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September 8, 2014

Daniel K. Podolsky, M.D., President
Office of the President
The University of Texas Southwestern Medical Center
5323 Harry Hines Boulevard
Dallas, Texas 75390

Dear President Podolsky:

We have completed our audit of The University of Texas Southwestern Medical Center's (UT Southwestern) Medical Service, Research, and Development Plan (MSRDP) faculty compensation audit as requested by the UT System Executive Vice Chancellor for Health Affairs. The detailed report is attached for your review.

We conducted our engagement in accordance with The Institute of Internal Auditors' *International Standards for the Professional Practice of Internal Auditing*.

We will follow up on recommendations made in this report to determine their implementation status. This process will help to enhance accountability and ensure that audit recommendations are implemented in a timely manner.

We appreciate the assistance and support provided by UT Southwestern. We hope the information and recommendations presented in our report are helpful.

Sincerely,

J. Michael Peppers, CIA, CPA, CRMA, FACHE
Chief Audit Executive

cc: Francisco G. Cigarroa, M.D., Chancellor, UT System
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The University of Texas Southwestern Medical Center
Medical Service, Research, and Development Plan (MSRDP)
Faculty Compensation Audit Report
FY 2014

September 2014

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Audit Report

September 2014

OVERVIEW

At the request of The University of Texas (UT) System's executive vice chancellor for health affairs, and in accordance with the practice plan bylaws, the UT System Audit Office performs periodic audits of the practice plans at the six UT health institutions. In Fiscal Year (FY) 2013, we conducted a practice plan compensation audit at the UT Health Science Center at Houston. Similar audits were conducted by the internal audit offices at the remaining UT System health institutions. For The UT Southwestern Medical Center (UT Southwestern), the practice plan compensation audit was postponed to FY 2014 to allow UT Southwestern more time to fully implement its *Compensation Guidelines for Medical Service, Research, and Development Plan (MSRDP) Faculty Practice Plan of UT Southwestern Medical Center* (Compensation Guidelines).

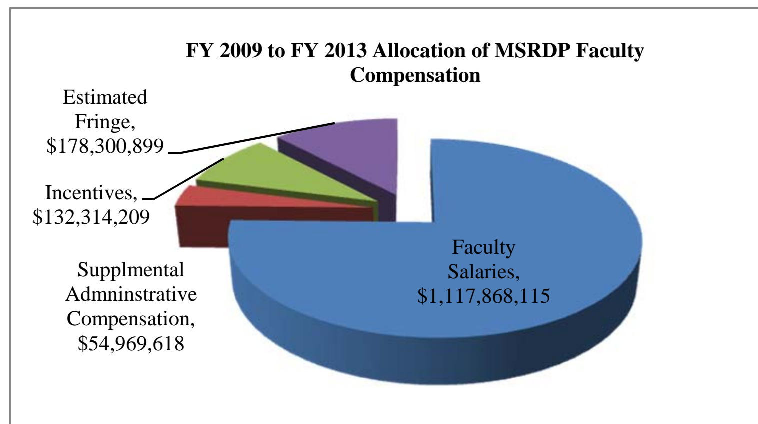
AUDIT OBJECTIVES

The objectives of this audit were to:

- Determine whether the *Compensation Guidelines for the MSRDP Faculty Practice Plan of the UT Southwestern Medical Center* (Compensation Guidelines) have received the appropriate approval in accordance with the practice plan bylaws,
- Determine whether the Compensation Plan is transparent and understood by plan members,
- Determine whether management is monitoring the Compensation Plan and making modifications where or if needed, and
- Trend changes in productivity and changes in incentive compensation over the past five fiscal years.

EXECUTIVE SUMMARY

Between FY 2009 and FY 2013, compensation for MSRDP faculty, including estimated fringe benefits, exceeded $1.4 billion. Over $132 million of this amount was for incentive payments. During this same period, billed collections increased from $310.2 million to $404.4 million, and work relative value units (wRVUs), a common productivity benchmark representing the clinical work performed by faculty physicians, increased from 4.3 million wRVUs to 5.3 million wRVUs.



The Compensation Guidelines provide direction to the clinical departments for administration of faculty compensation and "a framework for all MSRDP faculty members to receive compensation for services provided in support of the missions of UT Southwestern including teaching, research, administration, institutional service, and clinical services." The Compensation Guidelines require the clinical departments to provide both individual and group-based incentives. While the individual incentive focuses on clinical productivity, group incentives can include a variety of departmental, and in some cases, division-specific metrics. These metrics include, but are not limited to, achievement of superior patient satisfaction measures, as well as achievement of superior quality, safety, and outcome measures. The Compensation Guidelines have been in place since FY 2013 and were approved by the UT System executive vice chancellor for health affairs in September 2012.

Administration of incentive compensation is largely decentralized, and responsibility rests with the department chairs. Each department has implemented unique compensation practices, and most of the clinical departments have documented incentive plans. Prior to implementation, the departmental plans underwent comprehensive

review by the Faculty Compensation Advisory Committee and were approved by the provost/dean and the executive vice president for health system affairs. Oversight and monitoring of the plan is centralized and resides primarily with the dean's office, which is responsible for monitoring all components of faculty compensation. The health system affairs' office shares responsibility for oversight of compensation paid from MSRDP accounts and the president's office reviews and approves final clinical departmental budgets. The president's office is also responsible for final approval of changes to the Compensation Guidelines and the departmental incentive plans.

Implementation of the Compensation Guidelines and the respective departmental incentive compensation plans is in their beginning stages, and the clinical departments reviewed have experienced challenges in administering their new plans. Transition to the new plans and enhanced expectations have also been preceded and accompanied by recent changes in departmental leadership—for the departments reviewed, only one of the five chairs has been at UT Southwestern in his current role for more than five years. To ensure that desired outcomes are achieved, a biennial review process of the departmental plans has been established by the Compensation Guidelines. This review will begin in FY 2015.

In addition, the Centers for Medicare & Medicaid Services (CMS) continues to develop clinical quality measure reporting requirements for multiple CMS programs. UT Southwestern has incorporated quality, safety, and outcome measures within the Compensation Guidelines, and many related measures are incorporated as metrics for the determination of group incentives within the departmental incentive plans. We believe this to be a best practice. As the departmental incentive plans become due for biennial review, executive management will have the opportunity to work with the clinical departments to evaluate the quality, safety, and outcome metrics within the departmental incentive plans and determine whether any of the metrics may need to be changed and the feasibility and value of including any additional metrics for determining group incentives.

AUDIT SCOPE & METHODOLOGY

The scope of this engagement included 20 clinical departments. For this audit, we selected five departments for detailed testing, including Internal Medicine, Ophthalmology, Pediatrics, Radiology, and Surgery. Detailed compensation testing was generally limited to calendar year 2013; however, we obtained information from prior years for the trend analysis. We did not audit the information provided to us for the trend analysis and relied on the information provided by management.

To meet our objectives, we:

- Reviewed the UT Southwestern Practice Plan bylaws, Compensation Guidelines, and relevant Regents' *Rules and Regulations*;
- Read the departmental incentive compensation plans for the clinical departments selected for review;
- Reviewed questionnaires completed by the clinical departments selected for review to gain an understanding of the departmental compensation practices;
- Interviewed the chairs, key departmental administrators, and 15 faculty members from the five departments selected;
- Interviewed the dean/provost, the executive vice president for health system affairs, the executive vice president for business affairs, the senior associate dean for strategic development, and the associate dean for quality, safety, and outcomes education;
- Obtained and reviewed supporting documentation provided by the selected clinical departments; and
- Selected a sample of individual faculty members' compensation to test controls over administration of incentive compensation.

We conducted this audit in accordance with the guidelines set forth in The Institute of Internal Auditors' *International Standards for the Professional Practice of Internal Auditing*.

CRITERIA

In performing this audit, we utilized as our criteria UT Southwestern's MSRDP bylaws, the Compensation Guidelines, departmental incentive compensation plans, relevant Regents' *Rules and Regulations*, and the Chancellor's "A Framework for Advancing Excellence."

DEPARTMENTAL RESULTS

We have also reported on department-specific observations and recommendations in Appendices A through E, beginning on page 24 of this report.

CONCLUSION

UT Southwestern's Compensation Guidelines were approved by the UT System executive vice chancellor for health affairs in September 2012 and have been in place since FY 2013. The Compensation Guidelines include five components that incorporate the required "X, Y, and Z" elements as described within UT Southwestern's Practice Plan bylaws. The Compensation Guidelines also provide direction to the clinical departments for administration of incentive compensation and includes a requirement for both individual and group-based incentives. Implementation of the Compensation Guidelines and the respective departmental incentive compensation plans is in its beginning stages, and the clinical departments reviewed have experienced some challenges in administering their new plans.

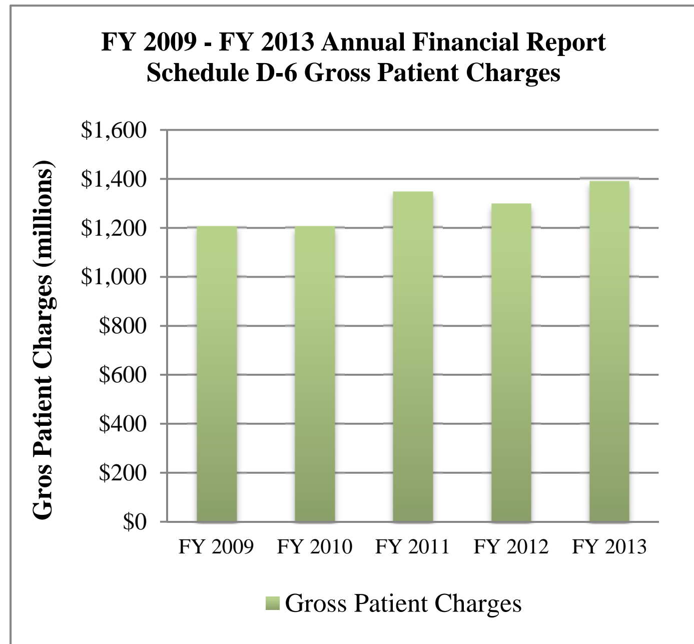
It is anticipated that biennial review of the department plans will begin in FY 2015. Based on the audit procedures performed, opportunities exist for management to enhance its review of faculty clinical full-time equivalent percentages as part of the existing incentive payment approval process; assess the appropriateness of department chair participation in departmental incentive compensation plans; improve transparency, communication, and clarity of the departmental incentive compensation plans and the Compensation Guidelines; ensure consistent administration of incentive compensation practices over time; facilitate evaluation of group incentive payments; ensure that the requisite approvals of the departmental incentive plans and Compensation Guidelines are documented; and ensure that the clinical departments include all disclosures required by the Compensation Guidelines within their incentive compensation plans.

J. Michael Peppers, CIA, CRMA, CPA, FACHE
Chief Audit Executive

Eric J. Polonski, CPA, CIA
Assistant Director of Audits

BACKGROUND

UT Southwestern's MSRDP has grown over last five fiscal years. As illustrated in the table to the right, gross patient charges have increased by over $180 million from $1.21 billion in FY 2009 to over $1.39 billion in FY 2013. This represents a 14.9 percent increase over the last five fiscal years or approximately 3.5 percent per year. Over this same period, full-time equivalent (FTE) faculty, faculty compensation, and incentive compensation have increased by 25, 41, and 28 percent, respectively.



