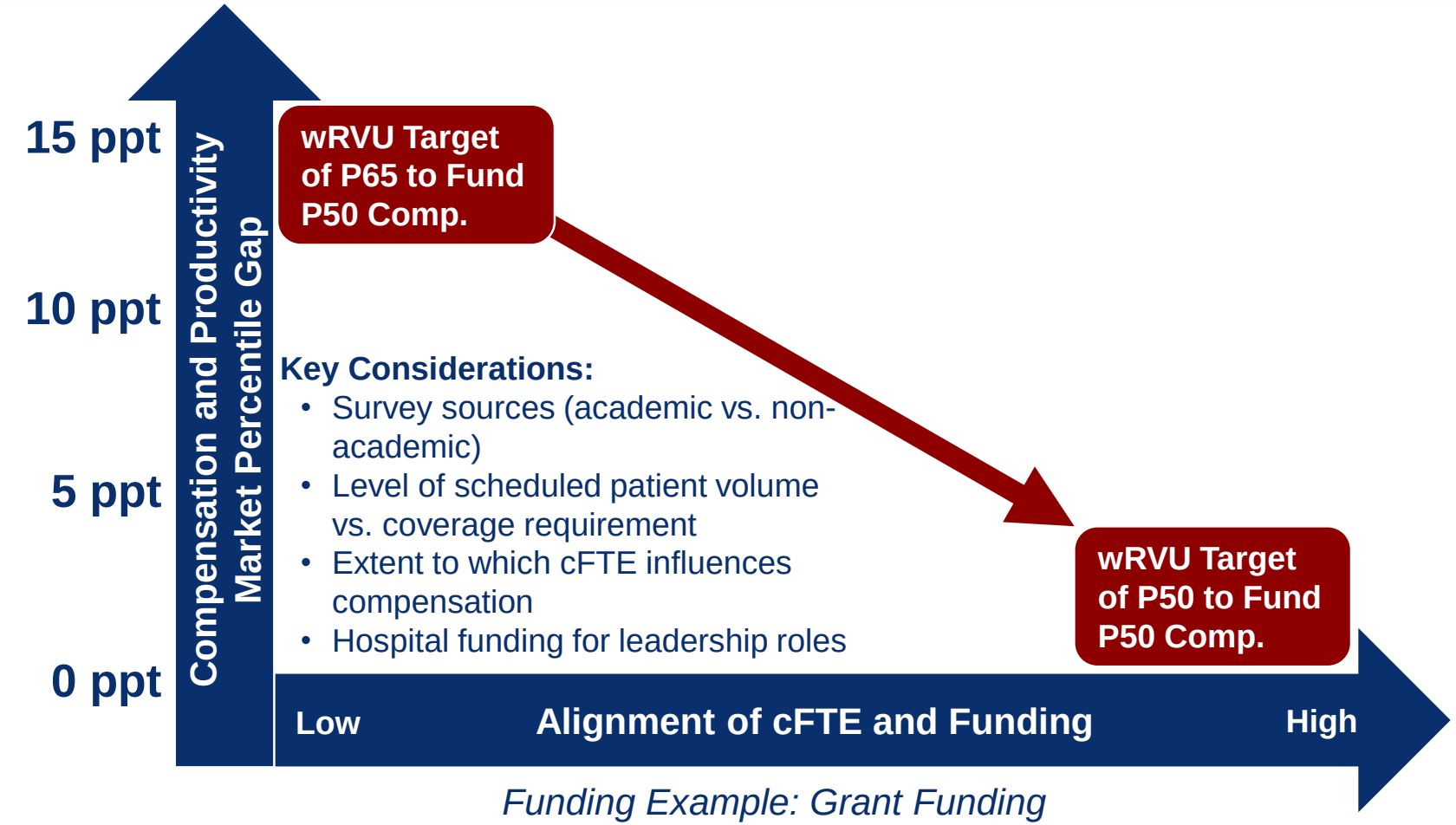
Clinical FTE and Benchmarking

Factors Impacting Compensation and Productivity Alignment

cFTE reductions based on "unfunded" effort(s) can create gaps between compensation and productivity targets relative to market benchmarks



Funding Example: Grant Funding

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Benchmarking Approaches

Organizations continue to report a variety of survey sources used to benchmark compensation and productivity for faculty and community-based physicians

