AMERICAN COLLEGE of CARDIOLOGY

Sample Compensation Plans

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AMERICAN COLLEGE of CARDIOLOGY

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Compensation Plan Construct

Base compensation exists only rarely and usually only for the first ful new year of practice in a new market, with a minimum WRVU threshold expectation at approximately 80% of target WRVU, subject to fair-market-valuation. Minimum expected monthly emergency call shifts are included in base rate.

Thereafter, a flat $ rate per WRVU, either paid individually, or paid to a larger practice group foundation (to allow distribution of work and compensation). The rate per WRVU is subject to fair market value both individually and as a group (in the presence of group practice foundation). Baseline call expectation is again included.

In either case, administrative, research, or teaching hours, only as required by the health system, are contracted separately at an hourly fixed rate and with a maximum hours/month commitment. The hourly rate for these duties and the potential total compensation is subject to both discrete and stacked (with clinical compensation) fair market value, as well as a full review and resolution of conflict of commitment and conflict of interest. Such hours and contracted explicit duties are tracked against the contracted duties and maximum monthly hours.

Abbreviations:
wRVU: work relative value unit

Large Health Care System with Employed Physicians—Example 2

Primary Care—

Plan Summary:

- Base compensation determined annually from prior year production
  - Base compensation changes when production is <90% or >105% of threshold
- Conversion factor compared annually to 3rd party compensation survey data
- Production bonus for work RVUs exceeding threshold (semi-annual payouts)
- Advanced practitioner supervision stipend
- Guarantees for new hire, relocation, adding net new physician within existing practice
- Discretionary quality bonus option

Physician Distribution:

- 44% physicians on guarantee
- 56% physicians on productivity

Hospitalist—

Plan Summary:

- Base compensation determined by years of experience, nocturnist, director
- Production bonus for work RVUs exceeding threshold (semi-annual payouts)
- 5% quality bonus option based on metrics
- Extra shifts compensated on hourly basis and production is not credited for bonus

Physician Distribution:

- 100% physicians on compensation plan

Cardiology—

Plan Summary:

- Base compensation determined annually from prior year production
  - Base compensation changes when production is <90% or >105% of threshold
- Conversion factor compared annually to 3rd party compensation survey data
- Citizen standards - 20% of base compensation at risk if not met
- Call reduction adjustment – up to 35% of base compensation for full call removal
- Production bonus based on group productivity and new patient visits
- Compensation pooling option – requires approval by executive committee and legal
- Proxy work RVUs and stipends credited for various approved activities that are not billable

Physician Distribution:

- 56% physicians on compensation plan
- 44% physicians compensated on individual contract terms

Pulmonary/Intensivist/Sleep—

Plan Summary

- Annual draw determined from prior year compensation
  - Lesser of ceiling amount or 85% of prior year compensation
- Pulmonary and Sleep compensated based on production
- Conversion factor reviewed compared annually to 3rd party compensation survey data
- Intensivists compensated based on hourly rate times hours worked
- Compensation reduction for partial or no-call schedule
- Annual reconciliation of earned compensation to draw – surplus paid to physicians and a deficit will reduce the following year's base draw.
- No production or quality bonus option

Physician Distribution:

- 59% physicians on compensation plan
- 41% physicians on guarantee

Emergency—

Plan Summary:

- Compensation based on hours worked – day rate and separate night rate
- Quarterly reconciliation to restrict the compensation per worked RVU rate from exceeding the 75th percentile

Physician Distribution:

- 100% physicians on compensation plan

Surgery/OB-GYN/Urology—

Plan Summary:

- Base compensation determined annually from prior year production
- Production bonus for work RVUs exceeding threshold (semi-annual payouts)
- Conversion factor compared annually to 3rd party compensation survey data
- Call reduction adjustment – up to 35% of base compensation for full call removal
- OB delivery pool option – requires unanimous election by all OB physicians
- Production bonus for work RVUs exceeding threshold (semi-annual payouts)
- Metric standards - 5% of base compensation at risk if not met
- Discretionary quality bonus option

Physician Distribution:

- 61% physicians on compensation plan
- 39% physicians on guarantee

Urgent Care—

Plan Summary:

- Base compensated determined by hourly rate times hours worked
- Production bonus for work RVUs exceeding threshold (semi-annual payouts)
    - Threshold determined by hours worked times standard work RVUs per hour
    - Qualifying bonus work RVUs are limited to the 75th percentile of work RVUs per hour as reported in the 3rd party compensation survey data
- Advanced practitioner supervision stipend

Physician Distribution:

- 100% physicians on compensation plan

All remaining physicians compensated based on individual contract terms.

Academic Institution: Moderate Sized Private Medical School

- Basis for the Plan: *Currently fixed salary, with "bonus"*
- Goals and Metrics used for salary and productivity:
  - *50-70th percentile AAMC salary*
  - *Considering salary adjustment based on % of wRVU*
- Method for determining annual increases
  - Dept pool, averaged per section, with individual adjustment
- Special considerations for subspecialists: *None*
- Special considerations for "off-site" practitioners:
  - *VA presents unique problems, especially when part-time*
- Basis for Starting Salaries:
  - *50-70th percentile of AAMC*
  - *10-20% unfunded time for early career academicians*

INCENTIVE COMPENSATION/BONUS

Offered in Full as Long as Section has a Positive Variance.

Clinical productivity: Up to 3% of salary
Based on clinical RVU production & RVU threshold for specific sub-specialty
>55% of target: 1%
>65% of target: 2%
>80% of target: 3%
Scholarly work: Up to 1% of salary
Based on local and national presentations and publications
Research activities: Up to 1% of salary
Grants and awards to be considered
Funded effort to be subtracted from cFTE
Service commitment: Up to 1% of salary
Consideration for staff meeting and cardiology grand rounds attendance
Miscellaneous: Up to 1% of salary
At Chief's discretion

Academic Institution: Private Medical School

- Basis for the Plan: – Clinical productivity based on weighted wRVU effort
- Goals and Metrics used for salary and productivity: Perform at the 65th percentile of a MGMA blended 50:50 AMC and private practice benchmark
- Method for determining annual increases: Clinician Base pay set at 80% of the prior year comp; 20% reserved as variable comp based on wRVUs
- Special considerations for subspecialists: wRVUs generated at non-Core clinical sites receive a greater weight during salary calculation. Special considerations for “off-site” practitioners: Affiliated hospital staff operate under a contract rate.
- Basis for Starting Salaries: $250K (General and CHF); $300K (Interventional and EP) and protected for 2 years with ability to earn VC in year 2.