Direction for administering MSRDP faculty compensation is documented within the Compensation Guidelines, which became effective in FY 2013 and "provides a framework for all MSRDP faculty members to receive compensation for services provided in support of the missions of UT Southwestern including teaching, research, administration, institutional service, and clinical services."

AUDIT RESULTS

The Compensation Guidelines

The MSRDP bylaws require that the Compensation Plan include three basic components—base salary, supplemental compensation (including augmentation), and incentive compensation. Together, these three components are also known as an "X, Y, Z" compensation plan.

MSRDP Bylaws Component	MSRDP Faculty Compensation Components
"X "- Base Salary	• The portion of a faculty member's salary that is based on one's academic rank.
"Y" - Supplemental Compensation	• **Supplemental Compensation** is the difference between Total Salary and Base Salary and is the portion of salary adjusted for market factors related to specialty and productivity. Supplemental Salary is composed of a **Fixed Component** and **Clinical Augmentation**. Clinical Augmentation may be decreased during a budget period if productivity decreases or if the departmental accounts have insufficient funds to cover existing practice plan commitments.
SAC - Supplemental Administrative Compensation	• **Supplemental Administrative Compensation** (SAC) is intended to compensate the faculty member for taking on additional duties or responsibilities, which are usually administrative, and which may be of a transient nature.
"Z" - Incentive Compensation	• **Incentive Compensation** may be paid to a MSRDP faculty member to promote future performance. The amount is determined through an established and equitably applied formula set forth in the Department Incentive Plan. Incentive Compensation is not guaranteed or fixed. To be eligible to receive Incentive Compensation a faculty member must be a UT Southwestern employee on the date the payment is made. Incentives can be paid up to four times per and are not eligible for inclusion for contributions to the mandatory retirement programs.

The Compensation Guidelines include four major components which include <u>Base Salary</u>, <u>Supplemental Compensation</u>, <u>Supplemental Administrative Compensation (SAC)</u>, and <u>Incentive Compensation</u>. Base Salary is based upon academic rank. Supplemental Compensation includes both a fixed component and an at-risk component referred to as clinical augmentation. SAC represents remuneration for administrative duties, and Incentive Compensation is provided to faculty members who exceed productivity expectations and/or meet or exceed group goals. As illustrated in the table above, the compensation components described in

the Compensation Guidelines sufficiently incorporates the required “X, Y, and Z” elements described within the MSRDP bylaws.

The MSRDP bylaws require approval of the Compensation Guidelines by the UT System Executive Vice Chancellor for Health Affairs. He approved the Compensation Guidelines on September 12, 2012.

Compensation Monitoring

Faculty compensation undergoes multiple levels of review and is closely monitored:

- The executive vice president for health system affairs reviews and approves the MSRDP budgets, including funding of faculty compensation for each clinical department.
- The provost/dean reviews and approves each faculty member’s proposed compensation annually as part of the annual faculty review and budget process.
- The president’s office reviews and approves final clinical departmental budgets.
- Before the beginning of the fiscal year, each faculty member signs a memorandum of appointment (MOA) which defines each base and supplemental compensation amounts. Each MOA is approved by the president and department chair.
- The dean’s office reviews and approves all supplemental administrative compensation (SAC), requested changes to faculty compensation, and requested incentive and SAC amounts prior to payment.

For the sample of faculty selected from the five clinical departments, we confirmed FY 2013 and FY 2014 faculty MOAs and SAC letters received the appropriate approvals. We confirmed that amounts recorded in the MOAs and SAC letters agreed to payment stubs with one exception—the chair of the Department of Surgery’s first SAC payment was incorrectly calculated, resulting in an underpayment. Surgery is working with the dean’s office to make the correction. We verified that the dean’s office reviews and approves the requests for SAC and incentive payments, and we confirmed that approved incentive compensation agreed to incentive paid as recorded on applicable paystubs. For applicable faculty in our sample, we verified that requests for incentive payments greater than 30 percent of total faculty compensation were approved by the dean’s office prior to payment of incentives.

Performance Evaluation and Highly Compensated Individuals

The Compensation Guidelines requires consistency with the UT System Board of Regents’ *Rules and Regulations (Rules)*. Regents’ *Rule* 30501 – *Employee Evaluations* requires “an annual evaluation program for all employees (administrative, faculty and classified) within…the institutions…to be used for the improvement of performance, promotion consideration, and merit salary review.” We confirmed that performance evaluations were completed for all faculty tested in our sample.

Regents’ *Rule* 20204 – *Determining and Documenting the Reasonableness of Compensation* states “compensation for employees whose total annual compensation is $500,000 or more but less than $1,000,000 and who are not covered in Regents’ *Rules and Regulations*, Rule 20203 must be approved by the appropriate Executive Vice Chancellor.” UTS144 – *Establishing Compensation for Highly Compensated Employees* defines the process for approval and requires UT institutions to “submit recommendations for total annual compensation of $500,000 or more to the appropriate executive vice chancellor.” Nine faculty members within our sample, including the chairs, met the compensation threshold for reporting. We confirmed that UT Southwestern appropriately reported these individuals for approval to the executive vice chancellor for health affairs.

Clinical Departments without Incentive Compensation Plans

Though most departments have incentive compensation plans, two divisions within the Department of Surgery currently do not have them—Emergency Medicine and Pediatric Surgery. In FY 2015, Emergency Medicine will become a distinct clinical department led by its own department chair. During the audit, UT Southwestern completed its recruitment of, and hired, a department chair. A key expectation for UT Southwestern's first chair of Emergency Medicine is the development of an incentive compensation plan in alignment with the Compensation Guidelines. Pediatric Surgery also does not have an incentive plan. We were informed that UT Southwestern is working with a hospital partner on a new contract, and after an agreement is reached, development of a Pediatric Surgery incentive plan will be considered. Lastly, Orthopaedic Surgery, a separate clinical department, has an incentive compensation plan; however, it is a legacy plan that has not yet been updated since implementation of the Compensation Guidelines. At the time of our audit, this department was under the leadership of an interim chair and executive management will not require a change to the department's incentive compensation plan until a permanent chair is determined.

Incentive Payments Dependent on cFTE

Clinical FTE (cFTE), in combination with an applicable Medical Group Management Association (MGMA) clinical productivity benchmark (or other applicable specialty benchmark), is a key factor in determining the individual component of incentive compensation for faculty in Internal Medicine, Pediatrics, Surgery, and Radiology. Each clinical department can determine how to calculate cFTE and takes into consideration all categories of professional effort. There are tools in place and available through the dean's office that provide guidance to department chairs for validating all categories of professional effort.

During our testing, we noted instances where faculty members who had a relatively low cFTE (including those with less than a 50 percent cFTE) earned more incentive than faculty with much higher cFTEs. There also were some high-producing faculty members with low cFTEs whose actual clinical effort may be higher than the cFTE used to determine their incentive compensation. In addition, the Compensation Guidelines advises that "department incentive plans should limit incentive compensation paid to physicians who spend less than 50% of their time clinically."

Currently, the departments must request incentive payment approval from the dean's office. These requests include the names of faculty, their respective salaries, the proposed incentive payments, and other relevant information. It also includes the percentage of incentive compensation divided by total compensation. However, it does not include the cFTEs of the faculty members. Inclusion of the cFTE on the incentive payment request could assist the dean's office in identifying and following up on potential incentive payment outliers, particularly for faculty members with less than a 50 percent clinical appointment. Follow-up could validate whether a proposed incentive payment is reasonable, whether the department has processes in place to limit incentive compensation paid to faculty with less than a 50 percent clinical appointment, or whether any corrective action needs to be considered.

> **Recommendation:** Management should require the clinical departments which use cFTE to determine incentive payments to report the cFTE for each faculty member as part of their incentive payment approval requests to the dean's office. For potential outliers identified, management should follow up with the departments to confirm whether those payments are reasonable or whether any corrective action needs to be considered.
>
> **Management's Response:** *UT Southwestern already has in place a requirement that proposed assigned cFTE and projected incentive payments for each faculty member are reported and monitored as part of the annual budget process. In addition to this prospective monitoring of cFTE assignments, a new management report has been developed and is included as Appendix A. At the end of each fiscal year, Departmental Chairs and chief financial officers will be asked to report amounts of incentive paid to each*

faculty member for productivity measures and for group quality, safety and practice efficiency measures. The amounts paid will be directly compared to the assigned clinical effort upon which these incentive payments are based. The departments will be asked to provide letters of justification for faculty with low amounts of assigned clinical effort (<50%) and high amounts of incentive compensation (>15% of total compensation). These letters and the total professional effort assignments for each faculty member in this category will be reviewed, and, when indicated, the Dean's Office will provide direction for changes in assigned effort to the Departmental Chair and Faculty member.

Anticipated Implementation Date: *The request to complete the new annual report on incentive payments from departmental plans was sent to all clinical departments on September 1, 2014 with expectations that it will be completed by October 31, 2014.*

Chair Incentive Compensation Plans

According to the Compensation Guidelines, separate incentive plans for department chairs should be devised. Of the five departments reviewed, only the Radiology chair participates in the same incentive plan as faculty. The Radiology chair was a primary author of the department's plan, and there are subjective elements within the incentive plan that are subject to the chair's discretion. In addition, the chair has the ability to make final adjustments to faculty members' scores, including his own. Because of inherent conflicts of interest in the plan's structure and administration, the chair should not participate alongside eligible Radiology faculty. Currently, the review by the dean's office is limited to reasonableness of the incentive amount awarded, relative to other faculty participants. We were informed that the executive vice president for health system affairs and the provost/dean are in the process of developing uniform incentive plans for clinical department chairs, and that, ideally, the chairs' incentives should be based upon global, as opposed to individual, outcomes.

Recommendation: Until the development and approval of department chairs' incentive plans are completed, management should request that the Radiology chair discontinue participation in the department's incentive plan. Executive management should also determine whether any other clinical department chairs are participating alongside faculty as part of the departments' incentive plans and determine whether their participation in the departmental incentive plans is appropriate. In some cases, clinically-productive chairs may be able to participate as long as their participation is approved by the dean, their incentives are calculated outside the department, and requests for incentive payments are reviewed and approved by the dean prior to payment.

Management's Response: *The Chair of Radiology will no longer participate in the Radiology Departmental Incentive Plan. Components of compensation for all departmental chairs for FY 2015 have been reviewed and a subset of Chairs (currently 7) with significant personal clinical practices has been identified. These Chairs and their departmental financial managers will be informed that they will be eligible for incentive compensation from their Departmental Plans in FY 2015, but all calculations of incentive pay must be performed by financial staff reporting directly to the EVP of Health System Affairs. The amount of incentive calculated will then be reviewed by the EVP Health System Affairs and the Dean, UT Southwestern Medical School for potential modifications based on availability of funds and/or compliance with standards and expectations and only the amount of incentive pay that they approve will be paid. All other departmental chairs are not approved for any incentive compensation from their departmental plans.*

Anticipated Implementation Date: *October 15, 2014.*

Communication of the Compensation Guidelines and Departmental Incentive Plans

Another objective of this audit was to determine whether the Compensation Guidelines and departmental incentive compensation plans are transparent and understood by plan members. To accomplish this objective, we interviewed department chairs, key departmental administrators, and a small sample of faculty members. We also interviewed members of executive management.