Note: Results based on combined 2018 and 2020 responses

Surveys	Faculty n = 49		Community-Based n = 30	
	Comp.	Prod.	Comp.	Prod.
AAMC	**86%**	--	17%	--
MGMA – Academic	69%	**51%**	27%	20%
MGMA – Private/Medical Group	57%	47%	**93%**	**80%**
SullivanCotter Surveys*	41%	27%	63%	53%
Vizient – CPSC	4%	43%	--	13%
AMGA	20%	12%	33%	27%
Other	20%	20%	10%	13%

* Reflects physician, medical group and Large Clinic surveys

A growing trend is to set compensation targets that lag productivity expectations by as much as 10 percentile points (e.g., P50 compensation tied to P60 productivity)

Source: *2020 AAMC/SullivanCotter Faculty and Community-Based Physician Compensation Methodologies in Academic Medical Centers*

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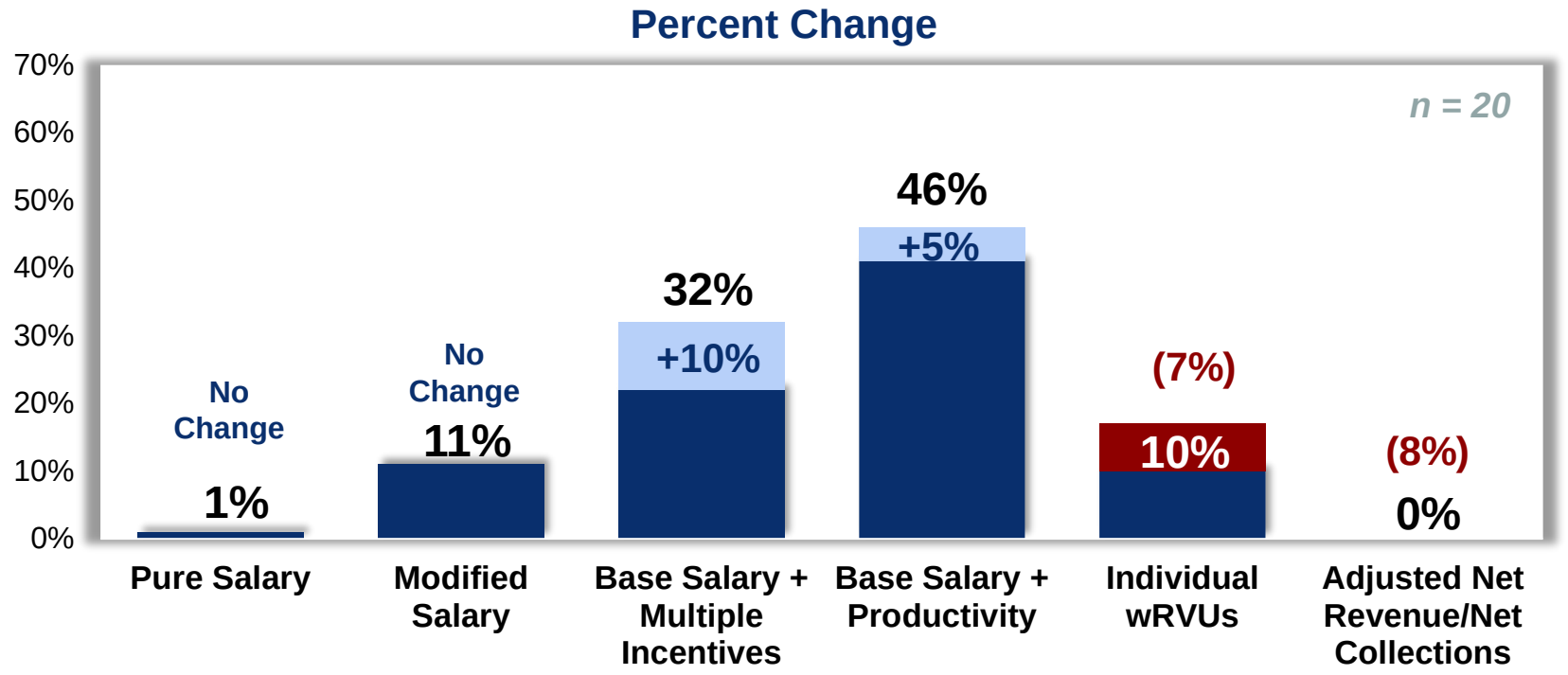
Compensation Strategy: Evolution

AMCs continue to move away from a pure productivity and/or net collections approach



Source: *2020 AAMC/SullivanCotter Faculty and Community-Based Physician Compensation Methodologies in Academic Medical Centers*

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Key Factors: Base Salary and Variable