Academic Institution: Private University

Division of Cardiology
Faculty Compensation Plan

Compensation Committee: [REDACTED]

Background

The Cardiology Division at [REDACTED] University is comprised of a talented and diverse faculty with the common goal of advancing the understanding and treatment of cardiovascular diseases. The breadth of faculty expertise ranges from fundamental laboratory investigation to management of complex clinical syndromes. Each faculty is committed to advancing the science of healthcare through the development and/or testing of novel research ideas and educating the next generation of clinician-scientists. The success of the Division has earned national and international recognition for excellence in clinical medicine, research and education.

Historically, Cardiology faculty compensation has been based upon metrics that are not easily quantifiable. Various factors have contributed to salary determination including academic rank, clinical productivity, research awards, institutional leadership roles, and market forces. However, the determination of salary has neither been transparent nor linked to productivity or professional effort. Therefore, the [REDACTED] Health System as well as the current Divisional leadership requested the development of a new effort-based compensation plan that rewards both individuals and groups for high performance.

The present compensation model at [REDACTED] involves two payment sources: the School of Medicine and the faculty physicians' practice. The School of Medicine component accounts for support of research salary and School of Medicine leadership activities. Salary support from the clinical practice is remitted via the PRACTICE. Additionally, faculty members who practice at the VA are paid directly by the VA and this compensation has traditionally been considered part of their total compensation.

Guiding Principles

The following general principles guided the development of the Cardiology compensation plan:

1. The plan will provide competitive market compensation within the Division and Sections.
2. The plan will provide faculty members with a level of income security by providing a base salary accompanied by an opportunity for all faculty members to earn additional production-based incentives based upon predetermined performance benchmarks.
3. The plan will be managed by the Cardiology Division.
4. The plan will be transparent and easily understood.

5. The plan will be designed so that it is easily tracked and administered.
6. The plan will operate within the fiscal bounds defined by the Health System and University.

Plan Summary:

All full time Cardiology faculty in good standing will participate in this program. Full time faculty are expected to work 46 weeks/year and contribute at least 80% of their total effort to Divisional activities.

Salaries will be comprised of several components based upon an "X-Y-Z" system. Total compensation will be determined by summing the support in each component. Individual faculty may not receive compensation support in each component, but rather total compensation will reflect the sources of salary and incentive monies applicable to the individual. The components of X-Y-Z are:

X: Base compensation
Y: Individual productivity-based compensation
Z: High productivity incentives/group incentives

Definitions of each component of the Cardiology compensation plan are as follows:

University Compensation

X: Cardiology Faculty Base Compensation. This component is the guaranteed minimum that could be paid to a full-time member of the Cardiology faculty and is expected to represent a small percentage of the overall compensation. The Cardiology Base represents payment for unfunded research, teaching, mentoring and service to the University.

The Cardiology Base will be rank-based:

	Dollars
Associate in Medicine/ Instructor	$ 0
Assistant Professor	$10,000
Associate Professor	$20,000
Full Professor	$30,000

, It is intended that this compensation will be funded by the Division utilizing institutional funds that flow to the Department and the Division, and monies generated by the faculty.

Y: Cardiology Individual Production is intended to represent the portion of salary generated by research activities, teaching and University leadership

positions. This is non-guaranteed salary that will be set annually based upon the following:

1. **Research Compensation**. Financial support from grants, industry-sponsored projects and institutional educational funds will be attributed to the individual faculty member in the following manner:

    a. Competitive research award (NIH, AHA, NSF, etc.) recipients will receive direct salary reimbursement based upon the monies allocated in the grant budget for faculty salary support.
    b. Industry-sponsored awards
        i. [For industry-sponsored research projects and activities that provide salary support, the portion of the budgeted faculty salary committed to individual faculty compensation will be determined by leadership in conjunction with the faculty member participating in the activity.
        ii. Many Cardiology faculty participate in industry-sponsored trials as the institutional site Principal Investigator (PI). The Plan will address industry-sponsored site-based research activities as follows:
            1. Faculty are expected to report a reasonable approximation of their effort associated with industry-sponsored trials.
            2. Faculty will attribute a minimum of 1% of their University salary to each project. However, in accordance with University policy, individuals participating in multiple trials may elect to aggregate their effort/support so long as it can be well documented and is consistent with their effort expended on the projects.

2. **Educational activities (UME/GME).** School of Medicine payments to the Division for educational activities will be attributed to individual faculty based upon participation.

3. **School of Medicine leadership.** Activities from which salary is derived from [REDACTED] will be included in this component of salary. Examples of Cardiology leadership positions include Division Chief, Section Director, Fellowship Director, etc. These salary components are typically non-guaranteed, and dependent upon maintenance of the leadership position throughout the fiscal year.

Practice Compensation

Practice compensation is a reflection of the faculty's relationship with the practice and related clinical activity. By definition, members of the practice are [REDACTED] University faculty.

X: **Practice Base Salary** will be direct dollars from the practice that support medical directorships, QA Board payments, administration and contract clinical work. This portion of salary support is intended to represent work performed on behalf of the practice that is not linked to direct patient care.

Y: **Practice Individual Production** reflects reimbursement for clinical activities performed on behalf of the practice. The Cardiology Division performs a large number of varied clinical activities that range from interpretation of diagnostic testing to performance of invasive, complex cardiovascular procedures. Further, in an attempt to serve the State of [REDACTED] more broadly, the faculty participates in these activities at various outreach sites.

Reimbursement for clinical activities is based upon payments received by the practice and is dependent upon an RVU system of payment. The practice then passes these collections to the Division to support compensation and practice expense. The amount of reimbursement received by the faculty for their clinical activity is dependent upon specialized training, market forces, and relative risk to the patient or physician. The current RVU-based reimbursement system is thought to over-value procedural activity and under-value Evaluation and Management (E/M) activities.