According to the Compensation Guidelines, "the metrics and calculations to be used in determining incentive compensation should be presented to faculty prospectively in a written and understandable format." In addition, "a copy of the Department Incentive Plan should be included, as an appendix, with each memorandum of appointment and should be provided to all MSRDP faculty members eligible for Incentive Compensation at the time of approval of any changes to the Departmental Incentive Plans." Overall, the faculty members we interviewed had a mixed understanding of their respective incentive compensation plans. Ophthalmology faculty members interviewed appeared to understand their incentive plan the best, followed by faculty from Internal Medicine. However, faculty from Pediatrics, Radiology, and Surgery communicated that they would like more information on how incentives are calculated. In addition, several faculty members interviewed indicated that they did not recall receiving either the Compensation Guidelines or their respective departmental incentive plans. They also did not appear to be aware that the Compensation Guidelines are available on a UT Southwestern intranet site. However, faculty members interviewed generally understood that clinical productivity was the key to earning incentives.

There appear to be various reasons contributing to an uneven understanding of the departmental incentive plans. Surgery made the departmental plans available to division chiefs, but not directly to all individual faculty members. It was left to the division chiefs to communicate how the plan works to faculty. The Surgery faculty we interviewed indicated that understanding of the compensation plan and incentive pay amongst faculty is low. One division chief interviewed indicated that he is frequently approached by other faculty members with questions about the mechanics of incentive compensation but does not have definitive answers.

Pediatrics faculty interviewed understood that a primary purpose of the department's plan was to improve clinical productivity and that wRVUs were a key factor in determining incentive pay. However, faculty indicated that they did not understand specifically how the compensation plan worked and found descriptions in the plan to be complex and difficult to follow. Since implementation of the compensation plan, Pediatrics faculty members have not been provided a report card that provides information on how incentive payments were calculated. Like Surgery, there was an expectation in Pediatrics that the division chiefs would play a key part in facilitating faculty understanding of the incentive plan.

Unlike Pediatrics, Radiology faculty members are provided a report card with their incentive payments. The score card indicates how many points a faculty member earned for a six-month period and the dollars assigned to those points. The faculty we interviewed understood that their performance in clinical, research, teaching, and other activities are assessed to determine incentive, but did not understand how activities and wRVUs are translated to points. Faculty members interviewed were generally unclear about the source of the data used to determine their incentives.

As previously mentioned, Ophthalmology faculty appeared to understand their plan well. Individual incentive worksheets are prepared for faculty members, who are asked to sign them. Though faculty may review their worksheets and take notes, they are currently not allowed to retain a copy for their own records.

> **Recommendation:** To improve communication and faculty understanding of the Compensation Guidelines, remind faculty that the Compensation Guidelines are available on a current UT Southwestern intranet site. To facilitate faculty access to and understanding of departmental plans, require all clinical departments to post their departmental plans on a departmental intranet site and ensure that faculty members know how to access copies of the plans. To improve transparency, require the clinical

departments to provide their respective faculty members with score cards that precede each periodic incentive payment. The score cards should reasonably illustrate how both individual and group incentives are clearly calculated. Departments should consider soliciting faculty feedback in finalizing the format of the score cards. Lastly, to enhance clarity and facilitate faculty understanding of departmental plans, executive management should require that the clinical departments include illustrative examples that clearly demonstrate how incentive compensation and annual productivity-based changes in fixed compensation would be determined.

Management's Response: *An attachment B to the MSRDP Compensation Guidelines will outline policies and procedures for implementing incentive plans (a draft is attached as Appendix B). Included in these policies and procedures is a requirement that: 1.) All departments will be instructed to post their departmental plans and the MSRDP Guidelines on a departmental intranet site. 2.) The departments also will be asked to place on their intranet site illustrative examples of how incentive compensation is calculated and examples indicating how different levels of high or low productivity might lead to increases or decreases to the supplemental component of faculty salary. 3.) All faculty should be provided, on at least a quarterly basis, with scorecards outlining their performance on all incentive plan metrics.*

In addition, Health System is developing reports that will be sent on a monthly basis to all MSRDP members detailing productivity metrics such as wRVU that can be used by the faculty member to estimate their progress in achieving incentive payment goals.

Anticipated Implementation Date: *We anticipate that all incentive plans and illustrative examples of incentive calculations will be posted on departmental intranet sites and departments will develop and provide incentive metric scorecards by 12/1/2014.*

Group Incentive Payments

The Compensation Guidelines state that "there must be both group and individual components to the department incentive plans" and that "group components must account for a minimum of 25 percent of the incentive compensation calculation." They also state that, "group components should include some measure of clinical outcomes, quality, and safety."

The department plans reviewed describe group incentives whose implementation varies by department. We observed adherence to the Compensation Guidelines' requirement that group incentive account for a minimum of 25 percent of total incentive within the Pediatrics department and certain Surgery divisions. Radiology's group incentive is based on sectional productivity performance and targeted at 20 percent of total incentive. In FY 2013, Internal Medicine budgeted $5,000 per plan participant to the group pool and provided the division chiefs with the discretion to allocate earned incentive among their faculty members. Ophthalmology budgeted $5,000 per faculty member for the group incentive. As a group, Ophthalmology did not meet or exceed its goal and no group incentive was paid; however, had the goal been met, the group incentive paid would not have been at least 25 percent of total incentive paid.

As previously mentioned, the dean's office approves periodic incentive payments; however, the incentive amounts listed by faculty member are not allocated between individual and group components. Consequently, the dean's office may not have data to determine the extent of compliance with the Compensation Guidelines or the amount of group incentives actually paid by each department. Such information may assist executive management in determining the extent to which group goals are actually being rewarded and whether any changes need to be considered for either the Compensation Guidelines or applicable departments.

Recommendation: To assist management in determining whether group incentive payments align with management's objectives as described in the Compensation Guidelines, management should request that the departments prepare an annual report that illustrates the amounts of individual and group incentives paid. As part of this report, the departments should include an explanation when incentives paid for achievement of group goals account for less than 25 percent of total incentives paid. Management should determine whether the explanations are reasonable and consistent with its objectives and whether any changes to the departmental plans or Compensation Guidelines need to be considered.

Management's Response: *As detailed earlier in this document, a new management report has been developed and is included as Appendix A. At the end of each fiscal year, Departmental Chairs and chief financial officers will be asked to report amounts of incentive paid to each faculty member for productivity measures and for group quality, safety and practice efficiency measures. Plans found to be out of compliance will be suspended until the incentive plan and/or its implementation is brought into compliance with MSRDP guidelines.*

Anticipated Implementation Date: *The request to complete the new annual report on incentive payments from departmental plans was sent to all clinical departments on September 1, 2014 with expectations that it will be completed by October 31, 2014.*

True-Up Mechanism

Unless there are extenuating circumstances, faculty members with individual incentives based upon wRVUs and cFTE are expected to produce an agreed-upon number of wRVUs for an entire fiscal year. Internal Medicine and Ophthalmology have a true-up mechanism in place to determine whether expectations were met or exceeded for the entire fiscal year. This reduces the risk or impact of potential incentive overpayments. Pediatrics has a true-up mechanism based on uneven payments of quarterly incentives described in its plan (20 percent for the first three quarters of the fiscal year and 40 percent for the fourth quarter); however, Pediatrics had not yet implemented this practice. Supporting documentation provided by Surgery and Radiology indicate that neither has a true-up mechanism in place. For Radiology, there is less of a risk of overpayment, since the individual component is targeted at 20 percent of the total incentive point calculation.

Recommendation: To ensure that faculty meet or exceed individual productivity goals for the entire fiscal year and to reduce the risk or impact of potential incentive overpayment, management should consider updating the Compensation Guidelines to require that the departments have a true-up process to ensure that faculty productivity expectations are met or exceeded for the entire fiscal year. The Compensation Guidelines should also provide guidance on types of extenuating circumstances that can legitimately reduce expected productivity.

Management's Response: *As detailed earlier in this report, an attachment B to the MSRDP Compensation Guidelines will outline policies and procedures for implementing incentive plans (a draft is attached as Appendix B). Included in these policies and procedures is a requirement that plans making quarterly payments include a true-up mechanism prior to payment of 2nd, 3rd, or 4th quarter payments to avoid overpayment of incentives to faculty who do not meet or exceed individual productivity goals for the entire fiscal year. This document also explains that prolonged periods of FMLA (Family and Medical Leave) represent extenuating circumstances in which formula driven reductions in salary do not apply.*

Anticipated Implementation Date: *This recommendation will be implemented prior to payment of the second quarterly FY15 incentive payments on January 15, 2014.*

Administration of Incentive Payments Greater than 30 Percent

According to the Compensation Guidelines, departmental incentive plans should not provide for potential Incentive Compensation of more than 30 percent of total compensation; however, incentive payments greater than 30 percent of total compensation may be individually approved by the provost/dean and executive vice president of health system affairs. While performing our audit, we learned about different ways in which two of the departments seek approval for incentives greater than 30 percent of total compensation. Radiology has interpreted this guideline to mean that a faculty member cannot be paid incentive that exceeds 30 percent of a faculty member's compensation. We were informed that if this occurs, Radiology sets aside the portion above 30 percent for a faculty member's professional development. This process is not described in the Radiology plan. Ophthalmology has several faculty members who have earned incentive compensation greater than 30 percent of total compensation and has a practice of "banking" incentive compensation earned in excess of the 30 percent incentive threshold. The banked incentive compensation is paid out to the faculty member (plus accrued interest) in a period when their incentive compensation does not exceed 30 percent of their total compensation. This practice also reduces the amount of times Ophthalmology has to seek approval to pay such incentives. This process is not described in the department's plan.

> **Recommendation:** Because the practices of Ophthalmology and Radiology affect the timing and amount of incentives paid to their respective faculty, these practices, provided they are approved by executive management, should be described within the departmental incentive plans. Executive management should inquire of the other clinical departments not included within the scope of this audit to ensure that the departments are administering incentive compensation greater than 30 percent of a faculty member's total compensation in an approved manner and that applicable departments disclose the approved methodology within their departmental compensation plans.
>
> **Management's Response:** *A standardized template for departmental incentive plans has been drafted. Included in this template is wording indicating that amounts of calculated incentive earnings not paid during a fiscal year are retained in departmental accounts for use in promoting departmental missions.*
>
> **Anticipated Implementation Date:** *This new template will be used for all plans coming up for the required every two year review and revision. In the interim, a copy of this new template will be distributed and Departmental Chairs and financial managers will be instructed by October 15, 2014 of the expectations that unpaid incentive is to be retained in departmental accounts for use in promoting departmental missions.*

MSRDP Baseline Expectations

In accordance with the Compensation Guidelines, "incentive compensation earned by individual faculty members requires compliance with baseline expectations of MSRDP policies for:

1. Timely completion of medical records [inpatient and outpatient] (7 days or less);
2. Timely submission of professional billings (7 days or less);
3. Billing compliance training and adherence to billing guidelines;
4. Appropriate coverage of expected amounts of night and weekend call coverage;
5. Adherence to clinic session scheduling and cancellation policies; and
6. Patient satisfaction evaluations at the minimum expectations for the practice."

Our interviews suggest that faculty members understood that keeping encounters open for more than seven days could result in a reduction of incentive payments. However, it did not appear that compliance with remaining baseline elements above, where applicable, were considered by all departments reviewed before requests for payment of incentive were made.