Prevalence

The top factors influencing compensation remain largely unchanged from 2017

Base Compensation | Prevalence (%)	
Factor	**%**
Faculty Rank	95%
Length of Service	59%
Funded Research	55%
Work Relative Value Units (wRVUs)	45%
Medical Student Teaching	45%
Chair Discretion	41%

n = 22

Variable Compensation | Prevalence (%)	
Factor	**%**
wRVUs	86%
Patient Satisfaction	64%
Citizenship	59%
Patient Care Outcomes	59%
Chair Discretion	59%
Funded Research	55%
Patient Access	50%
Professionalism	45%

n = 22

5% of total cash compensation is the median weighting placed on value-based metrics across all specialty groups *(n=21)*

3 is the median number of value-based metrics used in each specialty grouping *(n=14)*

Source: *2020 AAMC/SullivanCotter Faculty and Community-Based Physician Compensation Methodologies in Academic Medical Centers*

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Primary Care and Population Health

Care optimization through panel size and team-based care (Physicians and APPs) can help to shape an organization's population health strategy

91% of organizations are planning on **increasing the number of primary care providers** in the next year (*n = 22*)

85% of organizations use APPs as Primary Care providers (*n = 20*)

APP Panel Approach	Prevalence *(n=17)*
APP Panel	24%
APP/Physician Panel	17%
Both Approaches	**53%**
No APP Panel	6%

Currently Using Panel Size in Primary Care

21% Physicians *(n=19)*

5% APPs *(n=19)*

Considering Using Panel Size in Primary Care

76% Physicians *(n=21)*

50% APPs *(n=18)*

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Key Takeaways

COVID-19 Impact

- Increased financial pressure
- Acceleration of virtual care strategies
- Expansion of APP scope and optimization of the workforce

Benchmarking Approaches

- Growing number of organizations creating an intentional gap between compensation targets and productivity expectations (up to 10 percentile points)

Growth Strategy

- Recent growth of APPs outpacing physician growth
- Accelerated growth projections in the community
- Primary care is a core growth area

Compensation Strategy

- Continued movement away from pure productivity models towards salary plus incentive approaches
- More fixed compensation will require strong performance management

Work Effort

- Consistent and clear definition of cFTE continues to be an issue
- Time-based and funded approaches continue to be most prevalent

Population Health

- Panel size increasingly used in primary care
- Reimbursement changes via advanced payment models are challenging typical fee for service compensation approaches in primary care

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Part Two

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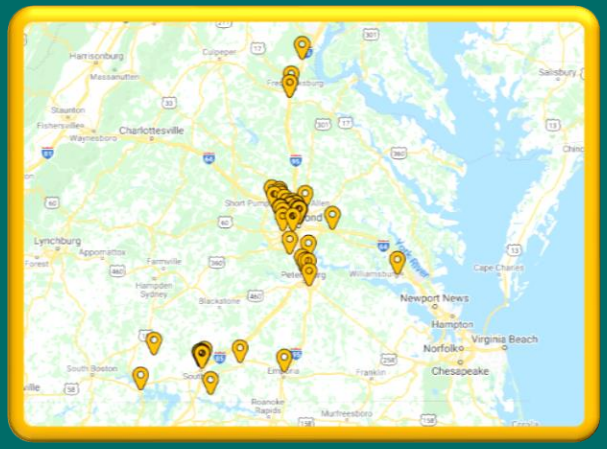
VCU Health™

Agenda

- Overview of VCU Health and MCV Physicians (MCVP)
- Overview of MCVP Faculty Compensation Plan
- Compensation Plan Challenges and Responses
- Clinical Work Effort Methodology and Challenges

VCU Health – a snapshot

- Commonwealth of Virginia's largest and fully-integrated academic medical center
- Integrated leadership/governance of SoM, FPP and health system
- Four schools and one college of health sciences
- Commonwealth's largest Level 1 trauma center verified for adult, pediatric and burn
- One of only two NCI-designated cancer centers in Virginia
- The region's only full-service children's hospital



By the Numbers (FY19)