In an attempt to simplify a relatively complex RVU system, provide equity amongst the various cardiovascular sub-specialties, value the contributions of all providers of clinical cardiology and account for an inability to control uneven scheduling patterns, the RVU system has been converted into a time- and effort-based clinical activity reimbursement scheme (appendix).
This system is generally based upon RVU generation by the provider but relatively weights E/M activities more favorably as these activities drive the remainder of the collective clinical efforts.

In order to provide equitable reimbursement, it is assumed that clinically active faculty will fully participate in each of the clinical activities for which

a payment is being made. For example, it is anticipated that individuals who have a one-half day clinic will utilize the "superslot" template and that individuals reading echocardiograms or performing cardiac catheterization will evenly divide the work during the committed time. The Division leadership in conjunction with the Section Directors will monitor individual and group performance to ensure equity.

Adjustments will be made in January and at fiscal year-end to address variances (favorable and unfavorable) in clinical activity from that which is planned at the beginning of the academic year. In an effort to smooth variances, 25% of the January adjustment value will be reserved, i.e. not assessed in January. There will not be an adjustment when rounding is disproportionately planned in the second half of the year. As an example, a physician who attends 10 more clinics in the first 6 months of the fiscal year than originally planned would receive a payment of $5,625 in January ($750 x 10 x 0.75) The converse would occur if that individual attended 10 fewer sessions than planned.

Clinical Operations Management:

It will be the responsibility of the Division Clinical Chief, in conjunction with the Division Administrator, to work with Section leadership to insure appropriate balancing of clinical schedules and for monitoring throughput of all activities to appropriate levels. Quarterly reports will be sent to all faculty and Section Leaders that quantify activity performed versus commitments such that adjustments in activity can be proactively made.

Z: The Cardiology Incentive provides financial reward to individual faculty who perform at the highest levels while also rewarding groups of faculty who work together to accomplish Divisional goals. Importantly, all faculty will have the opportunity to participate in this compensation. The payments will be made annually at the end of each fiscal year and will typically be paid in August after the books have been closed. To be eligible for payment, the faculty member must be employed by [REDACTED] UNIVERSITY and a member in good standing of the Cardiology Division at the time of distribution.

The funding for these payments will be derived from monies generated by total incremental Divisional clinical revenues less the incremental compensation already paid as well as additional sources that are yet to be defined. If there is no increase in TOTAL divisional clinical revenue from

the previous year, there will be no available monies for incentive payments.

Prior to faculty distribution, the incentive pool will be divided into three distinct components:

A. Individual clinical incentive (1/3)
B. Group incentive (1/3)
C. Chief discretionary incentive (1/3)

Individual Clinical Incentive

The individual clinical incentive is designed to reward the faculty for high clinical productivity. In order to qualify for the individual clinical incentive, faculty must commit at least 40% of their effort to clinical activities, as defined by total professional effort (TPE), and generate wRVUs at or beyond the 50th percentile of effort- adjusted MGMA benchmark for their specialty.

Once the amount of money available for the individual clinical incentive has been determined, qualifying faculty will be reimbursed according to the following formulas:

$$\frac{\text{Individual faculty wRVUs}}{\text{The sum of wRVUs for qualifying faculty}} \times \text{Total Individual Incentive Pool}$$

This percentage will be paid out to the faculty member. For example, if the total individual incentive pool was $100,000 and a qualifying faculty member contributed 10% of the total wRVUs the faculty member would receive an individual incentive payment in the amount of $10,000.

Section Incentive

At the beginning of each academic year, the Section Heads will meet with the Division Chief and the Director of the Heart Center to determine appropriate goals for each section. These goals may include, but not be limited to, clinical growth, improvements in efficiency, demonstration of quality, patient satisfaction, novel research initiatives, etc. The goals will be quantitative and feedback regarding performance of the Section will be

provided quarterly. Payment of the Section Incentive will be dependent upon achievement of these pre-defined goals.

Distribution of the Section Incentive will be at the discretion of the Section Head. However, it is intended that all faculty in the Section will share equitably in the Section Incentive. If the Section Head plans unequal distribution of these funds, the discrepancy must be justified to the Division Chief and the Director of the Heart Center who must approve it.

Sections not meeting the defined Section Incentive goals will forfeit the monies to the Division Chief.

Chief Discretionary Incentive

The Division Chief incentive is designed to reward academic excellence, research accomplishments, and faculty with < 40% of TPE committed to clinical medicine. The sources of these monies include 1/3 of the total incentive pool as well as any monies forfeited by a Section for failure to meet the Section goals. It is recognized that the Division Chief requires an annual operating budget and is allowed to keep 15% of the money allocated in the Chief Discretionary Incentive as well as all monies forfeited by the Sections.

During the first year following implementation of the plan, the Compensation Committee will develop a worksheet that accounts for faculty academic (non-clinical) accomplishments. An objective scoring system that assists in Chief Incentive determination will accompany the worksheet.

Two months prior to the end of each fiscal year, the faculty will be asked to submit their worksheet outlining academic accomplishments in the past year, new grant awards, innovative research, teaching awards, important manuscripts, and non-reimbursed contributions to the Division ("citizenship"). The Division Chief will allocate available monies to faculty based upon the relative contribution of the individual to the overall success of the Division.

ADMINISTRATIVE OVERSIGHT:

The Cardiology Division leadership will have the responsibility of tracking wRVU generation and clinical effort. This information will be reported at

least quarterly in a manner that is easily understandable and allows the faculty to project annualized compensation.

In the case of Medical Leave the faculty member shall be paid in accordance with [REDACTED] University policies. Salary may decrease if a Faculty member fails to meet reasonable expectations, is terminated, loses a significant funding source such as a significant grant(s), or exceptional market forces result in disproportionate decreases in revenue or increases in expense that affect all faculty alike. If a faculty member experiences a salary decrease, the Divisional leadership, the Chairman of Medicine and the faculty member will determine the best strategy to manage the situation. However, it is anticipated that limited situations such as this will arise because of the quality and motivation of the Cardiology faculty as well as the construct of this plan which affords ample opportunities to earn.