We also noted that the Department of Surgery included evaluation of the applicable elements of the baseline expectations above, by division, as part of the determination of divisional group metrics. In addition, Ophthalmology included achievement of patient satisfaction scores in excess of UT Southwestern's minimum baseline expectations for its group metric. However, no other department reviewed provided its faculty incentives for achievement of baseline expectations that are applicable to clinical faculty members at UT Southwestern.

> **Recommendation:** As part of determining periodic incentives payments, executive management should request that the clinical departments confirm compliance with applicable baseline MSRDP expectations at least annually. In addition, executive management should prevent clinical departments from providing group incentives for achievement of baseline expectations that are applicable to all UT Southwestern clinical faculty members. However, consideration could be given to retention of the expectations as group metric elements so long as the related goals reasonably exceed the baseline expected of all clinical faculty members.
>
> **Management's Response:** *Just to clarify, compliance with the above baseline expectations is and has been monitored on a regular basis by Health System administration with monthly, quarterly, or, in the case of billing compliance education, annual reports sent to all leaders of the practice plans including departmental chairs and medical directors of clinics. These reports routinely provide data at the level of individual physicians for expectations 1 and 3 and for groups of physicians for expectations 2, 4, 5, and 6. Additional review of individual data can be performed for expectations 2, 4, 5 and 6 although, in the realm of patient satisfaction surveys, statistical significance of calculated percentiles will not be routinely available at the individual physician level until the Fall of 2014 with the scheduled implementation of electronic Press Ganey survey tools. The results of recent audit interviews suggests that there might have been a failure to communicate the findings from these reports to the business staff involved in incentive payment calculations. To assure that, in the future, this data is shared with departmental business staff and utilized by departmental physician leadership prior to approval of calculated incentive payments, we have included in Attachment B to the MSRDP Guidelines (see Appendix B), the expectation that the clinical departments will develop and implement procedures to integrate these management reports into the process of leadership approval of incentive compensation payments. The Department of Surgery plan, which inappropriately offered incentive pay for only meeting baseline expectations, is being extensively revised by the new chair and departmental administrator.*
>
> **Anticipated Implementation Date:** *December 1, 2014.*

<u>Procedures for Determining Incentive Compensation</u>

The departments use Excel spreadsheets for performing incentive compensation calculations. The spreadsheets include information obtained from different sources. For example, wRVUs are obtained from Epic data maintained by MSRDP finance. Quality and patient satisfaction information are from other sources and can include data from hospital partners. Departmental administrators are very familiar with, and know the steps necessary in, determining incentives; however, not all departments have documented procedures for determining incentive payments. Over time, administrators assigned to determine incentive compensation can change, but well-written procedures should be independent of the individuals performing the assigned functions, include clearly defined roles and responsibilities, and provide clear instructions on what needs to be done. Well-written procedures also reduce the risk of errors and can help ensure consistent application of processes over time.

> **Recommendation**: Executive management should require the clinical departments to develop well-written procedures for administration of incentive compensation. Such a requirement could be included within the Compensation Guidelines.

Management's Response: *The expectation that the departments will develop well-written procedures for administration of incentive compensation has been included in the new Attachment B to the MSRDP Compensation guidelines.*

Anticipated Implementation Date: *December 1, 2014.*

Approval of the Compensation Guidelines and Departmental Compensation Plans

Similar to the MSRDP Bylaws, the Compensation Guidelines require certain approvals of the departmental incentive compensation plans. According to the Compensation Guidelines, "departmental incentive plans require the review and approval of the Provost/Dean and the Executive Vice President for Health System Affairs and are subject to the approval of the President before implementation." In addition, the Compensation Guidelines describe that the Faculty Compensation Advisory Committee (FCAC) serves the provost/dean, the executive vice president for health system affairs, the chairs, faculty, and the president in an advisory capacity concerning issues related to faculty compensation. The FCAC is a standing committee of the MSRDP Board and performed the first review of the departmental incentive compensation plans. We were provided evidence of thoughtful review that focused on the goals of the plans and adherence to the Compensation Guidelines. Changes suggested by the FCAC were incorporated into the departmental plans. After final review, the FCAC submitted its recommendations to the provost/dean and the executive vice president for health system affairs for their review and approval. We believe that this is a best practice to ensure consistent implementation of core incentive compensation principles across the clinical departments. However, it appears opportunities exist to formalize the approval of incentive plans. Currently, evidence of approval is limited to and managed by email; however, neither Ophthalmology nor Radiology had evidence of approval by the provost/dean and the executive vice president for health system affairs. In Radiology's case, we were informed that hundreds of emails were lost during an upgrade of Microsoft Outlook. We requested copies of approval from the dean's office. The dean's office provided evidence of approval for the Radiology plan. We were also were provided evidence of the dean's written approval of the Ophthalmology plan; however, it did not include the approval date.

It also appears that there are no supporting documents which include the president's written approval (signature and date) of the Compensation Guidelines or the departmental incentive plans. We were informed that the president performed a comprehensive review of the Compensation Guidelines and that he requested, reviewed, and approved the departmental plans. We also noted that the departmental incentive compensation plans that we were provided did not include evidence of formal approval (signature and date) of the department chairs.

Recommendation: Together, the Compensation Guidelines and the departmental incentive compensation plans describe compensation goals and practices for hundreds of MSRDP faculty members. As illustrated with Radiology and Ophthalmology, approval emails are at higher risk of loss over time. Final approvals of the Compensation Guidelines and departmental incentive compensation plans should be formalized to include evidence of written approval (signature and date) from the provost/dean, the executive vice president for health system affairs, and the president. The departmental plans should also include formal approval (signature and date) of the department chairs.

Management's Response: *A standardized template for departmental incentive plans has been drafted (see Appendix C). Included in this template is a signature page that includes signatures and dates of written approval from the departmental chair, provost/dean, the executive vice president for health system affairs, and the president.*

Anticipated Implementation Date: *The new incentive plan template will be implemented as all plans come up for the required two year review and revision. For most plans this will occur during FY2015. For departments who have already submitted revised plans within the past year, we will ask that the*

recently approved revised plan by inserted into the new template format and this be resubmitted for written signature approval.

Missing Required Compensation Plan Disclosures

Section VI of the Compensation Guidelines states that the department incentive plans must clearly state the following six items:

A. Incentive Compensation is paid to incentivize future performance. Therefore, to receive Incentive Compensation, a faculty member must be an employee of UTSW on the date of payment.

B. Incentive Compensation is not eligible for inclusion in the formula for contributions to the mandatory retirement programs, but is subject to all deductions required by state and federal law.

C. Incentive Compensation can only be made to MSRDP faculty with an active signed MSRDP agreement.

D. Incentive compensation earned by individual faculty members requires compliance with baseline expectations of MSRDP policies for:
   1. Timely completion of medical records [inpatient and outpatient] (7 days or less);
   2. Timely submission of professional billings (7 days or less);
   3. Billing compliance training and adherence to billing guidelines;
   4. Appropriate coverage of expected amounts of night and weekend call coverage;
   5. Adherence to clinic session scheduling and cancellation policies; and
   6. Patient satisfaction evaluations at the minimum expectations for the practice.

E. The upper limits of Incentive Compensation (as a percentage of Total Compensation) for which members are eligible should be stated, and the Departmental Incentive Plans should indicate how payments will be reduced if the total Incentive Compensation calculated to be paid is greater than available departmental profit or reserves.

F. Fees for all court appearances, depositions, expert testimony, or legal consultations are deposited into the departmental fund, and the percent distribution is determined and approved prospectively in the Departmental Incentive Plans.

We compared the departmental incentive compensation plans to the Compensation Guidelines. Two of the departments reviewed did not include all disclosures required by the Compensation Guidelines.

Recommendation: To ensure that the clinical departments include all disclosures required by the Compensation Guidelines, executive management, as part of the upcoming incentive plan review process, should consider developing an incentive plan document template for the departments which includes all necessary disclosures required in each departmental plan.

Management's Response: *A standardized template for departmental incentive plans has been drafted (Appendix C). This template addresses the disclosures A-E as detailed above. Disclosure F is individualized by department and is reviewed individually at time of MSRDP Faculty Compensation Advisory Committee review as shown in the review template provided during the audit.*

Anticipated Implementation Date: *The new incentive plan template will be implemented as all plans come up for the required two year review and revision. For most plans, this will occur during FY2015. For departments who have already submitted revised plans within the past year, we will ask that the*

recently approved revised plan by inserted into the new template format and this be resubmitted for written signature approval.

Elements of Group Metrics

There is increasing pressure from payers of health care services to improve the quality, safety, and outcomes of patient care. The Centers for Medicare & Medicaid Services (CMS) continues to develop clinical quality measure reporting requirements for multiple CMS programs. Starting in 2015, CMS will apply a value modifier to the physician fee schedule. Large group practices can be subject to penalties if they do not meet certain thresholds that consider both the quality and cost of patient care.

According to the Compensation Guidelines, "the Departmental Incentive Plans could also give consideration to…where applicable, achievement of superior patient satisfaction measures based on the team and/or individual Patient Satisfaction Survey score of the clinical area as well as achievement of superior quality, safety or outcome measures." Ten out of 20 clinical departments, including Ophthalmology, Internal Medicine, Pediatrics, and most divisions within Surgery, include the results of patient satisfaction surveys as a group incentive element. Nine departments, including Pediatrics and Internal Medicine, include safety metrics as an element of group incentives within their incentive compensation plans. The plans for several divisions within Surgery describe a penalty assessment against individual incentives if a faculty member does not meet certain goals for certain criteria, patient satisfaction scores, and timely removal of Foley catheters. In addition, the plans for four departments, including Pediatrics and Internal Medicine, describe clinical outcomes as an element of group incentives. Five departments, including Radiology, were in the process of developing safety metrics to include within their group elements.

Some of the clinical departments have experienced practical challenges with incorporating quality and safety measures. For example, Pediatrics distributed the group incentives as if goals were met because the department did not have sufficient quality data that that could be used to determine achievement of group metrics. Pediatrics anticipates incorporating evaluation of quality data to determine achievement of group goals beginning with the third quarter of FY 2014. Radiology found it challenging to incorporate quality measures based on industry standards since those standards were more applicable to radiology technologists than to faculty physicians. In addition, the clinical departments are also dependent on quality and safety data that can originate from their hospital partners, and we were informed that it has been a challenge to collect data at the individual faculty level. Overall, the departments will not incorporate quality, safety, and outcome measures into the incentive plans unless the underlying data is sufficient, reliable, and applicable to the department. Moreover, the departments do not want to evaluate faculty against outcomes over which they do not have an appropriate degree of control.

We believe UT Southwestern's incorporation of the quality, safety, and outcome measures to be a best practice. As the departmental plans come up for the biennial review, executive management will have an opportunity to work with the clinical departments to evaluate the quality, safety, and outcome metrics within the departmental incentive plans and determine whether any of the metrics may need to be changed, whether the metrics are appropriate and incenting the right behaviors, and the feasibility and value of including any additional metrics.

Five-Year Trends

As part of this engagement, we summarized and trended changes in productivity with changes in incentive compensation. The information presented within this section of the report covers the five-year period from FY 2009 to FY 2013. We compiled the data from information provided by MSRDP finance. The information is limited to data provided for 20 clinical departments[1] as well as data from the Simmons Cancer Center, Genetic Diagnostics, and the Multi-Specialty Clinic. We did not audit the data compiled and presented in the table below.