200+ Clinical Specialties

1,081 Licensed Beds

19 Clinical Departments

12,500+ Team Members

850+ Physicians

400+ Advanced Practice Professionals

668 Patients enrolled in clinical trials

1,020 Patients in research studies

306 Studies open to enrollment

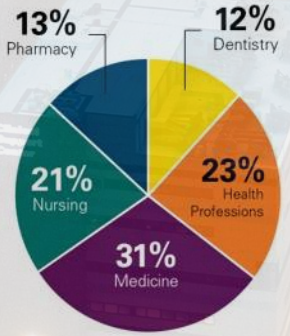
252 Clinical trials open to enrollment

$310.2M Total Amount of Research Awards

4,078 Total Students

779 Total Residents*

2019 Enrollment by College or School



*as of Fall 2019

VCU Health™

MCV Physicians

Faculty practice plan

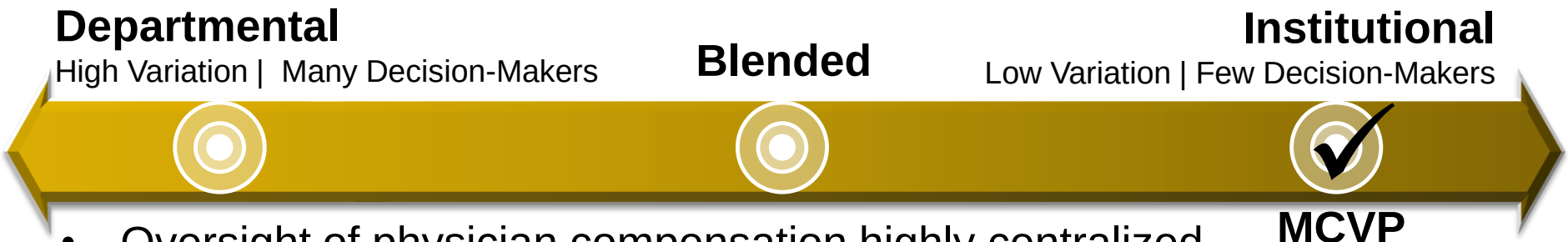
Employs near 2,000 clinicians and team members

- 804 physician FTEs (615 cFTEs)
  - 21% growth in last three years
- 360 APP FTEs
  - 48% growth in last three years
- 706 staff FTEs
- $462M in total operating revenue (FY20)

At MCV Physicians, our mission is to set the standard for quality in patient care and to support the physician members and the mission of the VCU School of Medicine.

Overview of MCV Physicians Faculty Compensation Plan

Physician Compensation Oversight



- Oversight of physician compensation highly centralized

Strengths	Weaknesses
Able to make decisions quickly when necessary (e.g., response to COVID-19)	Decisions not made at the lowest appropriate levels of organization • Substantial senior leadership time spent evaluating individual physician situations
Better ability to ensure equity among different departments and specialties	Departmental leadership not accountable for good stewardship of financial resources
Consistent rules across departments	Departments lack ability to quickly respond to individual circumstances
	Departments lack expertise to adequately explain compensation models to faculty

- Recent efforts to move towards center

VCU Health

Benchmarking Approach

- MCVP uses blend of many community and academic benchmarks

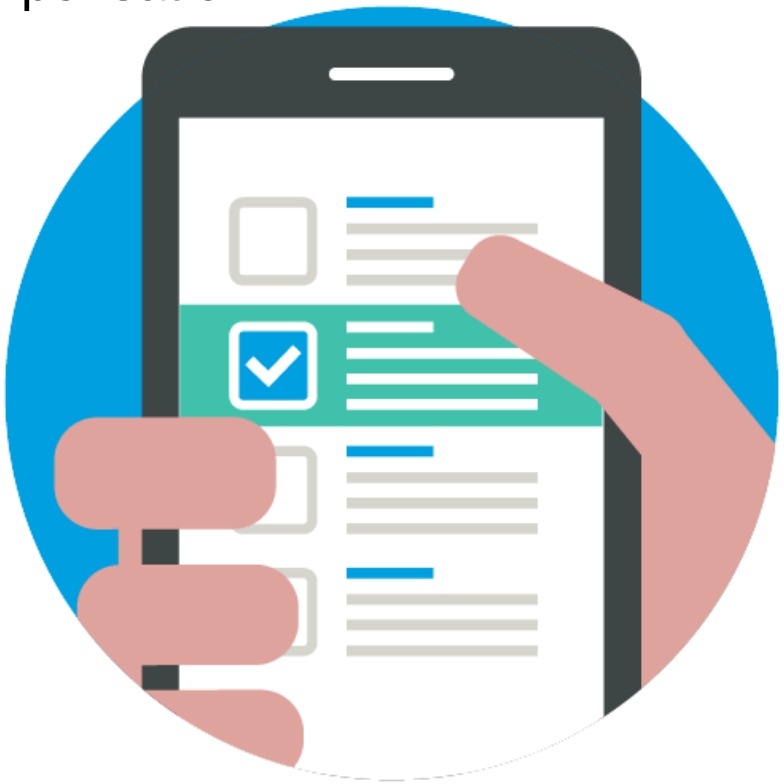
Survey	Compensation	Productivity
AAMC	X	
AAAP	X	X
AARAD	X	X
AMGA (Academic)	X	X
AMGA (Community)	X	X
CPSC		X
Gallagher IHS	X	X
MGMA (Academic)	X	X
MGMA (Community)	X	X

- Recently developed compensation models have specifically targeted AAMC benchmarks or blend of AAMC and SullivanCotter

Polling Question

Does your organization use CPSC (AAMC/Vizient) wRVUs or CMS wRVUs for purposes of physician compensation?