The Compensation Committee will meet at least quarterly to discuss operational issues related to faculty remuneration and the performance of the Plan. Each Spring the Committee will meet with the division administrators to assess the finances of the Division relative to faculty salaries and to review monies available in the incentive pool. During that meeting a new fee schedule for clinical activities will be developed.

CLINICAL COMPENSATION MENU – PRACTICE Y (Appendix)

Division of Cardiovascular Medicine
Clinical Compensation Worksheet

Faculty Member
Academic Rank
Category
MGMA Clinical Type

CLINICAL	FYxx (July 20xx- June 20xx)		
Clinical Activities	Units	$ Per Unit	FYxxProjected Clinical Comp
Rounding Days			$ -
Cath Lab Days			
Cath Call Nights (M-F)			$ -
Cath Call Weekends (S/S)			$ -
EP Lab Days			$ -
Outpatient Clinic Sessions			$ -
ECG Reading Sessions			$ -
ECG Reading Weekends			$ -
Holter Reading Sessions			$ -
Echo Reading (1/2 day)			$ -
MRI Reading Days			$ -
Outreach Days (including Mobile Cath)			

New services and opportunities that generate revenue will arise which are not included in the current reimbursement menu. As the revenue generated from new activities is difficult to determine in advance, the adoption of these activities is likely to be variable and the faculty effort is undefined, the compensation plan will approach these activities as follows:

A. Once a new activity has been identified, the faculty member will notify the business manager who will discuss with Division Leadership and put into place an appropriate tracking of volume and revenue.
B. The faculty will estimate the time required for participation in the activity.
C. Assuming Divisional leadership approval, the initial reimbursement will be paid semi-annually consistent with other menu variables. After a sufficient experience has been obtained to estimate appropriate reimbursement, a line item will be added in the compensation menu for the following year.

Academic Institution: Public University

Date: November 1, 20xx

To: Human Resources Committee

The Department of Medicine proposes the following Physician Compensation plan for eligible participants for Fiscal Year 20xx (July 1, 20xx to June 30, 20xx).

Eligible Job Titles:	Physicians providing patient care services
Clinic:	Department of Medicine
Supervising Medical Director:	John Doe
Effective date:	July 1, 20xx

COMPENSATION GOALS

It is the Department of Medicine's goal to provide an attractive compensation package to retain and recruit outstanding faculty (50% of AAMC Schedule). Furthermore, the Department will sustain the financial integrity of the Department by operating within budgeted capabilities and constraints in order to meet our academic and service missions. The Department seeks to reward faculty for their clinical, research, education and administrative contributions and provide incentives for adherence to clinical practice standards, participation in high priority educational programs, and department-wide education and research activities. Total compensation per faculty physician cannot exceed the 80th percentile for AAMC Public and Private U.S. Medical School salaries for the specific academic rank of the physician (or some other salary survey approved by the Dean), unless the Dean of the Medical School approves an exception.

COMPENSATION PLAN ELEMENTS

Salary Payment Components:

A. "Base salary" payments (known as the "X Component"). Base salary is paid by the University to compensate faculty for service to the University. For those faculty members who are governed by the Tenure Code, this is the component of salary that is guaranteed. These payments are not guaranteed for faculty not governed by the Tenure Code.

B. "Supplemental salary" payments (known as the "Y Component"). This salary component may be paid by the University to its faculty members and may include both "augmented" salary for defined administrative appointments, and "increments" which are variable components of compensation that may be earned by participating in academic or administrative activities, or for academic productivity under criteria determined by the department as agreed to by the Department Head or Dean of the Medical School. This criteria may include exemplary teaching activities, research grant acquisition, research grant maintenance, or scholarly productivity as evidenced by publications or awards. Included in this salary component are technical pay adjustments to support competitive pay practices with targeted markets, and pay terms established in employment agreements. This category of compensation is not guaranteed by the Tenure Code or otherwise and does not automatically recur each year.

C. "Clinical Practice" payments (known as the "Z Component"). Clinical practice payments are paid by UNIVERSITY Physicians for the clinical services performed by its employed physicians. These payments are made to faculty members through a common paymaster arrangement between UNIVERSITY Physicians and the University, where the University functions as UNIVERSITY Physicians paying agent. Payments for clinical practice services may be in the form of fixed salaries and/or variable payments based on clinical productivity results. Clinical practice payments are not guaranteed by Practice Physicians nor the University, through the Tenure Code or otherwise, and may vary by productivity and may be adjusted by the Clinic Manager/Department Head.

Total monthly salaries paid to physicians by the Department and UNIVERSITY Physicians Clinic will be the sum of the three compensation components: "base salary" plus "supplemental salary" plus "clinical practice" payments. Non-faculty physicians are only paid through the third compensation component, i.e., clinical practice payments.

SECTION I: DEPARTMENT OF MEDICINE SALARY ADJUSTMENT PROCESS

The Department of Medicine will adjust physician salaries periodically throughout the plan year. Salaries may need to be adjusted to reflect changes in physician productivity, changes in divisional or department revenues and expenses, or other financial realities that occur. Each individual physician will be evaluated using the following review and adjustment grid:

1	**Revenue =**	
		Patient Net Receipts, or Recorded RVUs (depending on Division)
	plus	Contracts
	plus	Medical Legal Consulting
	plus	Veterans Administration Contracts
	plus	Research Grants
	plus	Miscelaneous revenue (philanthropic, collegiate, university)
	=	Total Revenue
2	**Intra-University Subsidized Augmentations**	
	plus	Faculty Leadership role
	plus	Supplemental Academic duties
	plus	IRC Fund
	=	Total Subsidized Augmentations
3	**Compensation**	
	minus	University and UMP salary
	minus	Employee benefits expense
	minus	Academic business expense
	=	Amount Available for Compensation
4	**Other Expenses**	
	minus	Division overhead
	minus	Transcription expense
5	**=**	Physician net position

Individual Physician Budget Reconciliation Template

A physician is eligible for an augmented salary review when the physician's net receipts (receipts collected after fixed and variable expenses) exceed the 2009 budget. This salary augmentation, if earned, is payable in the form of increased total salary in 2010. The general template used to determine if net receipts exceed a physician's budget is displayed in the chart that follows.