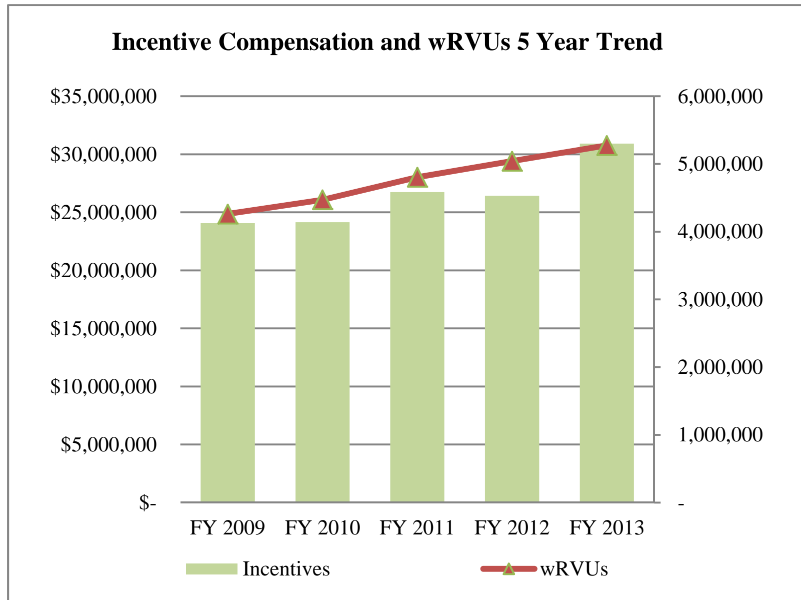
Faculty Compensation and Productivity Trends
The wRVU is a common clinical productivity benchmark. It represents the official work performed by faculty physicians, and comprises the relative time, effort, skill and intensity in providing a procedure or service. In general, the more time, skill, intensity, and effort, the higher the wRVU. As illustrated in the table below, full-time equivalents (FTEs) grew by 25.3 percent, and total compensation increased by 41.4 percent, from FY 2009 to FY 2013.

Description	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 09 – FY 13 % Change
Faculty Salaries	$199,865,154.66	$201,727,660.12	$233,733,540.53	$254,489,134.00	$283,022,244.10	41.6%
Incentives	$24,068,300.37	$24,143,554.80	$26,749,692.07	$26,432,509.00	$30,920,152.47	28.5%
Total Faculty Compensation	$223,933,455.03	$225,871,214.92	$260,483,232.59	$280,921,643.00	$313,942,396.57	41.4%
Incentive as % Total Compensation	10.7%	10.7%	10.3%	9.4%	9.8%	-8.4%
MSP FTE	1,033	935	1,047	1,181	1,294	25.3%
wRVUs	4,261,857	4,472,031	4,804,776	5,043,257	5,273,954	23.7%
Billed Collections	$310,175,875	$344,367,587	$363,730,695	$379,495,693	$404,416,828	30.4%
Contractual Revenue +UPL+ Other	$197,272,233	$155,817,714	$166,335,884	$178,473,117	$195,841,977	-0.7%
Total Clinical Revenue	$507,448,107	$500,185,300	$530,066,579	$557,968,810	$600,258,806	18.3%
Net Income	($4,744,606)	$143,009	($6,471,643)	$21,249,069	$28,431,645	N/A*

*Percent change is not necessarily a meaningful comparison when the beginning and ending year are not both positive and both negative. However, the change from FY 2012 to FY 2013 was an increase of 33.8%.

[1] Anesthesiology and Pain Management , Cardiovascular and Thoracic Surgery, Dermatology, Family and Community Medicine, Internal Medicine, Neurological Surgery, Neurology and Neurotherapeutics, Obstetrics and Gynecology, Ophthalmology, Orthopaedic Surgery, Otolaryngology, Pathology, Pediatrics, Physical Medicine and Rehabilitation, Plastic Surgery, Psychiatry, Radiation Oncology, Radiology, Surgery, and Urology.

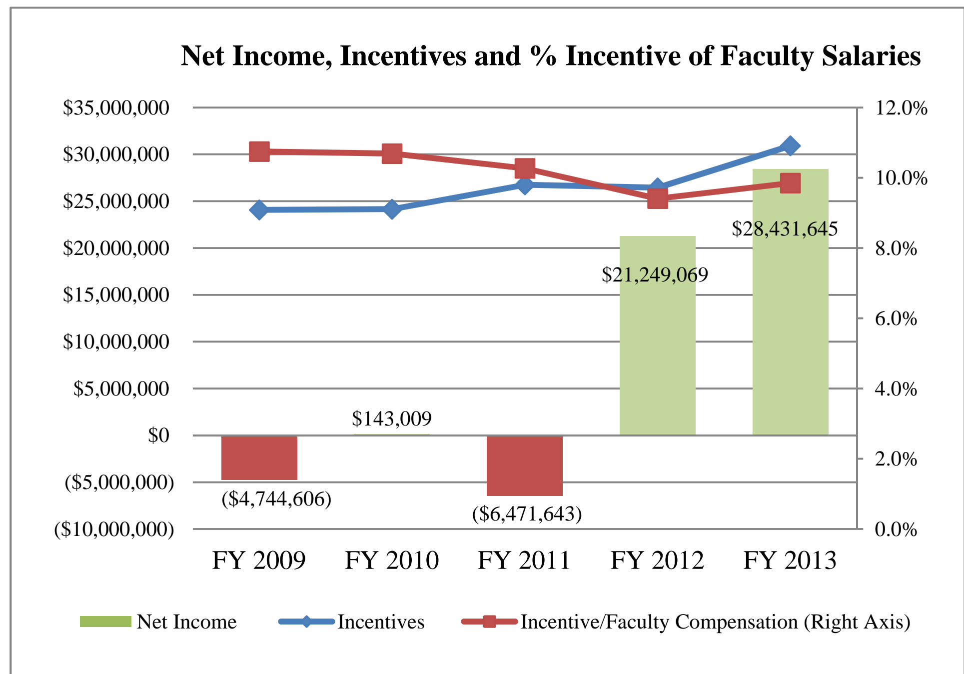
The addition of faculty and increases in faculty compensation have been accompanied by an increase in total faculty productivity as illustrated by increases in wRVUs and billed collections (which includes Parkland Memorial Hospital Epic-billed collections), which have increased by 23.7 and 30.4 percent, respectively. Total net clinical revenue, which includes income from UT Southwestern's hospital partners, Veterans Health Administration hospitals, and billed collections, increased by 18.3 percent. These increases in net clinical revenue and billed collections have also been accompanied by increases in productivity and incentive pay. From FY 2009 to FY 2013, wRVUs have increased 23.7 percent while incentive pay has increased by 28.5 percent.



Incentive Compensation

A key recommendation from the Chancellor's Framework for Advancing Excellence is to "enhance compensation strategies for faculty and administrators to reward and incentivize performance." UT Southwestern's Compensation Guidelines appear congruent with the Chancellor's framework. According to the Compensation Guidelines, the purpose of incentive compensation is to "encourage prospective performance that leads to the generation of growth in clinical volumes and income, as well as improvements in patient satisfaction, clinical quality, safety, and outcomes." A key limiting factor for paying incentives is adequate departmental and divisional financial resources. Each year, the clinical departments budget for incentive pay, which considers both financial performance and departmental reserves; however, this does not necessarily guarantee that incentives will be paid.

As part of our work, we trended net income, incentives, and the percent of incentive pay relative to total compensation (incentives divided by faculty compensation without benefits). As illustrated in the table to the right, incentives paid did not appear optimally aligned with net income during FY 2009 to FY 2011. For FY 2009 and FY 2011, net income was negative and just over break-even for FY 2010. However, net income improved significantly from FY 2011 to FY 2012 and improved again from FY 2012 to FY 2013. Over the five-



year period, incentives, as a percentage of faculty compensation, have ranged from a high of 10.4 percent in FY 2009 to a low of 9.4 percent in FY 2012. Though incentives as a percentage of total faculty compensation have decreased, it appears that incentives paid across the clinical departments are now more closely aligned with net income.

Appendix A – Management Report Example (Prepared by UT Southwestern)

ANNUAL ACCOUNTING OF INCENTIVE FUND DISTRIBUTION
DEPARTMENT:
For the period: 9/1/13 to 8/31/14

MSRDP MEMBER			INCENTIVE PAY								
NAME	EMP#	cFTE*	INDIVIDUAL	GROUP	SAC PAYMENTS	SALARY	SUBTOTAL ADD'L COMP	TOTAL COMPENSATION	% Incentive Comp**	% ADD'L COMP	APPROVAL DATE
A	1	0.85	20,000	5,000	-	200,000	25,000	225,000	11.1%	11.1%	
B	2	0.20	8,800	4,000	10,000	150,000	22,800	172,800	7.4%	13.2%	
C	3	0.65	5,000	6,000	-	185,000	11,000	196,000	5.6%	5.6%	
D	4	0.85	37,000	13,300	20,000	160,000	70,300	230,300	21.8%	30.5%	5/14/2014
E	5	0.45	-	2,000	-	300,000	2,000	302,000	0.7%	0.7%	
F	6	0.75	-	3,000	-	176,000	3,000	179,000	1.7%	1.7%	
G	7	0.45	24,600	3,300	-	197,000	27,900	224,900	12.4%	12.4%	9/5/2014
H	8	0.90	33,800	7,000	-	125,000	40,800	165,800	24.6%	24.6%	
TOTAL			129,200	43,600							
		Undistributed Group***		5,400							
			% Group	**27.5%**							

DO NOT INCLUDE PAYMENTS FOR LEADERSHIP INCENTIVE PLANS, CANCER CENTER, MOONLIGHTING, ETC. THIS REPORT SHOULD REFLECT PAYMENTS FOR SERVICES PERFORMED WITHIN THE DEPARTMENT.

* Provide cFTE averaged over the 12 month period used to calculate incentive pay.

** For MSRDP members with <50% cFTE receiving incentive payments that were >15% of total compensation, provide a letter of justification. Letters of justification must clarify how cFTE was calculated and report on level of productivity in all areas of professional effort assignment.

***Provide amount of group incentive that was budgeted but not distributed due to failure to achieve metrics.

Appendix B – Incentive Plan Implementation Guidance (Prepared by UT Southwestern)

POLICIES AND PROCEDURES FOR INCENTIVE PLAN IMPLEMENTATION

Effective September 1, 2014

1.) Copies of MSRDP compensation guidelines and of departmental compensation and incentive plans should be posted on a departmental intranet site accessible to all departmental MSRDP participants in the plan.

2.) Departments should also post on departmental intranet sites illustrative examples explaining how incentive compensation and productivity based changes in fixed compensation outlined in the departmental plan are calculated.

3.) Each department should develop written policies and procedures for administration of incentive plans. At a minimum these policies and procedures should include mechanisms for:
   a. Obtaining the data metrics used in calculating incentive pay.
   b. Assuring that faculty receiving quarterly or biannual productivity based incentive payments are held accountable for meeting or exceeding productivity expectations for an entire year. Extenuating circumstances such as extended absences for approved FMLA can be considered as exceptions to this rule but such policies must be prospectively defined and uniformly applied to all forms of FMLA.
   c. Policies for at least annual review of compliance by departmental MSRDP members with baseline expectations of the MSRDP policies detailed in Section 2, VI. (E) of the MSRDP compensation guidelines.

4.) Departments should provide departmental MSRDP participants with scorecards detailing metrics contributing to their individual incentive calculations on at least a quarterly basis.