- ❑ CPSC (AAMC/Vizient)
- ❑ CMS



Compensation Strategy: Continuum

Guaranteed Total Compensation → **At-Risk Total Compensation**

1	2	3	4	5	6
Pure Salary	**Modified Salary/Work Effort**	**Base Salary + Multiple Incentives**	**Base Salary + Productivity Incentives**	**Draw Based on wRVUs and/or Performance**	**Adjusted Net Revenue / Net Collections**
• Salary set by internal/ external data approach • Generally, minimum accountability for "effort" • Annual market adjustments	• Base salary set by experience and/or performance • Defined minimum work standards to "earn" salary • Shift-based for hospital-based specialties • May include incentives	• Base salary • Productivity incentive plus other non-productivity incentives such as academic, quality, etc.	• Base salary • Majority of incentive driven by productivity. • Incentives adjusted periodically	• Salary draw based upon personally performed wRVUs, multiplied by rate per wRVU or other performance criteria	• Total credited personal collections, less actual/ allocated expenses • Resulting variance equals "earned" compensation

New MCVP Models ← Most MCVP Models

Factors Contributing to Current Compensation Plan

Physician productivity was declining

- wRVUs were down
- Surgeries were down
- Outpatient visits weren't meeting budget targets
- Inpatient visits were down
- Payer mix was declining

Physician morale was lagging

Salaries were below AAMC benchmarks in many specialties

- Limited incentive opportunities for most

Key Goals for Current Compensation Plan

VCU Health™

Basic Compensation Plan Components

Clinical Salary Floor
(Base salary determined by prior year productivity)

Clinical Incentive

Administrative Compensation
(Clinical and Academic Administration)

Research (Equal to Funding)

Teaching

Strategic

Total Cash Compensation

VCU Health

Basic Construct of Plan

- Contract salary set based on prior year's clinical productivity and current year's anticipated ARTS roles.
- Annual contract salary cannot be decreased more than 15% from prior year's salary for first 12 months in plan
- Once set, contract salary **guaranteed not to decrease during the year.**
- Incentives based on **current year** productivity over clinical salary floor
- Incentives paid out quarterly with withholds in early quarters
  - 1Q – 50% withhold
  - 2Q – 30% withhold
  - 3Q – 10% withhold
  - 4Q – Remaining annual incentive paid in full

Establishing a Clinical Salary Floor

Productivity-Based Departments/Specialties[1]

- Anesthesiology (pain management only)
- Dermatology
- Family Medicine
- Internal Medicine (excluding hospitalists)
- Neurology
- Neurosurgery
- Ophthalmology
- Orthopedic Surgery
- Otolaryngology
- Pediatrics (excluding hospitalists and intensivists)
- Physical Medicine & Rehabilitation
- Psychiatry
- Radiation Oncology
- Surgery (excluding pediatric surgery)

Shift-Based Departments/Specialties[2]

- Anesthesiology (excluding pain management)
- Emergency Medicine
- Pathology
- Radiology

Hybrid Departments/Specialties[3]

- Obstetrics and Gynecology (excluding reproductive endocrinology)

[1]Based on wRVUs and collections from elective cash procedures (where applicable)
[2]Based on clinical hours (Anesthesiology/EM) or clinical days (Pathology/Radiology)
[3]Based on wRVUs, L&D sessions, and health department sessions

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Compensation Plan Challenges

Compensation plan is confusing and difficult to explain

- Plan administration relies on few key individuals
- Providers and administrators don't understand plan, leading to mistrust

Benchmark approach is difficult to understand and costly

- Not being able to point to one published survey leads to perception that benchmarks are not transparent
- Use of community/academic blend leads to high compensation levels compared to AAMC benchmarks

wRVU-based plan makes it difficult to incentivize patient access

- Inpatient work and procedures more lucrative than ambulatory practice
- Focus on wRVUs leads to competition for certain practice domains

Plan leads to retention issues after guarantee period

- Providers who succeed in model receive salary increases while many exceptions are requested for providers who do not succeed in model