Productivity = Total Revenues ÷ Total Expenses	**Compensation Review & Adjustment Process***
100% & Above	Eligible for increase in compensation, in addition, increases due to advancement in academic rank, incremental responsibilities recognized by the department or division, or equity adjustments will be considered
≥ 95% but < 100%	No change in compensation. Plan will be developed to improve effort/funding activities to achieve ≥ 100% productivity during this year.
≥ 85% but < 95%	Optional 0 - 5% decrease. Plan is required to achieve ≥ 100% producitivity this year.
≥ 70% but < 85%	Strong likelihood of 10% decrease. Plan is required to achieve ≥ 100% productivity this year.
Recurring productivity that is < (less than) University salary (base)	No professional business expense allocation, and a plan is required to produce revenues ≥ base salary plus fringe benefits expense. Division support is at the discretion of the Divisi

** Excludes faculty in Development Phase or Early/Phased Retirement Plan.*

SECTION II: CARDIOVASCULAR DIVISION SALARY DETERMINATION

Cardiovascular Division salary determination principles:

1. Compensation for clinical, administrative and educational work should be proportional to the amount of time spent on those activities and the total, pooled Divisional funds available for compensation.
2. Faculty time devoted to all clinical, administrative, and dedicated educational activity is equally valued except that:
   a. We recognize an additional value of experience and seniority
   b. We recognize that on-call and outreach activity is more burdensome and should carry a higher weight
3. Individual salary support from research grants should flow to the funded faculty member

4. Salary augmentation from other funds controlled by a faculty member or the leadership, where such funds are appropriate for compensation, is permissible.
5. The Division honors contracts with individual faculty members.
   a. Salaries specified in employment contracts will have precedence over salaries determined by the standard method (see below)

Cardiovascular Division salary calculation: Standard Method

Salary = [[(Fac time*SF)/(T Div Time)]*T Pooled Funds] + Res GNT Sal Supp + Sal Aug

Where:

Fac time =	"Faculty Time" = Total number of days/year devoted to clinical, dedicated teaching, and administrative duties by an individual faculty member. This includes on-call time. > Note #1: The actual time value of "*on-call*" and outreach activities are augmented to reflect the added effort of these activities which is as follows: Interventional & Imaging call duties are valued at 1.5 Days/weekend call day and 0.75 days/ weeknight call day. General, EP & Heart Failure call duties are valued at 1.0 day/weekend call day and 0.5 day/weeknight call day. Concurrent call duties are valued at base higher level call + 0.5 (lower level call). > Note #2: "Administrative time" (estimated actual time by category of administrative duty) is valued by a formula that includes responsibility level. Each responsibility level (Section Leader, Site Director, Steering committee memberships, etc.) has a time value, and each activity has an estimated time commitment in days.
T Div Time =	"Total Division Time" = Total number of days/year devoted to clinical, dedicated teaching, and administrative duties by the entire section

SF =	"Seniority factor" schedule = 1.0 for faculty in the first two years of faculty appointment, 1.1 for faculty 3-7 years on the faculty, and 1.2 for faculty > 7 years or Associate Professor rank)
T Pooled Funds =	"Total Pooled Funds" = Total pool of clinical income, leadership and educational funds available for compensation
Res GNT Sal Supp =	"Research grant salary support"
Sal Aug =	"Salary augmentation" = intra-University subsidized funds from other sources (endowed chairs, MMF funds, institutional commitments)

General Disclaimer

While it is expected that this plan will not be subject to frequent change, the University and UNIVERSITY Physicians reserves the right, at its sole discretion, to terminate or change this plan at any time. This plan does not represent an employment agreement for any specified term. The employee and the University reserve the rights to terminate employment at any time. The earnings potential identified or implied in this document are for illustration purposes only. Actual performance and productivity results will determine total compensation.

All compensation payments will be governed by The Physician Compensation Policy of Practice Physicians, as well as other University Compensation requirements that may apply. The Clinic Governing Board attests with its approval of this physician compensation plan document that compensation payments comply with all regulatory and University governance requirements, including the Physician Compensation Policy of Practice Physicians.

Academic Institution: State University

- Basis for the Plan: – **70% wRVU** (1/4 Chief's discretion)**, 20% quality, 10% leadership.**
- Goals and Metrics used for salary and productivity: **e.g. 50th percentile MGMA for Base Salary wRVUs targets. Pure E&M (CHF) 75% of wRVU target**
- Method for determining annual increases: **When MGMA changes by >5%.**
- Special considerations for subspecialists: **Prepaid incentive.**
- Special considerations for "off-site" practitioners: **e.g., 80% of MGMA Private Practice, no fellows, etc.**
- Basis for Starting Salaries: **10% reduction (Salary/wRVU) x 2 years, no downside.**

Academic Institution: State University with Hospital Owned by Large Non-Profit Corporation

- Basis for the Plan: – wRVU
- Goals and Metrics used for salary and productivity: 60th percentile of Sullivan Cotter benchmarks used for clinical incentive, 40th percentile AAMC for research effort compensation
- Method for determining annual increases: +/- 10% max based on prior year productivity
- Special considerations for subspecialists: Base salaries specialty specific
- Special considerations for “off-site” practitioners: N/A
- Basis for Starting Salaries: Use Sullivan Cotter model but tweak for goals/effort of individuals

Academic Institution: Compensation for Teaching/Scholarly Activity

- Private University - $50,000 stipend for clinician-educators.
- Private University–Education: fixed amount for most at 7-10% total comp, except program director; for research component: just above NIH cap.
- State University– Offset of wRVU target based on $ available.
- State University with Hospital owned by Nonprofit Corp. - No teaching compensation, 40th percentile AAMC used if academic compensation included in a package (rare for clinical people).
- State University – Time teaching compensation generally benchmarked to NIH cap.
- Private University – Fixed allocation, figures in “bonus”.
- Private University - Protected time covered at 70th percentile AAMC for researchers. Teaching for leadership roles at percentage of NIH cap.

