Clinical Compensation Plan

Frequently Asked Questions

UVA Health
School of Medicine

Overview

Achieving excellence across all elements of our mission is core to what we do at UVA, and our exceptional faculty are critical to our success. We want to create an energizing and enriching experience for faculty, starting with a compensation plan that is market-competitive, equitable, and easily understood. The School of Medicine Clinical Compensation Plan (hereinafter "Clinical Compensation Plan") redesign process is divided into four phases as described below. This list of frequently asked questions (FAQs) has been developed for your information and reference. You can also reach out with additional questions to clinicalcompplan@uvahealth.org.

1. **What are the four phases in the development of the Clinical Compensation Plan?**
   The Clinical Compensation Plan redesign includes four distinct phases:

   - **Phase 1:** The overarching Clinical Compensation Plan principles and structure were developed.
   - **Phase 2:** Department-level planning commenced to develop the departmental metrics of the Clinical Compensation Plan.
   - **Phase 3:** A focus on analysis and modeling, during which feedback will be provided to each department.
   - **Phase 4:** A shadow period during which time individual faculty total cash compensation on the redesigned Clinical Compensation Plan will be modeled and compared to total cash compensation on the department's current compensation plan. We anticipate beginning Phase 4 in the third quarter of FY25.

   Full implementation of the redesigned Clinical Compensation Plan is planned for FY26, provided that no further adjustments are required.

2. **Who is driving the decision-making around compensation plan redesign?**
   For Phase 1, a Project Management Team, Steering Committee, and Executive Committee were formed. The Steering Committee consisted of faculty members across the clinical departments. Recommendations from the Steering Committee were presented to the Clinical Chairs for input before review and approval by the Executive Committee. Once each phase of the process was approved, the information was shared with the Clinical Chairs, who presented this information at their department faculty meetings. For Phase 2,

each department formed a Compensation Plan Committee to work on developing their departmental plans. The goal was for all departmental plans to be submitted by the end of May 2024, which has been achieved by all departments.

3. **What are the overall guiding principles of the redesigned Clinical Compensation Plan?**
   There are 5 principles that guide the Plan. The Plan will:

   1. Be fair, transparent, simple, and explainable.
   2. Require and recognize professionalism, collaboration, service, and citizenship.
   3. Align, incentivize, and reward productivity, quality, and excellence across all missions.
   4. Provide total compensation that will allow UVA to recruit and retain the best clinical faculty, aligned with nationally recognized compensation and productivity benchmarks.
   5. Follow all applicable laws and regulations.

4. **What is the general compensation model across all clinical departments?**
   The SOM will establish a standard base + incentive clinical compensation model, similar to what most departments currently utilize. Incentive payment methodology will be defined in the department-derived compensation plans based on the parameters of the Clinical Compensation Plan.

5. **Will there be caps on clinical incentive payments?**
   There will be **no cap** on individual clinical incentive payments, provided that total cash compensation remains consistent with fair market value (explained in Question 6) and School of Medicine Faculty Compensation – Policies and Guidelines (virginia.edu). Payments will be aligned with work-product on all mission areas and consistent with national benchmarks.

6. **What do we mean by "fair market value?"**
   The fair market value of physician compensation is a fundamental consideration in healthcare compliance. Specifically, fair market value compensation is a requirement for compliance with the federal Physician Self-Referral Law (Stark Law) and Anti-Kickback Statute (AKS). These laws are designed to prevent overutilization of healthcare services and increased costs, unnecessary services, and compromised patient care.

7. **What is the process for department-level compensation planning?**
   For Phase 2, each department formed a Compensation Plan Committee. These committees have been meeting on a regular basis with support and guidance from the School of Medicine Chief Operating Officer and team members. The goal was for all departmental plans to be submitted by the end of May 2024, which has been achieved by all departments.

8. **What will the compensation structure look like as a result of Clinical Compensation Plan redesign?**
   The compensation structure will be relatively similar to current practice:

- Base salary will be paid in 12 monthly payments.
- Incentive pay will be paid annually in the fall.
- This structure does not imply a cap on individual annual base salary or incentive payments, provided that compensation remains consistent with fair market value (explained in Question 6).

9. **How will faculty members be updated regarding the compensation redesign progress?**
   Communication will take a variety of formats including emails to clinical faculty, a website dedicated to the Clinical Compensation Plan, a living FAQs document, general faculty meetings, town halls, updates in *Medicine in Motion*, as well as department faculty meetings. Various informational pieces are also being produced and will be distributed to increase awareness and understanding of the plan redesign, including instructional videos and a website. A "Question of the Week" email series is underway and being disseminated. Chairs will also be providing regular updates to their faculty throughout the process.

