

THE UNIVERSITY OF TENNESSEE HEALTH SCIENCE CENTER
The College of Medicine

Dear Colleagues,

June 10, 2008

Last month I began a column to address faculty concerns. Feedback from that column made it clear there were ways to improve this process. First, more faculty input is needed to define the specifics of the question to be addressed and do give-and-take with me on my response. As such, I have asked the Dean's Faculty Advisory Committee (DFAC) to help in this regard. Second, since some faculty may be hesitant to send in concerns or respond to past columns via e-mail, your DFAC departmental representative can be contacted to bring concerns and comments to my attention anonymously. I look forward to working more closely with DFAC, and in continuing to receive individual concerns and comments via e-mail (COM@utmem.edu).

This month's column addresses clinical variable compensation. Specifically, I have been asked to discuss and set down steps for a tentative timeline for implementation at the College level and to address several concerns. These include concerns that (1) UTMG billing has been untrustworthy in the past so it is problematic to tie compensation to UTMG billing, (2) a physician caring for a large number of indigent patients could, under some proposed compensation systems, receive considerably lower remuneration, and (3) clinicians in specialties that are poorly reimbursed by insurance will be at a distinct disadvantage, as compared to clinicians who do lucrative procedures. Further, I want to discuss if and how nuances in a department or division may affect how a plan works in that unit.

The why and how of variable compensation: Simply put high performing clinicians demand clinical compensation tied to their performance. If they do not receive it they will leave. The best way to address this reality is by a clinical compensation system that is in effect "pay for performance". We must provide clinical compensation tied to market driven compensation or we will not have any high performers. In addition we must have a mechanism that incents low performers to do better. A fixed salary structure does neither. A fixed base portion plus a variable portion seems to be the best mix of security and incentive. This is not a new idea as many University practice groups have chosen this path.

Time Line: We want to have such a system in place and working within 18 months. Within 6 months, we plan one or two pilot studies based on the principles discussed above to look for problems within the system.

Creation, Department Nuances: A special committee of the UTMG board will set the guidelines and review the proposals. Using those guidelines, departments and divisions will submit their proposals to the UTMG subcommittee for approval. Thus we anticipate fixed principles, but potential variability between departments.

UTMG billing: UTMG bills and collects better than national standards for University practice groups. However, if a resident or fellow is involved in care of a patient, the attending physician must document his or her involvement according to CMS standards for a bill to be issued. We can bill for resident services only if the attending documents their involvement. This is our largest billing problem. Billing from private clinics has worked very well. Since clinical compensation will be tied to and depends on UTMG billing (or its non-monetary surrogate Relative Value Units; RVU), we need to come into compliance with CMS documentation.

A lesser problem is that we have some poor paying contracts. We are rectifying these.

Indigent Care: Indigent care generates much less income than care of private patients. We can compensate for this in an incentive plan by using RVU derived from bills to obtain a unit of measure of work. If we assign a physician to a venue where there is a poor payer mix the RVU generation can serve as the measure of productivity. The systems we develop will use either collections or RVUs, depending on the venue, as units of measure of productivity.

Specialty Differences: Medicare and other payer systems determine value for services. This is true at Universities and in Private Practice. AAMC salary rates reflect that clinical practice pays at different rates. These are the realities of the market which we are tied to.

Summary: Our primary objective in going to a variable compensation incentive plan is to retain high performing clinicians by making clinical income proportional to work done. However, we will be going slowly with modest levels of risk in the first years to insure that objective is met and unintended consequences are minimized.

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The e-mail address to send in concerns, questions and comments to Dr Schwab is COM@utmem.edu.