5.) Time absent for approved FMLA must first be taken into account and productivity targets proportionally reduced to account for period of absence, before calculations that might lead to reduction in salary are performed.

Appendix C – Template for Departmental Plans (Prepared by UT Southwestern)

Medical Services, Research and Development Plan (MSRDP), Incentive Compensation Plan for the Department of ___________________________, UT Southwestern Medical Center

(Insert text of department plan here)

The Following Rules Apply to All Incentive Plans at UT Southwestern Medical Center:

A. Incentive Compensation is paid to incentivize future performance. Therefore, to receive Incentive Compensation, a faculty member must be an employee of UTSW on the date of payment.

B. Incentive Compensation is not eligible for inclusion in the formula for contributions to the mandatory retirement programs, but is subject to all deductions required by state and federal law.

C. Incentive Compensation can only be made to MSRDP faculty with an active signed MSRDP agreement.

D. Incentive compensation earned by individual faculty members requires compliance with baseline expectations of MSRDP policies for:

1. Timely completion of medical records [inpatient and outpatient] (7 days or less);
2. Timely submission of professional billings (7 days or less);
3. Billing compliance training and adherence to billing guidelines;
4. Appropriate coverage of expected amounts of night and weekend call coverage;
5. Adherence to clinic session scheduling and cancellation policies; and
6. Patient satisfaction evaluations at the minimum expectations for the practice (currently the 50th percentile).

Additional/alternative criteria may be developed for certain specialties where all the above measures are not precisely applicable (e.g. Radiology).

E. The upper limits of non-salary (SAC + incentive + MSRDP funded parking) provided by this plan without special approval and review by the EVP for Academic Affairs and Provost, Dean of UT Southwestern Medical School and EVP for Health System Affairs is 30% of total compensation for all faculty. In addition, for MSRDP faculty with < 50% assigned clinical effort who receive incentive compensation that exceeds 15% of total compensation, special justification is required. In addition, if there are insufficient funds available in departmental MSRDP reserves, calculated incentive amounts for all faculty may be proportionally reduced. Amounts of calculated incentive earnings not paid during a fiscal year due to any of these factors are retained in departmental accounts for use in promoting departmental missions.

Appendix C – Template for Departmental Plans (Prepared by UT Southwestern)

Medical Services, Research and Development Plan (MSRDP), Incentive Compensation Plan for the Department of ____________________________________, UT Southwestern Medical Center, was reviewed by the MSRDP Faculty Compensation Advisory Committee on ____________ and recommended for approval.
(date)

Approvals:

____________________________________ ____________
Departmental Chair **Date**

____________________________________ ____________
Executive Vice President for Academic Affairs and Provost **Date**
Dean, UT Southwestern Medical School

____________________________________ ____________
Executive Vice President for Health System Affairs **Date**

____________________________________ ____________
President **Date**

Appendix D – Department of Internal Medicine

BACKGROUND

The University of Texas (UT) Southwestern Medical School's Department of Internal Medicine strives "to be academic in the fullest sense of the word, with no neglect of teaching, clinical care, or scientific investigation." David H. Johnson, M.D., became chair of the department in July 2010 and is the primary author of the department's incentive compensation plan, which is referred to as the Clinical Educator Plan (CE Plan). According to the department chair, the CE Plan was modeled after faculty physician compensation plans in place at the University of Michigan, Vanderbilt University, and the University of Pennsylvania.

Incentive Compensation Plan Mechanics

Faculty members who participate in the CE Plan are assigned a clinical full-time equivalent (cFTE) percentage. The cFTE is the proportion of the faculty member's professional effort apportioned to clinical activities. As most faculty members are expected to have some academic duties in addition to their clinical responsibilities, the model for plan participation is 80 percent clinical and 20 percent academic effort, with variations on an individual basis. Faculty members with full-time appointments start with an initial FTE of 1.00 less a 0.20 FTE academic credit. However, plan participants who are 0.50 FTE or lower will generally not receive academic credit. Clinical FTE is further reduced if the faculty member has any administrative or research responsibilities. Conceptually, the cFTE is reduced by the same proportion as the funding for administrative or research effort is to the faculty member's total salary.

The individual component of incentive compensation is based on clinical productivity, as measured by work relative value units (wRVUs). An expected wRVU threshold is calculated as the faculty member's cFTE percentage multiplied by a benchmark number of wRVUs. In general, the benchmark comes from the Medical Group Management Association's (MGMA) wRVUs at the 50th percentile for each specialty. Work RVUs in excess of an individual's threshold, but only up to a certain point, are eligible for incentive compensation. Group incentive compensation, which is earned for achieving group goals set by each division, is paid in conjunction with the fourth quarter's incentive payment. Internal Medicine has a true-up process in place to limit the risk or minimize the impact of any potential incentive overpayments. If there are any incentive overpayments after the true-up process and netting against any group incentive earned at the end of the fiscal year, they are not recouped and are regarded as an expense to the department.

Finally, faculty productivity can also impact changes to a faculty member's fixed annual salary in the following fiscal year. The mechanism used to adjust total salary is a multiplier of the current year's sum of fixed annual salary and incentive compensation earned. For example, if the fixed annual salary in the current year is $90,000 and incentive earned is $10,000, the total annual compensation would be $100,000. If the maximum multiplier percentage of 95 percent is applied, the total salary in the following year would be $95,000 ($100,000 multiplied by 95 percent). The multiplier mechanism could also result in a downward adjustment to the fixed annual salary.

RESULTS

The Internal Medicine compensation plan was reviewed and approved by the faculty compensation committee and approved by the dean/provost as well as the executive vice president for health system affairs. In accordance with the UT Southwestern's *Compensation Guidelines for the Medical Service, Research, and Development Faculty Practice Plan* (MSRDP Compensation Guidelines), the Internal Medicine plan encourages prospective performance that appears to encourage growth in clinical volumes and income and includes group incentive goals. Our testing indicated that incentive payments were appropriately authorized. However, we identified opportunities to enhance administration of the compensation plan. Details of our observations and recommendations are detailed as follows.

Clinical FTE and Incentive Limits

According to the MSRDP Compensation Guidelines, "incentive compensation available through a department incentive plan should be congruent with the percentage of total effort devoted by the MSRDP faculty member to clinical activities. Department incentive plans should limit incentive compensation paid to physicians who spend less than 50% of their time clinically."

Internal Medicine has mechanisms in place to limit incentive compensation. It has implemented a tiered incentive structure such that not all individual clinical productivity over the threshold is paid the same dollar amount. Generally, any wRVUs above the threshold and up to a certain percentage over the threshold are paid at the "Tier 1" rate per wRVU, which varies based on division. Then, any wRVUs above Tier 1 and up to an upper limit, which is set partially based on the preceding year's actual wRVUs, are paid at the "Tier 2" rate per wRVU. The Tier 2 rate per wRVU is half of the Tier 1 rate. Finally, any wRVUs above Tier 2 do not receive incentive pay. This collaring mechanism is intended to encourage faculty productivity, but within a reasonable range relative to their expected clinical FTE, so that those who have been assigned administrative or other departmental responsibilities do not neglect them in favor of their own clinical productivity.

However, one faculty member we selected for testing had an assigned cFTE of 0.17 and a final, trued-up cFTE of 0.20 in FY 2013, but the collar on the wRVUs on which he could earn incentive was raised to 304 percent over the threshold (based on the ratio of FY 2012 wRVUs billed to the threshold). This resulted in all of that faculty member's wRVUs being eligible for incentive payment, and their Tier 2 incentive payment was more than their Tier 1 incentive payment. Other faculty members we tested had their incentive capped at around 100 percent over their thresholds.

According to the CE Plan, "Plan Clinical Effort may not necessarily equate to assigned clinical effort." The credits to cFTE are not calculated by scheduling or other time-based sources but rather by the sources of salary support funding. Because of this methodology, it can be a challenge in certain cases to precisely capture the cFTE and distinguish it from total "professional" effort. Converting the proportion of salary supported by external funding into effort spent and reducing the cFTE by that proportion may not result in an accurate determination of time spent on clinical activities.

> **Recommendation:** We encourage Internal Medicine to revisit how it determines plan cFTE. We also encourage faculty members to review historical clinical productivity and determine whether the cFTE used to determine incentive compensation reasonably approximates the faculty member's actual clinical effort.
>
> **Management's Response:** *The department was transitioning from a long-established incentive program that allowed buy-downs based on a financial model. Therefore, the prior plan's clinical FTE did not always correlate well with actual clinical effort. The emphasis was on the faculty's funding of his/her actual salary. Departmental leadership is well aware of this issue and is working diligently to transition into more fully into a true Clinician Educator Compensation Plan with appropriate minimum clinical effort expectations.*
>
> *We needed to retain a "safety valve," allowing management judgment regarding administration of the collar. If, due to clinical demands, a participant is required to have significant clinical duties while maintaining administrative accountabilities, the chair may elect to waive the collar. Recognizing that we did not have viable alternate plans for faculty with significant research and/or administrative accountabilities, we granted exceptions to this minimum on a case by case, by chair approval.*
>
> *In FY 2014, we set a participation floor of 0.60 clinical FTE and eliminated the collar for those above that floor. This also had the effect of encouraging faculty who had buy-downs driving his/her clinical*

FTE value below 0.60 to reassess actual clinical effort and when appropriate, agree to a minimum of 0.60 with the corresponding benefit of eliminating the collar.

Departmental leadership is also aware of the issue regarding the application of limits on incentive and intends to address this problem by moving towards a more strict application of clinical effort and by developing alternative compensation plans designed to fit outliers to our current Clinician Educator plan. The implementation of the Physician Scientist incentive plan will enhance correlation between clinical FTE and the need for variable limits on incentive tiers.

With regard to the example cited in the report, please note that that faculty member's metric is set at 0.45 clinical FTE for FY 2014, which reasonably correlates to his assigned clinical effort. Also note that he has a 25 percent collar applied to his individual productivity incentive. This individual is an example of a faculty participant who has significant clinical and administrative effort, and who extends himself to accomplish both. The waiving of the collar for him was specifically approved so as not to cause undue harm by significantly reducing his year-over-year compensation. Departmental leadership and his division chief assigned his clinical and administrative duties in accordance with needs of the department and his ability and interests. Thus, the best mechanism available during the FY 2013 plan year was to waive the collar on his wRVUs over the benchmark.

Anticipated Implementation Date: *September 30, 2015*

Procedures for Determining Incentive Compensation

Internal Medicine uses Microsoft Excel spreadsheets for determining incentive compensation. The spreadsheets include information obtained from different sources. For example, wRVUs are obtained from Epic information maintained by MSRDP finance. Quality and patient satisfaction information are from other sources and can include data from hospital partners. Department administrators are very familiar and know steps necessary to determine incentives. However, implementation of the compensation plan is in its initial phases and documented procedures or guidelines for administering quarterly incentive payments have not yet been developed. Over time, administrators assigned to determine incentives can change. Well-written procedures should be independent of individuals performing assigned functions, include clearly defined roles and responsibilities, and provide clear instructions on what needs to be done. Written procedures also reduce the risk of errors, and can help ensure consistent application of processes over time.

Recommendation: Internal Medicine should develop written procedures for administration of incentive compensation.