Plan does not encourage team-based care or APP-physician collaboration

Plan does not support academic mission or recognize academic work/rank

- Citizenship/Teaching funding allocated to every provider regardless of contributions

Highly variable salary from year to year leads to provider dissatisfaction

Compensation Plan Challenges

One-size-fits-all model does not recognize all extraordinary performance

- Extraordinary performance only measured in terms of wRVUs

Centralized structure does not empower department chairs or drive accountability

- Organization lacks a funds flow structure that encourages tradeoff decisions and financial sustainability

Many challenges in ARTS methodology

- Funded research additive to salary, leading to extremely high salaries for well-funded researchers; compounding effect
- Endowed funds additive to salary rather than being used purely as funding source
- Plan encourages creation of medical director roles to fill compensation gaps
- Plan allows for providers to be funded at greater than 1.0 FTE

Lack of quality or patient satisfaction incentives encourages only volume of work

Plan design threatens financial sustainability

- Compensation and productivity percentiles misaligned
- Plan results in wide range of compensation percentiles

Use of benchmark payout rates creates issues

- Benchmark payout rates include compensation not attributed to wRVUs (e.g., call pay, APP supervision stipends, administrative compensation)
- Providers may earn incentives for lower clinical productivity than that used to set salary

Recent Compensation Plan Changes

Introduced organizational definition of CFTE	•Detailed later in presentation
Piloted ability for department chairs to define metrics to determine eligibility for Citizenship/Teaching funding	•All providers previously received same funding amounts regardless of contributions
Introduced Minimum wRVU Threshold for Incentive Eligibility	•All providers must be meet 100% of CFTE-adjusted median wRVU benchmarks to be eligible for clinical incentives
Delayed annual benchmark updates	•Decision made in response to misalignment between compensation and productivity percentiles
Payout rates held steady for multiple years	•First step towards moving to “calculated” rate (clinical salary benchmark divided by wRVU benchmark) to eliminate phenomenon of providers earning clinical incentives for doing less than the prior year
Recognition of academic rank	•Modest differential for associate professors and professors added in response to most common criticism of plan •Years of experience recognized for non-dually employed providers
New patient access incentive pilot	•Incentive pay per new patient visit targeted in areas with access challenges that can be partially attributed to compensation model

Compensation Plan Changes Under Consideration

Tiered Payout Structure	• Payout rates would decrease after providers exceed median and 65th percentile productivity • Intended to decrease incentives to "churn" patients as well as to underreport CFTEs
Capping Clinical Salary Floor at Reported-CFTE	• Clinical salaries would be no more than CFTE-adjusted benchmark • Intended to better align reported CFTEs with actual clinical effort
Enhanced Medical Director Funding	• Intended to more appropriately fund medical directors for effort as a percentage of clinical salary floor benchmark as opposed to a historical, generic benchmark
Introduction of Monthly Draw vs. Quarterly Incentives	• Intended to smooth out cash flow for providers who earn large clinical incentives and reduce pressure to inflate base salaries

Compensation Plan Redesign Efforts

- Compensation plan redesign efforts, in collaboration with SullivanCotter, began in 2018
- Goal was to pursue transformational changes to compensation plan design rather than incremental tweaks to existing plan design
- Primary care and transplant program were first areas of focus
  - Completion of redesign and implementation delayed several months by COVID-19 pandemic but new models went live January 1, 2021

Guiding Principles for Compensation Plan Redesign

VCU Health

New Compensation Models – January 2021

Primary Care Compensation Model

- Reduces salary variability from year to year, moving from model where every incremental wRVU impacts salary to a model with a larger guaranteed salary tied to minimum work standards
- Maintains ability to rewards high performers through clinical performance salary based on mix of wRVUs and panel size
- Introduces incentive pay based on quality/patient experience metrics
- More departmental control than current model

Transplant Compensation Model(s)

- Separate models for transplant surgery and transplant medicine (ie., transplant hepatology and transplant nephrology)
- Reduces emphasis on wRVUs to encourage faculty to focus on other activities vital to the success of the transplant program (e.g., clinic visits rather than endoscopies)
- Introduces incentive pay based on group quality/program enhancement metrics
- Introduces procurement incentives to reward surgeons outside of wRVUs
- More departmental control than current model

CFTE Approach and Challenges

MCV Physicians CFTE Model

MCVP shifted from departmentally-reported CFTEs to centrally-tracked CFTEs using standard approach defined by practice plan leadership

- Shift led to more physicians being reported as 1.0 CFTE

Implementation of CFTE-adjusted wRVU standards in physician compensation plan increased significance of CFTE definition