Metrics for Setting PhD Researcher Salaries

- Private University: ~NIH cap.
- Private University: No formal metric.
- State University with Hospital owned by Nonprofit corporation: PhD scientists hired in collaborating basic Dept (eg: Cellular and Molecular Medicine).
- Private University: 50the percentile AAMC for the highest paid basic science department (currently Human Genetics) as a guideline.
- State University: AAMC, approx. 70% NIH funding.
- State University: 50th – 75th percentile AAMC.
- Private University: Based on maintaining parity across Dept of Medicine.

How do you Incentivize Meeting Quality Metrics?

- Private Medical School: Factored into comp and bonus.

- Private Medical School: Being planned.
- State University with hospital owned by nonprofit corp: 5% “academic” incentive at Chief’s discretion, standards minimal at present.
- Private Medical School: Individual citizenship component (as defined by cardiology leadership annually) of variable compensation returned based on achieving quality metrics (up to 5%).
- State University: approximately 3% incentive each year with other rewards through year.
- State University: Factored into quality pool.
- Private Medical School: patient satisfaction bonus.

Independent Cardiovascular Physician Group

Time Value Units (TVU's)

Time Value Units (TVU's) can be used in many ways by cardiovascular practices. A better understanding of what TVU's are, how they can be used, and the potential pitfalls of TVU systems will help the reader better understand the applicability to their own work environment.

What are TVUs and How do you Define Them:

TVUs need to be created by the user based upon their own work environment. The values should be a true measure of the time it takes the average physician to carry out a given billable or non-billable event. This allows us to track work in a meaningful way, not tied to the CMS work RVU values which do not necessarily correlate with the time involved to accomplish those billable events. This Physician Group maintains TVU values for every billable item, and arrives at those values through a survey of the practice overseen by a sub-committee of the Board (**figure 1**). Once our initial values were set, any billable codes that are altered are reviewed immediately and service line codes are reviewed at regular intervals. Other changes in workflow, technology, variations between hospitals or offices or other modifications to the work environment require review and adjustment of these values. What is most important is that it is understood that TVUs are not perfect, and are only a rough measure of work. The system is not meant to be an exact measure, and for us does not directly affect compensation. Many variables affect TVUs including efficiency of work in one location vs. another, and in an office vs. a hospital.

Non-billable TVUs are the TVUs that are associated with tasks and responsibilities that do not correlate to a billable event. Practices need to control and stipulate exactly which activities qualify for non-billable TVUs. Travel or windshield time can be automatically accounted for based upon physician schedules and applied without physician input (**figure 2**). Valuing the time that physicians dedicate to those activities that are supported by the practice or the system such as research, teaching, leadership positions and important committee participation helps to encourage physicians to take the time out of work RVU activity to carry out these other responsibilities, without worrying that it might affect their compensation. (**figure 3**) Physicians who have significant administrative leadership positions either in the practice or with the health system, are given blocks of time out of their clinical schedule to carry out those responsibilities, and are credited that appropriate amount of TVU time.

How do you account for TVUs:

TVU's that are associated with any billable event are easy to account for. We have created the equivalent of a fee schedule within our practice management system, and can therefore easily calculate TVUs based upon a physician's entered charges by CPT code. Non-billable TVUs unfortunately need to be tallied manually. Physicians need to submit their non-billable TVUs quarterly. Many of these are accounted for automatically when they involve practice meetings or committees, or time that is given to physicians as block time for any number of activities related to teaching, administration, leadership or research. TVU reports are distributed twice a year to all physicians (figure 4). Depending upon how you are using your TVUs, it may be important to distribute these more or less frequently per the discussion below.

How do they use TVUs:

This Physician Group is an equal share practice, meaning, that we believe that at the partner level, we are all equal. We should all work equally (even though we do different things to support the practice) as it relates to time and defined by the TVUs, be valued equally, , take equal call and share other responsibilities to the practice and share equally in compensation. In order to remain "equal", it is expected that every physician will remain within 15% of the mean of all partners. In an equal share environment, TVUs serve to assure the physicians that everyone is carrying their weight and doing their fair share. We work collaboratively, we make sure the global work is done before anyone goes home. If a physician would fall below 15% of the mean, that could affect their compensation if the TVUs are not corrected in the next six months. Since physicians do not control their own schedules (standard office templates are used and balance between office and hospital is controlled by our Scheduling Committee) it would be extremely rare for this to occur. We use TVUs as an aid to practice management as well. If we see a particular physician or group of physicians in a region with very high TVUs, we know that we need to dedicate more resources to that region. On the contrary, if a physician or regional group is low, we are either over staffed in that location, or need to address marketing and business related issues to increase the work. Regional TVUs also tell you whether work is evenly divided among regions or hospitals as it relates to daily workloads or weekend call assignments. (Figure 5) A successful TVU system requires transparency, integrity, consistency and a governance system that assures every individual a voice in decision making. Since we are an equal share practice as it relates to physician compensation, time becomes our currency, not money. For that reason, a TVU system that the physicians believe in and have confidence in is critically important.

The Difference between TVUs and work RVUs:

I don't need to remind the readers that the CMS work RVU system tends to be somewhat arbitrary and does not necessarily reflect either the complexity of work, or the time it actually takes to carry out the defined activities. As a good example how

this system can significantly alter physician compensation, let's look at two physicians in our practice who we believe do equal work based upon almost identical values in our TVU system, but have significantly different work RVUs. (**figure 6**) The correlation between work RVUs and TVUs can vary from 4.6 to 5.8 in our system. This means that depending upon the work that you do, you could get 4.6 or 5.8 work RVUs for every hour that you work. So, for our two physicians who have almost identical annual TVUs, there is a delta of _____ work RVUs, so that if each physician was being compensated purely on a work RVU basis, they could have a $120,000 difference in income for doing the same amount of work for the practice. This leads us to the question of how can TVUs be used in a variety of different practice environments.

Equal Share:

- Safeguard to Equality, takes potential resentment out of the equation.
- Values non-revenue generating work equal with all other work
- Encourages and facilitates teaching, leadership participation and research
- Manage efficiency of practice and physician resources
- Identify practice needs together with other metrics such as wait times, fill rates, trending, orders management and capacities.