Management's Response: *We are in the process of documenting our incentive calculation model and the steps needed to prepare and review the quarterly payments.*

Anticipated Implementation Date: *September 30, 2015*

Group Incentive Component

In accordance with the MSRDP Compensation Guidelines and the CE Plan, group incentive was initially budgeted to approximate 25 percent of total incentive compensation. However, as FY 2013 was the first year during which the current incentive plan was in effect, Internal Medicine decided instead to provide $5,000 per plan participant to the group pool because there was uncertainty regarding actual individual incentive. Each division chief had the discretion to determine how to allocate earned incentives among the faculty members within their divisions. For FY 2014, the budgeted group pool was calculated at 25 percent of the projected four

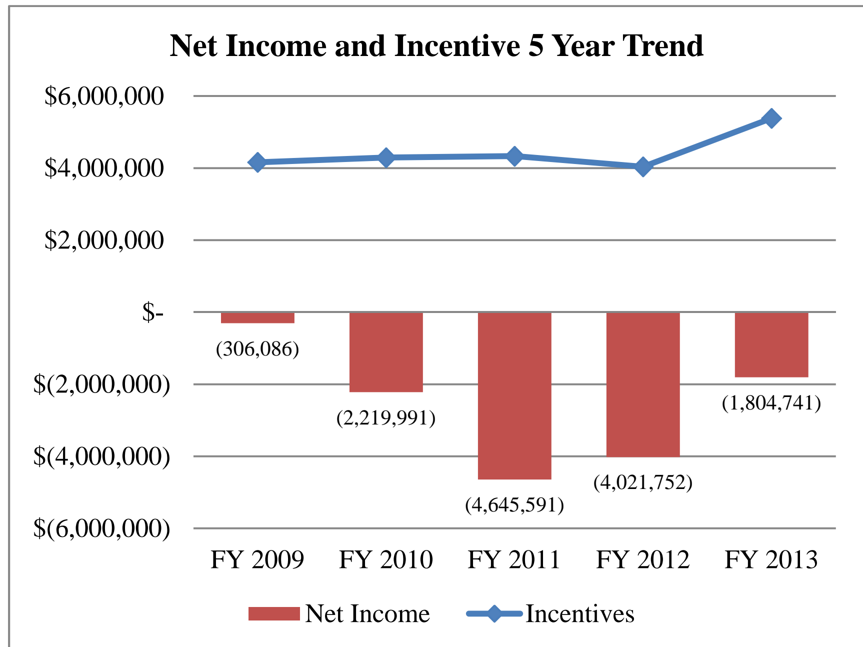
quarters of FY 2014's individual incentive payout so that actual group incentive payments will more closely align with the MSRDP Compensation Guidelines.

Summary Trends

As part of this engagement, we trended faculty compensation, incentive compensation, wRVUs, billed collections (which includes Parkland Memorial Hospital Epic billed collections), total clinical revenue, and other metrics for the period Fiscal Year (FY) 2009 to FY 2013.

Compensation Type	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 09 – FY 13 % Change
Faculty Salaries + Supplemental Administrative Compensation	$19,445,210	$21,386,324	$26,500,306	$30,821,147	$35,561,383	83%
Incentive Compensation	$4,159,725	$4,291,453	$4,330,350	$4,037,167	$5,382,278	29%
Total Faculty Compensation	$23,604,935	$25,677,777	$30,830,656	$34,858,314	$40,943,660	73%
All Department Compensation and Benefits	$44,121,467	$46,890,906	$55,698,319	$60,980,924	$67,893,271	54%
Incentives / Total Faculty Compensation	17.6%	16.7%	14.0%	11.6%	13.1%	-25%
MSP Full-Time Equivalent	195	188	212	236	271	39%
wRVUs	621,580	667,009	723,663	829,054	912,120	47%
Billed Collections	$31,611,459	$42,215,089	$48,187,205	$54,343,819	$60,464,314	91%
Contractual Revenue + UPL + Other	$24,663,079	$16,532,643	$15,593,738	$18,091,455	$21,256,331	-14%
Total Clinical Revenue	$56,274,928	$58,749,219	$63,780,885	$72,051,659	$81,720,645	45%
Collections/FTE	$162,315	$224,348	$227,320	$230,193	$222,853	37%
Net Income with Profit Sharing	($306,806)	($2,219,991)	($4,645,591)	($4,021,752)	($1,804,741)	-490%

As illustrated in the table above, faculty salaries (including supplemental administrative compensation) increased by 83 percent while the MSP full-time equivalent increased 39 percent and incentive compensation increased by 29 percent. Over this same period, total billed collections increased from $31.6 million to $60.5 million, or 91 percent, while total clinical revenue increased from $56.3 million to $81.7 million, or 45 percent. Work RVUs also increased over the last five fiscal years—from 621,580 to 912,120, or 47 percent. In addition, billed collections per FTE increased from $162,315 to $222,853, or 37 percent.



From FY 2009 through FY 2013, Internal Medicine experienced deficits each year ranging from $306 thousand in FY 2009 to $4.6 million in FY 2011. From FY 2011 to FY 2013, the deficits decreased by $1.8 million, or improved by 61%. Over the last five fiscal years, incentives increased by 29 percent from $4.2 million to $5.4 million. Though total incentive payments have increased, they decreased as a percentage of total faculty compensation—from 17.6 percent to 13.1 percent.

Internal Medicine has provided supplementary information to help readers of this report understand its compensation plan with respect to clinical productivity for the period FY 2011 to FY 2014. Internal Medicine's summary and analysis is presented on the following page of this report appendix. The System Audit Office did not audit the supplementary information and Internal Medicine is solely responsible for its content.

Supplementary Information Prepared and Provided by Internal Medicine

Internal Medicine's leadership proposed that evaluation of its CE Plan, in its current format, is best done by looking at the wRVU growth, wRVUs denominated by cFTE, and total compensation paid per RVU.

Net deficit financials, while obviously affected by productivity, are too far removed from the CE Plan metric of wRVUs. There are many factors that influence a reported deficit. Among these are funding shifts, success in negotiating contract terms, opening up of profit share opportunities (e.g., the Aston Infusion Center), and expansion of the ambulatory clinical practice. Each of these has the potential to have significant impact on the department's net margin, yet none are driven by wRVU productivity.

The information in the table below shows data from FY 2011 through projected FY 2014. For this period, Internal Medicine's wRVU/cFTE grew by 7.3 percent and total compensation per wRVU by 6.1 percent. One of the CE Plan's objectives was to be able to quickly to increase faculty compensation to a level commensurate with faculty productivity. Several divisions had faculty whose compensation lagged behind their wRVU productivity and an annual merit pool is not sufficient to address this issue.

The total compensation paid per RVU shows that this has indeed occurred. Internal Medicine compared the compensation paid per RVU to the MGMA metric. In FY 2014, total compensation was $27.80 per total RVU. The MGMA median weighted-average total compensation was $30 per total RVU. As illustrated in the table below, Internal Medicine has been increasing the compensation paid per RVU since implementation of the CE Plan to a level more commensurate with faculty productivity.

DEPARTMENT OF INTERNAL MEDICINE
Year-Over-Year Work RVUs - FY 2011 THROUGH FY 2014 PROJECTED (unaudited)

Facility Group	FY 2011 Work RVUs	FY 2012 Work RVUs	FY 2013 Work RVUs	FY 2014 Projected Work RVUs	Compounded Growth Rate
I. Year-over-year Work RVUs:					
Campus Ambulatory/Satellite	116,572	134,137	142,628	156,130	10.2%
University Hospital - Outpatient	92,124	108,845	118,359	127,518	11.4%
University Hospital - Inpatient	154,970	181,825	215,046	229,280	13.9%
Health System Total	**363,666**	**424,807**	**476,033**	**512,929**	**12.1%**
PHHS	**273,935**	**314,866**	**335,020**	**345,720**	**8.1%**
Miscellaneous	**28,412**	**29,062**	**29,127**	**29,527**	**1.3%**
Total Work RVUs	**666,013**	**768,735**	**840,180**	**888,176**	**10.1%**
II. Faculty Clinical Effort & Compensation					
Adjusted Clinical FTEs (1)		135.0	131.5	135.6	
Work RVUs/Clinical FTE		5,694	6,389	6,552	7.3%
Total Compensation - Salary + Incentive (1)		$ 31,084,709	$ 35,578,544	$ 40,422,038	
Total Compensation per Work RVU		$ 40.44	$ 42.35	$ 45.51	6.1%
Total Compensation per Total RVU		$ 24.63	$ 25.62	$ 27.80	6.3%

NOTES:
1. FY 2014 Total Compensation per work RVU equals $27.80 per total RVU. The academic MGMA median, weight-averaged to match the Department's service line mix is $30.
   81% of Department faculty achieved benchmark over the prior 12-month trail.

Appendix E – Department of Ophthalmology

BACKGROUND
The University of Texas (UT) Southwestern Medical School's Department of Ophthalmology's mission is "to provide excellence in clinical care of patients with diseases of the eyes, to advance medical knowledge of the causes and treatments of such diseases, and to instruct and educate physicians in the practice of ophthalmology." James P. McCulley, M.D., has led the department for over 30 years and developed Ophthalmology's X, Y, Z compensation plan. According to Dr. McCulley, the principles of Ophthalmology's compensation plan, including determination of incentive compensation, align with those from Harvard University and Washington University. The formula for determining incentive compensation is illustrated in the table to the right and can be generally summarized as the difference between collections attributable to a faculty member from professional services and salary supported by external sources less the total amount paid to a ***faculty*** member, including fringe benefits. Fringe benefits include taxes, deductions for health insurance, and retirement contributions. Incentive compensation also includes a group component that is based on Press Ganey patient satisfaction scores. If goal scores are achieved, faculty members can earn up to $5,000 in group incentive payments each year.

Incentive = (X + Y + Z) – (Salary Paid + Benefits)

X = Base salary as determined by academic rank

Y = Salary from external sources such as the NIH and hospital contracts

Z = Collections for professional services

RESULTS
Ophthalmology's incentive compensation plan was reviewed by the faculty compensation committee and approved by the provost/dean and the executive vice president for health system affairs. In accordance with the UT Southwestern's *Compensation Guidelines for the Medical Service, Research, and Development Faculty Practice Plan* (MSRDP Compensation Guidelines), the Ophthalmology plan, as evidenced by an increase in work RVUs (wRVUs) and collections, appears to encourage prospective performance that leads to the generation of growth in clinical volumes and income. In general, it appears that the Ophthalmology plan is achieving its objective to reward individual productivity. The plan also includes a group incentive that can help improve patient satisfaction. As part of our work, we interviewed the department chair, key departmental administrators, and a small sample of faculty members. Based on those interviews, it appears that the faculty members clearly understood how the department's incentive compensation plan works. However, we identified opportunities to enhance administration of the compensation plan as detailed below:

Calculation of Incentive Compensation
Ophthalmology determines and pays faculty incentive compensation on a semiannual basis. Faculty members are credited for patient care they provide at multiple places of service. Determination of incentive is largely based upon collections obtained from multiple sources, some of which exist outside of the UT Southwestern billing system.

As part of our work, we compared collection information provided by MSRDP finance to collection information used to determine faculty incentive compensation. We noted differences for 8 of 10 faculty members selected for review. The effect of these differences on incentive paid per tested faculty member was small, ranging from $17 to $1,256. Two of these differences were attributable to adjustments that had not been posted in the Epic billing system, but the actual incentive paid to the faculty members was correct. An additional two differences were attributable to timing differences related to collections recorded in Epic. Ophthalmology investigated the remaining four differences and found that they required correction. These differences were attributed to missing

procedures, credits to the incorrect faculty member, and timing differences of applied collections that crossed fiscal years. Ophthalmology has committed to making the identified corrections on the next incentive payments.