Reported CFTE has significant impact in new plan models (e.g., primary care)

- Potential compensation and targets for clinical performance salary/incentives adjusted by reported CFTE
- Minimum work standards tied to reported CFTE

MCV Physicians CFTE Model

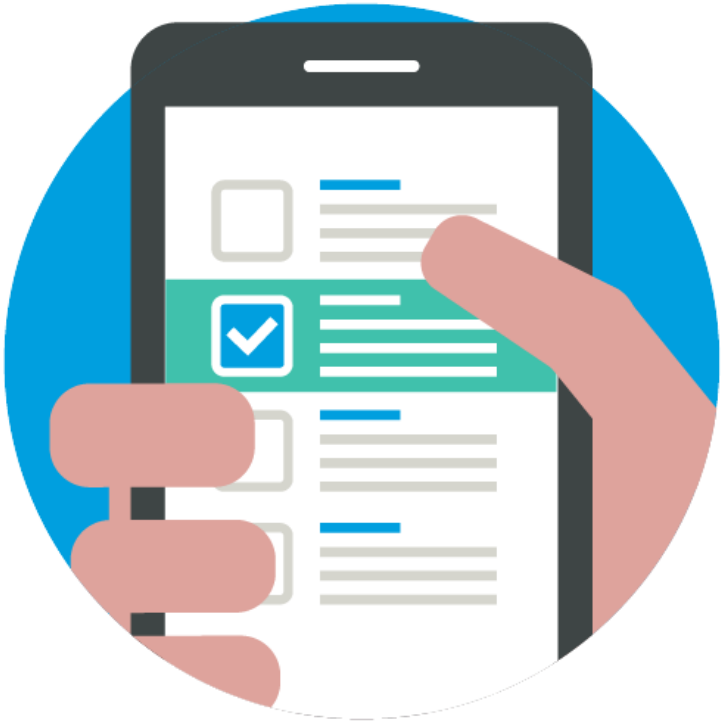
CFTE model begins at 100% clinical and factors in **approved** and **funded** reductions ("buy downs") for distinct administrative or teaching roles and funded research

- Roles must be supported with funding
- CFTE reduction ("Buy down") should be based on expected time-based effort for role (ie., not based on calculated percentage of compensation)
- Denominator equals 55 hrs/week x 46 weeks/yr (2,530 hours)
  - Example: Committee Member = 100 hrs / 2,530 hrs = 0.04 FTE
- Time spent on citizenship and standard teaching duties is included as part of CFTE
- Administrative time related to clinical services (e.g., documentation) is counted in wRVUs and is therefore included as part of CFTE

Polling Question

How does your organization handle committee membership (e.g., Promotion & Tenure Committee, Admissions Committee, etc.)?

- ❑ Stipend w. no CFTE impact
- ❑ Reduce CFTE w. no stipend
- ❑ Reduce CFTE *and* stipend
- ❑ None – part of baseline expectations



Challenges with CFTE Model – Role Stacking

- Some physicians with administrative roles and research effort adding up to more than 1.0 FTE before seeing a single patient
  - Example below:

Role	Effort
GME Fellowship Program Director	15%
GME Core Residency Associate Program Director	20%
Department Vice Chair	10%
Hospital Medical Director	10%
Funded Research	54%
Total	**109%**

- Oftentimes roles may have overlapping responsibilities (e.g. division chief and medical director of service)

Challenges with CFTE Model – Underreported CFTEs

- "Buy down" model can result in understated CFTEs
  - Clinical responsibilities of physician described in last slide:
    - 10 weeks inpatient service, 4 clinics per week
    - Equates to 0.65 CFTE[1]

- Clinical expectations usually not known at corporate level in as much detail as example above, but many examples of low reported CFTEs (e.g., 0.1) and high imputed CFTEs (e.g., 0.7) exist in the organization

[1]Assumes standard of 8 clinics per week for 1.0 CFTE

Challenges with CFTE Model – Accountability for Administrative Roles

Many examples exist where departments assign new administrative responsibilities to providers but claim that new responsibilities will not impact clinical expectations

Compensation plan leads to high compensation levels for providers with multiple administrative roles and high clinical productivity

- Providers often use protected administrative time to deliver clinical services
- Lack of comprehensive time reporting and/or performance metrics related to administrative roles could put organization at risk

VCU Health

Challenges with CFTE Model – Other

Challenges accounting for clinical call contracts

- Physicians receive funding for providing call coverage for external hospitals but this may or may not impact their internal clinical schedule
- Some departments assign effort to these contracts, thus reducing reported CFTE, while others do not

Challenges adjusting expectations for physicians with VA Medical Center appointments (VA 1/8s)

- MCVP developed standard adjustment to a physician's CFTE to correlate with each VA 1/8 for purposes of benchmarking productivity, but this standard adjustment may not match actual practice
- VAMC has very strict definition of each VA 1/8 based on 40-hour work week but a specific VA appointment does not always translate to the same effort at VCU/MCVP
  - For example, 2/8 VA always equates to 10 hours per week for the VA. That physician's effort at VCU/MCVP may translate to 3 or 4 days per week, depending on the physician and how the 10 hours are scheduled at the VA.