10. **Who will be responsible for developing the compensation plan for my department?**
    Each department has formed a compensation committee consisting of department leadership, administration, and faculty that have met many times over a period of several months in FY24 to recommend a customized departmental compensation plan aligned with the Clinical Compensation Plan framework. The draft plans developed by the committees during this Phase 2 have been finalized and submitted by Chairs to the SOM for review and impact modeling. The results of this analysis may require refinement to individual departmental plans. Ultimately, each department Chair will present a departmental compensation plan aligned with the SOM framework to be reviewed by a standing SOM Clinical Compensation Committee.

11. **How are faculty involved in providing input into the design of the Clinical Compensation Plan?**
    During Phase 1, a Steering Committee was established consisting of faculty from across different departments in the SOM. The faculty included some Chairs, the Chair of Committee on Women in Medicine and Science (COWIMS), a SOM representative from the Faculty Senate, a representative from the DEI office, the Senior Associate Dean for Faculty Affairs and Faculty Development, and the CEO of UPG. Administrative staff members were also included. The Steering Committee met 7 times over the fall and winter to develop recommendations around a broad Clinical Compensation Plan. As each topic was addressed, the recommendations were presented to the Clinical Chairs and department administrators to receive their input. The refined recommendations were then presented to the Executive Committee, which consisted of the Dean, CEO of the Medical Center, and CEO of UPG, for final approval. After approval, the information was disseminated in slide format to the Clinical Chairs to be presented in the departmental faculty meetings. During Phase 2, each department formed a Departmental Compensation Committee that met regularly over several months, with a minimum of 6 meetings. Each Department Compensation Committee was charged with developing their departmental compensation plans that are consistent with the overarching Clinical Compensation Plan. The membership of the Departmental Compensation Committees is mostly faculty.

12. **What mission areas will each department be expected to provide incentive payment criteria for?**
    Each department will create an incentive plan to recognize work and achievement in the following 5 mission areas: 1) clinical, 2) quality, 3) research/scholarship, 4) teaching, and 5) citizenship/service/community domains. Each department is expected to determine how much weight is allocated to each mission area.

13. **Why are we focused on compensation planning now?**
    Fair and competitive faculty compensation allows UVA Health to attract and retain the best and brightest academically oriented clinical talent aligned with our missions. Today, there is significant variability in faculty compensation and incentive plans across departments and divisions, providing some faculty an opportunity to earn significant variable compensation while others have a limited mix of fixed and variable compensation. The metrics used to calculate incentive compensation also vary greatly in how departments value and reward academic contributions. This was further validated by the SOM-wide salary study that was conducted and distributed in 2022-2023. Hence, the SOM is committed to developing a clinical compensation plan that provides market-competitive compensation, is based on an equitable, transparent, and consistent methodology, aligns to national benchmarks for compensation and clinical work, and encourages SOM clinical faculty to grow across all of our mission areas.

14. **Can departments provide group-based metrics to earn individual incentives?** Yes.
    The specific metrics and weighting of metrics will be proposed by each department; metrics may include a mix of individual and group metrics within applicable legal parameters.

15. **How will total cash compensation be determined?**
    Total cash compensation is defined as the sum of the annual base salary (including any supplemental pay) and the annual incentive payment. Total cash compensation will be established using a 3-year rolling average from the AAMC, the preferred national benchmark. Clinical productivity expectations will be determined for individuals using a 3-year rolling average from Vizient, the preferred national benchmark, and will be adjusted for cFTE and specialty. For specialties with limited AAMC or Vizient data, approved alternative benchmarks may be used.

16. **What is the Clinical Compensation Plan model that is being adopted?**
    Total cash compensation will be structured similar to what currently exists in the majority of the clinical departments, which is an annual base salary plus incentive payments. The annual base salary will be payable in equal installments over 12 months. The incentive payments will be made once annually in the fall.

17. **Will my total cash compensation be capped by the structure?**
    Total cash compensation targets will be set using the department's standard structure for all new hires. For existing faculty, conformance with this standard will be achieved over time at the department level. However, actual earned incentives will vary by providers within a department based on individual productivity and according to the department-defined incentive metrics. There is no cap on the earning of clinical productivity incentives, provided that compensation is based on national benchmarks and market pay and remains consistent with fair market value.

18. **Does the breakdown of incentives between missions need to be the same for each individual faculty member?**
    Each departmental plan will allocate the incentive payout pool among the mission areas in accordance with the Clinical Compensation Plan. However, individuals will earn incentive payouts based on personal performance related to the metrics defined in their applicable departmental compensation plan.