Productivity Based:

- Assure equality of work for shared portion of Comp
- Convert TVUs to work RVUs for productivity portion of comp or take average of the two.
- Use TVUs to value and compensate non-revenue generating work that aligns with practice and system goals

Blended:

- Assure equality of work for shared portion of Comp
- Convert TVUs to work RVUs for productivity portion of comp or take average of the two.
- Use TVUs to value and compensate non-revenue generating work that aligns with practice and system goals

Independent:

- Can build your work model and compensation model around a TVU system to accomplish the goals of the practice.
- Works for any of the compensation models above

Integrated:

- Added benefit, is that a TVU system gives you a 'tool' by which you can value non-revenue generating work to align with system goals or quality measures.
- These "value" TVUs can be modified on an annual basis as strategy and goals change to drive physician behavior.
- TVUs become an excellent tool as we move more aggressively into Population Health and a more Value dominated healthcare system.

Interventional TVU Survey

Enter your estimate of time required for each Procedure		
Procedure	CPT billed	Time in minutes
Diagnostic Left Heart Cath	93458-26	
Diagnostic LHC + grafts	93459-26	
Diagnostic Left and Right heart Cath	93460-26	
Right heart cath	93451-26	
Left heart cath and PCI	93458-26, 92928 (stent)	
PCI per vessel	varies	
IABP	33967	
Cath with CardioMEMS	93451-26, 93799	
IVUS per vessel	92978/92979	
TAVR	33361	
Mitraclip	33418	
Impella without intervention	33990	
Impella with intervention	33990 + cath/intervention	
Removal of Impella	33992	
CTO per vessel	92943	
Pericardiocentesis	33010	
Endocardial biopsy	93505-26	
Balloon valvuloplasty	92986	
ASD closure	93580	

Figure 1

From here to here	Xx OFFICE	xxx HOSP	xxOFF	xx HOSP	xx OFF	xxx HOSP	xx OFF	xxHOSP	xxOFFICE	xx OFF	xx HOSP	xxOFF	xx HOSP
xx OFF	0/0	0/0	2.5mile/ 10 min.	2.5 mile/ 10 min.	6.5 miles/ 20 min	6.5 miles/ 20 min	8.7 miles/ 19 min.	8.9 miles/ 19 min.	9.5 miles/ 25 min	17.1 miles/ 28 min	17.1 miles/ 28 min	16.4 miles/ 30 min.	16.4 miles/ 30 min.
xxHOSP	0/0	0/0	2.5mile/ 10 min.	2.5 mile/ 10 min.	6.5 miles/ 20 min	6.5 miles/ 20 min	8.7 miles/ 19 min.	8.9 miles/ 19 min.	9.5 miles/ 25 min	17.1 miles/ 28 min	17.1 miles/ 28 min	16.4 miles/ 30 min.	16.4 miles/ 30 min.
xx OFF	2.5 mile/ 10 min.	2.5mile/ 10 min.	0/0	0/0	4 miles/ 11 min.	4 miles/ 11 min.	6.9 miles/ 14 min.	6.11 miles/ 14 min.	10.2 miles/ 21 min	15.3 miles/ 23 min	15.3 miles/ 23 min	19.8 miles/ 31 min.	19.8 miles/ 31 min.
xxHOSP	2.5 mile/ 10 min.	2.5 mile/ 10 min.	0/0	0/0	4 miles/ 11 min.	4 miles/ 11 min.	6.9 miles/ 14 min.	6.11 miles/ 14 min.	10.2 miles/ 21 min	15.3 miles/ 23 min	15.3 miles/ 23 min	19.8 miles/ 31 min.	19.8 miles/ 31 min.
xx OFF	6.5 miles/ 20 min	6.5 miles/ 20 min	4 miles/ 11 min.	4 miles/ 11 min.	0/0	0/0	9.6 miles/ 19 min.	9.8 miles/ 19 min	12.6 miles/ 27 min	16.4 miles/ 29 min.	16.4 miles/ 29 min.	18.7 miles/ 35 min.	18.7 miles/ 35 min.
xx HOSP	6.5 miles/ 20 min	6.5 miles/ 20 min	4 miles/ 11 min.	4 miles/ 11 min.	0/0	0/0	9.6 miles/ 19 min.	9.8 miles/ 19 min	12.6 miles/ 27 min	16.4 miles/ 29 min.	16.4 miles/ 29 min.	18.7 miles/ 35 min.	18.7 miles/ 35 min.
xx OFF	8.7 miles/ 19 min.	8.7 miles/ 19 min.	6.9 miles/ 14 min.	6.9 miles/ 14 min.	9.6 miles/ 19 min.	9.6 miles/ 19 min.	0/0	.5 miles/ 2 min.	5.2 miles/ 15 min	10.1 miles/ 17 min.	10.1 miles/ 17 min.	15.6 miles/ 24 min.	15.6 miles/ 24 min.
xxHOSP	8.9 miles/ 19 min.	8.9 miles/ 19 min.	6.11 miles/ 14 min.	6.11 miles/ 14 min.	9.8 miles/ 19 min	9.8 miles/ 19 min	.5 miles/ 2 min.	0/0	5.2 miles/ 15 min	10.1 miles/ 17 min.	10.1 miles/ 17 min.	15.6 miles/ 24 min.	15.6 miles/ 24 min.
xxOFFICE	9.5 miles/ 25 min	9.5 miles/ 25 min	10.2 miles/ 21 min	10.2 miles/ 21 min	12.6 miles/ 27 min	12.6 miles/ 27 min	5.2 miles/ 15 min	5.2 miles/ 15 min	0/0	8.2 miles/ 17 min.	8.2 miles/ 17 min.	10.1 miles/ 20 min.	10.1 miles/ 20 min.
xx OFF	17.1 miles/ 28 min	17.1 miles/ 28 min	15.3 miles/ 23 min	15.3 miles/ 23 min	16.4 miles/ 29 min.	16.4 miles/ 29 min.	10.1 miles/ 17 min.	10.1 miles/ 17 min.	8.2 miles/ 17 min.	0/0	0/0	7.6 miles/ 13 min.	7.6 miles/ 13 min.
xx HOSP	17.1 miles/ 28 min	17.1 miles/ 28 min	15.3 miles/ 23 min	15.3 miles/ 23 min	16.4 miles/ 29 min.	16.4 miles/ 29 min.	10.1 miles/ 17 min.	10.1 miles/ 17 min.	8.2 miles/ 17 min.	0/0	0/0	7.6 miles/ 13 min.	7.6 miles/ 13 min.
RxxOFF	16.4 miles/ 30 min.	16.4 miles/ 30 min.	19.8 miles/ 31 min.	19.8 miles/ 31 min.	18.7 miles/ 35 min.	18.7 miles/ 35 min.	15.6 miles/ 24 min.	15.6 miles/ 24 min.	10.1 miles/ 20 min.	7.6 miles/ 13 min.	7.6 miles/ 13 min.	0/0	0/0
xxHOSP	16.4 miles/ 30 min.	16.4 miles/ 30 min.	19.8 miles/ 31 min.	19.8 miles/ 31 min.	18.7 miles/ 35 min.	18.7 miles/ 35 min.	15.6 miles/ 24 min.	15.6 miles/ 24 min.	10.1 miles/ 20 min.	7.6 miles/ 13 min.	7.6 miles/ 13 min.	0/0	0/0
xx OFF	26.1 miles/ 41 min.	26.1 miles/ 41 min.	26.6 miles/ 42 min.	26.6 miles/ 42 min.	28.4 miles/ 46 min.	28.4 miles/ 46 min.	25.6 miles/ 36 min.	25.6 miles/ 36 min.	21.2 miles/ 31 min.	18.9 miles/ 28 min.	18.9 miles/ 28 min.	14.1 miles/ 22 min.	14.1 miles/ 22 min.