Minimum Expectations for CFTE

In addition to challenges with reporting accurate CFTEs, opportunities exist to standardize expectations tied to specific CFTEs

Ambulatory Executive Council endorsed minimum clinical expectations of 8-9 half-day clinic sessions per week for 1.0 ambulatory CFTE

- Implementation of this standard varies across different departments and divisions
- Especially large variances in departmental approaches to adjusting ambulatory expectations in relation to inpatient time

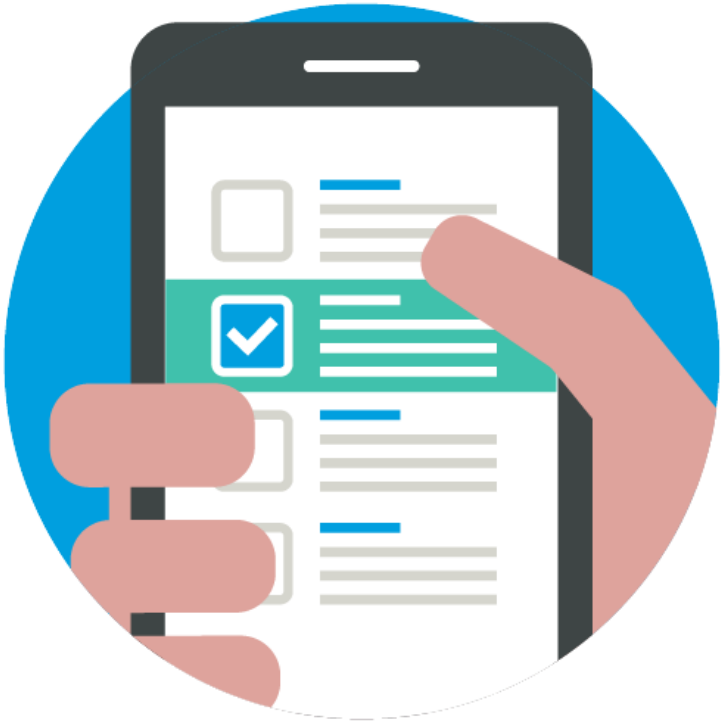
Focus tends to center on specified number of clinics per week rather than annual patient contact hours

- MCVP typically considers 46 weeks of effort per year to account for holiday/vacation/CME time
- Standing clinics, especially on Fridays, may be canceled more frequently than 6 times per year without being rescheduled elsewhere
- Providers may have less than 8 clinic sessions per week because their CFTE is less than 1.0, but then additional clinics are canceled related to the administrative responsibilities that have already been accounted for in the reduced sessions per week

Polling Question

Are clinical expectations set and approved by individual clinical departments or at the corporate level?

- ❑ Individual clinical departments
- ❑ Corporate level



Minimum Expectations for CFTE

Efforts underway to better standardize and track clinical expectations based on providers' reported CFTEs

Inpatient + Ambulatory CFTE Calculator		
	Reported CFTE	**1.00**
Inpatient Ward Coverage		
	Service Intensity	10 or more patients per day
	Days per Week of Coverage	6
x	Weeks	10
=	Total Inpatient Ward Days	60
x	Intensity Multiplier	1
=	**Inpatient Ward CFTE[1,2]**	**0.26**
Inpatient Consults Coverage		
	This section only to be used when inpatient consults is a separate service from inpatient wards	
	Days per Week of Coverage	0
x	Weeks	0
=	Total Inpatient Consult Days	0
x	Intensity Multiplier	0.5
=	**Inpatient Consults CFTE[3]**	**0.00**
Required Ambulatory Clinic/Procedural Sessions		
	Required Ambulatory Clinic/Procedural Sessions	306
	Ambulatory CFTE[4]	**0.74**
Total CFTE		
	Inpatient Ward CFTE	0.26
+	Inpatient Consults CFTE	0.00
+	Ambulatory CFTE	0.74
=	**Total CFTE**	**1.00**

Discussion

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