19. **Are the incentive metrics supposed to be achievable or stretch objectives?** Both. Incentive metrics should be defined and achievable and should also reward accomplishments that are above and beyond baseline expectations. All work is valuable, and we want to recognize and reward contributions across all mission areas.

20. **What is CART and why do we need to define effort according to the CART?**
    Standardized effort reporting ensures accurate and consistent comparisons between departments and to the benchmarks, which are important in a productivity-based clinical compensation system. It is important in this phase that we document all effort that is **C**linical, **A**dministrative, **R**esearch, and/or **T**eaching (CART). This includes the elimination of unfunded effort for undefined roles. The Steering Committee recommended that each defined CART role must be supported by budgeted dollars from an external source (e.g., grants), the SOM, the Medical Center, or the department. Each defined CART role will have a job description, defined outcomes, and a term limit, and annual reviews will be conducted for each defined role. Standardizing effort reporting in this manner results in a transparent and consistent process for effort and roles across all departments that is fair and equitable.

21. **What is the basic structure of the new Clinical Compensation Plan?**
    Each department will determine the percentage of target total cash compensation for a new hire that will be distributed as the annual base salary. This may range from 70% to 85% of the target total cash compensation based on national benchmarks. The remainder of the target total cash compensation can be earned as incentive, based on department-defined metrics, with no cap on individual payments, provided that compensation is aligned with national benchmarks and market pay and is consistent with fair market value.

22. **Are faculty members going to see their base salary decrease with implementation of the new Clinical Compensation Plan?**
    No. Faculty will not see a reduction in the annual base salary during the initial implementation of the Clinical Compensation Plan. There will be a transition period during which we model target total cash compensation based on productivity and apply the applicable departmental plan on an individual basis to assess impact. During that period, base salary will remain the same. We are hopeful that during this transition period those that need to increase their productivity to maintain their current base salary will have the opportunity to do so.

23. **Are the incentive dollars at risk in the event of poor financial performance of the department and/or institution?**
    Incentive pay will be modeled and approved as part of the budget process and accrued throughout the year based on the clinical productivity of the department. The incentive pool that accrues throughout the year is based on the clinical productivity of the department. For

example, if a department exceeds the budgeted clinical productivity, the department will accrue more dollars to the incentive pool for that year. If a department does not meet the budgeted clinical productivity, the department will accrue less dollars to the incentive pool for that year. Accrual of incentive dollars is not related to whether a department has a positive or negative financial bottom line. It is related to budgeted and actual clinical productivity of the department. Incentive payments are dependent on the financial stability of the institution. Extreme financial events (e.g., pandemic, facilities unusable for an extended period of time) would trigger a feasibility assessment related to distribution of incentive pay.

24. **Will there be expectations to earn the annual base salary?**
Yes. As part of the Phase 1 planning process, the Steering Committee developed baseline expectations as noted below. Should faculty not meet base salary expectations, there will be a conversation between the faculty member and Chair about why the expectations were not met. The base salary *may* be reevaluated by department leadership and adjusted prospectively. The specific process and parameters for base salary adjustments are being discussed and determined by Faculty Affairs, legal counsel, HR, the provost, etc.

These base salary expectations are:

- Adherence to UVA Health ASPIRE Values.
- No confirmed violations of any policies (State, University, SOM, UVA Health, Medical Center, UPG) that govern clinical faculty.
- Complete all mandatory University, SOM, UVA Health, Medical Center, UPG, and departmental training and disclosure requirements, including but not limited to compliance, credentialing, licensure, conflict of interest and financial disclosures, per policy.
- Accurately report all annual and professional leave per SOM and department leave policies.
- Show up on time for clinical assignments (e.g., clinic start, OR start, shift start) and participate in call coverage per commitments.
- Adherence to policies governing cancellation of scheduled clinical work (e.g., clinics, shifts, OR block time.).
- Close clinical encounters and sign surgical/procedural notes per Medical Center and UPG policies.
- Participate in undergraduate medical education and/or graduate medical education, if applicable.
- Meet at least 80% of individual productivity targets, e.g., wRVUs (prorated for organizationally approved leave and/or new hire ramp-up expectations).

25. **How will my total cash compensation be impacted with the new Clinical Compensation Plan?**
The compensation plans that are currently in place will be effective through the end of FY25 (6/30/25). Department leadership and administrators will ultimately meet with each individual faculty member in late 2024/early 2025 to share projected results based on the new Clinical Compensation Plan for the respective department, but no changes will be

effective before FY26. Annual base salary will not be reduced at the time of implementation.