Figure 2

TVU Report – 20xx

	TVU	TVU	TVU	TVU	TVU	TVU	TVU	TVU	TVU
	Total	Doc A	Doc B	Doc C	Doc D	Doc E	Doc F	Doc G	Doc H
Non-billable TVUs Jan-June in minutes:	287,781.00	5,060.00	2,940.00	2,855.00	3,680.00	3,115.00	5,455.00	9,890.00	2,320.00
Non-billable TVUs Jan-June in hours:	4,796.35	84.33	49.00	47.58	61.33	51.92	90.92	164.83	38.67
Total Non-Billable TVUs	4,796.35	84.33	49.00	47.58	61.33	51.92	90.92	164.83	38.67
Total Billable TVUs	34,238.15	1,056.20	748.42	738.98	756.91	646.32	904.01	774.75	1,319.28
Total TVUs	39,034.50	1,140.53	797.42	786.56	818.24	698.24	994.93	939.58	1,357.95
Total TVUs FEP Average	**899.59**								
% of Average		**126.78%**	**88.64%**	**87.44%**	**90.96%**	**77.62%**	**110.60%**	**104.45%**	**150.95%**
Partner Average w/o EP:	**832.23**								
% of Average w/o EP			**44.34%**	**43.73%**	**45.50%**	**38.82%**	**55.32%**	**52.24%**	

TVU Report – 20xx

	TVU	TVU	TVU	TVU	TVU	TVU	TVU	TVU	TVU
	Total	Doc A	Doc B	Doc C	Doc D	Doc E	Doc F	Doc G	Doc H
Non-billable TVUs Jan-June in minutes:	552,510.26	9,730.00	5,870.00	5,440.00	1,550.00	7,080.00	11,815.00	14,140.00	4,690.00
Non-billable TVUs Jan-June in hours:	9,208.50	162.17	97.83	90.67	25.83	118.00	196.92	235.67	78.17
Total Non-Billable TVUs	9,208.50	162.17	97.83	90.67	25.83	118.00	196.92	235.67	78.17
Total Billable TVUs	66,207.53	1,886.76	1,452.55	1,571.53	1,414.92	1,268.46	1,896.08	1,428.85	2,290.29
Total TVUs	75,416.03	2,048.93	1,550.38	1,662.20	1,440.75	1,386.46	2,093.00	1,664.52	2,368.46
Total TVUs FEP Average	**1,787.82**					4/1/17			
% of Average		**114.60%**	**86.72%**	**92.97%**	**80.59%**	**77.55%**	**117.07%**	**93.10%**	**132.48%**
Partner Average w/o EP:	**1,654.72**								
% of Average w/o EP			**86.20%**	**92.42%**	**80.11%**	**77.09%**	**116.38%**	**92.55%**	

Figure 3

Provider of Cardiology Management Services; Academic Practice

Bonus structure for ALL faculty

- Group compensation pool meet wRVU baseline to account for base salary
- 80% based on individual RVU production, 20% based on 4 nonRVU domains.

Summary of the nonRVU portion of the bonus: each section weighted 12.5%

Teaching –

A. Fellow evaluations - ≥4.0 – 100%
B. Internal medicine resident or fellow clinic preceptor for 12 months – 50%
C. Medical school cardiac pathophysiology small group – 50%

Research –

D. Mentoring a resident/ fellow on a project that is presented locally or nationally or published (case reports, reviews, original research)-50%
E. Peer-reviewed publications – 1-2 50%; >2 100%.
F. Receiving external funding for investigator initiated work -100% threshold
G. National meeting abstract accepted 1-2- 50% ; >2 100%
H. PI on a clinical trial – 50%
I. Submitting any funding proposal – 50%

Quality:

J. GROUP METRIC (50%):
   1. Inpatient transthoracic echo turnaround time (same day >95%)
   2. Inpatient nuclear cardiology turnaround time (same day> 95%)
   3. HCAPS for inpatient service (Stable percentile)

K. INDIVIDUAL METRIC (50%)
   1. EPIC inbox (results, messages, calls) total< 50 on two random reviews

Citizenship-

L. Maintains organizational awareness and stewardship 50%
   1. Support of institution's mission and work in constructive manner
M. Attendance at grand rounds and faculty meetings 25%
N. Program building/outreach/committee work 25%

Bonus structure for NEW faculty

- First three years prior to consideration for entering group compensation pool
- 50% based on individual RVU goals
- 50% based on 4 nonRVU domains.

Summary of the RVU portion of the bonus

Year 1	25 %	MGMA	4,700 – 100%
			4,000 – 80%
			3,500 – 60%
Year 2 & 3	50 %	MGMA	6,500 – 100%
			6,000 – 80%
			5,500 – 60%