26. **When will the new Clinical Compensation Plan be finalized and implemented?** The Steering Committee recommended a framework and key parameters for the Clinical Compensation Plan during Phase 1 of the process. Departmental Compensation Committees made preliminary recommendations for their departmental compensation plans that aligned with the SOM framework during Phase 2. During the summer and early fall of 2024, analysis and financial modeling will be done to determine the implications of the proposed plans developed and submitted by departments (Phase 3). Additional dialogue may be required following this analysis and modeling with refinement of recommendations required in some scenarios. Ultimately, there will be a "shadow period" (Phase 4) during the first half of calendar year 2025 in which there will be **NO CHANGES** to compensation for any faculty members, but there will be reports developed that demonstrate the hypothetical implications of moving to the new compensation plan. Implementation of the new compensation plan is expected to begin in FY2026 (starting July 2025), but with the pace of full implementation designed to minimize any adverse or abrupt changes to individuals. We aim to implement potential changes in the least disruptive way, so the timing and/or phase-in of the plan will be based on continual input from faculty members and leadership.

27. **If clinical productivity targets are exceeded by the department, does this increase the size of the entire incentive payout pool or is only the pool of dollars for clinical incentives grown?**
The dollars used for all incentive payouts for the departmental compensation plans are generated from the clinical mission. Hence, if a department exceeds budgeted clinical productivity targets, the entire incentive pool for that department will increase proportionally. The incentive pool accrues during the fiscal year the clinical work is performed and is paid out for the work accomplished in that fiscal year in accordance with the applicable departmental compensation plan. The percentage of the incentive pool dedicated to the different mission areas will be defined by each departmental compensation plan.

28. **How will clinical departments distribute the clinical incentive payout?**
This will be defined in the applicable departmental compensation plan. Some departments may use a dollar per wRVU payout metric, while others may tie the payout to percentile accomplishment in wRVUs based on national benchmarks (AAMC or Vizient as explained in Q15), cFTE, and specialty. Some departments may have group metrics.

29. **What is the target wRVU expectation in order to achieve median total cash compensation? Will this "delta" be 15%?**
Currently, many clinical departmental compensation plans in the SOM use a 15% delta between wRVU percentile and total cash compensation percentile. With the redesigned Clinical Compensation Plan, there has **NOT** been a determination of whether a "delta" will be required because the economic requirements of the plan have not yet been assessed. This will be evaluated during the modeling period.

30. **How much clinical time is required for a physician with a 1.0 cFTE effort?**
The Vizient definition for a 1.0 cFTE "represents the percentage of a full-time provider's week spent in billable clinical activity and the follow-up and documentation associated with

that activity...clinical activity includes clinical care and ancillary services, supervision of fellows and residents in the clinical setting, charity or courtesy work, chart documentation and review, and follow-up activities." Vizient recommends "that the provider's *full-time clinical week* be defined as 9 half-days. This includes 36 or more hours in the clinic seeing patients, in the operating room, or in the procedure suite and up to several hours per day in documentation and follow-up." For some primary care and specialty providers, this clinical work may be accomplished in 8 or 9 *patient-facing* 4-hour clinic sessions, while some may require less. Surgical departments, anatomic pathology, and hospital-based services each have different definitions of clinical time for a 1.0 cFTE. Each department will define how much patient-facing time is required to achieve the median wRVU benchmarks for a 1.0 cFTE, as it varies for different physicians based on specialty.

31. **Can we use our resident and fellow supervision dollars from funds flow to buy down effort from all of our faculty members cFTE?**
    No. This is not the intent of the cFTE buydown approach. The buydown of effort should be limited to distinct CART roles that have a job description, expected outcomes, term limit, and annual review. The supervision of residents and fellows generally occurs during clinical care and is not a distinct buydown role.

32. **If you don't meet the clinical expectation for base salary (i.e., 80% of targeted wRVUs prorated for approved medical leave or FMLA) are you still eligible to participate in other portions of the incentive compensation plan?**
    No. All base salary expectations must be met to be eligible for incentive compensation.

33. **How will the Clinical Compensation Plan keep up with inflation?**
    The new Clinical Compensation Plan will help maintain pace with inflation by looking at national compensation benchmarks and national productivity benchmarks that are updated annually.

34. **Why wouldn't we want to maximize the amount we put into base to access the higher retirement benefit for our faculty?**
    During the modeling phase, we will assess the implications of the proposed departmental plans on retirement benefits and make additional decisions that ensure uniform benefit opportunities across the faculty. Preserving an incentive pool that is large enough to reward and encourage performance should be balanced with optimizing annual base compensation.