> **Recommendation:** In addition to exceptions noted from the audit, Ophthalmology should review incentive payments for FY 2013 and FY 2014 to ensure incentives were determined and paid correctly for all applicable Ophthalmology faculty members.
>
> **Management's Response:** *The errors noted and identified in the audit are being rectified. We reviewed FY 2013 and FY 2014 incentive payments and found no other errors.*
>
> **Anticipated Implementation Date:** *Implemented*

Group Incentive

According to the MSRDP Compensation Guidelines, "there must be both group and individual components to the Department Incentive Plans. Group components must account for a minimum of 25% of the Incentive Compensation calculation." The guidelines further state that "group components should include some measure of clinical outcomes, quality, and safety."

The Ophthalmology plan emphasizes individual productivity that allows faculty to retain an allocable portion of what they earn in excess of their salary, benefits, and other expenses incurred by the department on behalf of faculty. The Ophthalmology plan also includes a group component, which is limited to the achievement of predetermined Press Ganey scores for the "*Care Provider - Overall*" and "*Moving Through the Visit*" elements. For FY 2013, the goal for both elements was to exceed the UT Southwestern average for the Ambulatory Medical Practice. In general, if Ophthalmology achieves its goal for the six months prior to the semiannual incentive period, then faculty members can earn up to $2,500 with each semiannual incentive payment.

In FY 2013, Ophthalmology did not achieve its goal scores for either element; consequently, Ophthalmology did not pay group incentives. Had scores been achieved and group incentives paid under the current Ophthalmology compensation plan, the group incentive would not have met the minimum 25 percent of incentive compensation calculation.

> **Recommendation:** According to the Compensation Guidelines, "department Incentive Plans must be reviewed by each clinical department every two years and sent for review by the provost/dean and executive vice president of the health system for approval by the president." When the incentive compensation plan comes up for its biennial review, Ophthalmology should evaluate additional group measures of clinical outcomes, quality, and safety to incorporate into the group component of incentive compensation. Such measures should be applicable to Ophthalmology and be based upon reliable, accurate data. Ophthalmology should also evaluate ways in which it can expand the group pool of funds available to faculty that is equitable and consistent with goals of both the Ophthalmology compensation plan and the MSRDP Compensation Guidelines. Any proposed changes should consider faculty input.
>
> **Management's Response:** *We will do the evaluation at the time of the next biennial review.*
>
> **Anticipated Implementation Date:** *Pending next biennial review*

Incentive Calculation Worksheets

Ophthalmology prepares an incentive worksheet that includes collection amounts and calculations used to determine incentive compensation. Faculty members are given the opportunity to review their respective incentive worksheets. The department keeps a record of the date and time of the meeting with each faculty

member, reports any questions to the department chair, and follows up on any issues. Faculty may also review the worksheet and take their own notes; however, faculty members are not allowed to retain a copy for their own records.

Recommendation: To enhance transparency, Ophthalmology should allow faculty members the option to retain copies of their incentive calculation worksheets to allow them ample time to review, gain a better understanding of how incentive is calculated, and ask any related follow-up questions.

Management's Response: *We will provide faculty with scorecards on incentive plan metrics.*

Anticipated Implementation Date: *December 1, 2014*

Administration of Incentive Payments Greater than 30 Percent

According to the MSRDP Compensation Guidelines, department incentive plans should not provide for potential incentive compensation of more than 30 percent of total compensation; however, incentive payments greater than 30 percent of total compensation must be individually approved by the provost/dean and executive vice president of the health system. Ophthalmology has several faculty members who have earned incentive compensation greater than 30 percent of total compensation and has a practice of "banking" incentive compensation earned in excess of the 30 percent incentive threshold. The banked incentive compensation is paid out to the faculty member (plus accrued interest) in a period when their incentive compensation does not exceed 30 percent of their compensation. This practice also reduces the number of times Ophthalmology has to seek approval to pay such incentives. This process appears to be a departure from the direction provided within the MSRDP Compensation Guidelines and is not described in the department's plan.

Recommendation: Because the current practice of handling incentive compensation greater than 30 percent of total compensation does not appear to align with the MSRDP Compensation Guidelines and because the current practice affects the amount and timing of incentives paid, Ophthalmology should request approval from executive management of how Ophthalmology handles administration of incentive compensation greater than 30 percent of total faculty compensation.

Management's Response: *When the excess incentive > 30% is substantial, we ask Senior Administration for a waiver for us to pay the excess. In the future, with smaller amounts in excess of the 30%, we will ask the Administration for approval to bank them and to pay the excess at the next incentive payment date including passbook interest on the amount.*

Anticipated Implementation Date: *December 1, 2014*

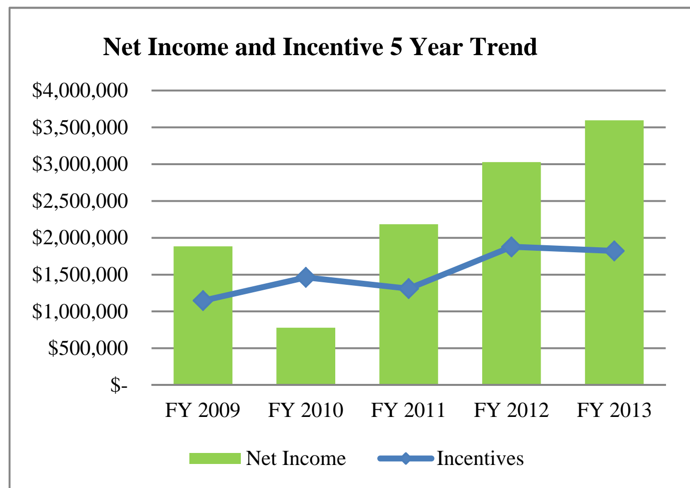
Summary Trends

As part of this engagement, we trended faculty compensation, incentive compensation, wRVUs, billed collections, total clinical revenues, and other metrics for the period from FY 2009 to FY 2013.

Compensation Type	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 09 – FY 13 % Change
Faculty Salaries + Supplemental Administrative Compensation	$4,225,835	$4,319,423	$4,817,510	$5,691,066	$6,208,533	47%
Incentive Compensation	$1,146,789	$1,462,476	$1,310,233	$1,877,186	$1,821,420	59%
Total Faculty Compensation	$5,372,624	$5,781,899	$6,127,743	$7,568,252	$8,029,953	49%
All Departmental Compensation and Benefits	$12,910,382	$13,537,914	$13,837,394	$15,836,691	$16,600,617	29%
Incentive / Total Faculty Compensation	21.3%	25.3%	21.4%	24.8%	22.7%	6.3%
MSP Full Time Equivalent (rounded)	22	19	19	21	21	-5%
Work RVUs	239,588	224,182	238,004	252,492	242,538	1%
Billed Collections	$16,712,824	$19,483,152	$20,800,738	$24,034,737	$24,618,281	47%
Contractual Revenue + Other Revenue	$5,946,866	$3,365,237	$3,609,867	$4,069,506	$5,160,889	-13%
Total Clinical Revenue	$22,659,690	$22,848,389	$24,410,605	$28,104,243	$29,779,169	31%
Collections/FTE	$757,306	$1,029,977	$1,099,631	$1,149,102	$1,170,627	55%
Net Income	$1,883,443	$778,984	$2,183,560	$3,029,247	$3,596,346	91%

As illustrated in the table to the right, faculty salaries (including supplemental administrative compensation) and incentive compensation increased by 47 percent and 59 percent respectively. Over this same period, billed collections increased from $16.7 million to $24.6 million, or 47 percent, while total clinical revenue increased from $22.7 million to $29.8 million, or 31 percent. Although wRVUs have remained relatively stable over the last five fiscal years, billed collections per FTE increased from $757 thousand to $1.17 million, or 55 percent.

Ophthalmology's net income earned and incentive payments have increased and have generally moved together over the last five fiscal years. From FY 2009, net income increased from $1.9 million to $3.6 million, or 91 percent, while incentives paid increased from $1.15 million to $1.8 million, or 59 percent. In addition, incentive payments, as a percentage of total faculty compensation (excluding benefits) has been relatively stable over the last five fiscal years, ranging from 21 percent to 25 percent.



Appendix F – Department of Pediatrics

BACKGROUND

The University of Texas (UT) Southwestern Medical School's Department of Pediatrics has a three-fold mission which includes "[providing] the highest quality patient care, acquiring new knowledge by pursuing unanswered scientific questions, and educating students and health care professionals." After being appointed as chair in January 2013, Julio Perez-Fontan, M.D., instituted a new incentive plan. Under the new plan, most faculty members have a work RVU (wRVU) benchmark that, in general, is determined by product of the American Association of Pediatrics (AAAP) wRVU at the 50th percentile times the faculty members percent clinical effort. Incentives are paid quarterly and have individual and group components. Group goals are developed with input from division directors, who propose goals during budget development. The Pediatric Compensation plan includes four classes of clinical faculty with incentive from each class handled in a unique way.

- **Class A -** Includes clinical faculty who have up to 70 percent of their incentive based on RVU productivity and 30 percent based upon achievement of group goals.
- **Class B -** Includes clinical faculty who have up to 50 percent of their incentive based on RVU productivity. These are doctors who work in the Intensive Care Unit (ICU) or see patients from referrals. The remainder of their incentive is based upon achievement of group goals.
- **Class C -** Includes research faculty. These faculty members spend up to 75 percent of their time on research and their productivity is not based primarily on RVUs.
- **Class D -** Includes division directors and includes faculty members who have administrative duties over divisions or programs. Because of this responsibility, their incentive is based on their leadership over their division or program and its performance.

RESULTS

Pediatrics implemented its current compensation plan in March 2013. Pediatrics' compensation plan was reviewed by the faculty compensation committee and approved by the provost/dean and the executive vice president for health system affairs. Pediatrics' positive trends over the last five fiscal years for both wRVUs (a 32 percent increase) and billed collections (a 63 percent increase) appears to indicate that the compensation plan encourages growth in clinical volumes and income. The compensation plan also includes both individual and group incentives. In general, the compensation plan appears to be achieving its objective to reward clinical productivity. However, we have identified opportunities, detailed as follows, to improve transparency and enhance administration of the compensation plan:

<u>Communication of the Pediatrics Plan and Feedback to Faculty</u>

According to the Compensation Plan Guidelines, "the metrics and calculations to be used in determining incentive compensation should be presented to faculty prospectively in a written and understandable format." In addition, "a copy of the Department Incentive Plan should be included, as an appendix, with each memorandum of appointment and should be provided to all MSRDP faculty members eligible for Incentive Compensation at the time of approval of any changes to the Departmental Incentive Plans." As part of our work, we interviewed the department chair, key departmental administrators and a small sample of faculty members. From the interviews we learned that the new compensation plan was communicated to faculty via town-hall meetings prior to implementation. Faculty interviewed understood that wRVU production was a key factor in determining incentive compensation and that a key goal of the department's plan was to improve clinical productivity, but they did not consistently recall whether they had received the compensation plan and indicated that they did not clearly understand how the compensation plan works. While the compensation plan describes the incentive calculations, faculty members interviewed found the descriptions to be complex and difficult to understand. Since plan

implementation, pediatric faculty members have not been provided a report card that describes on how their incentive payments were determined.

Those interviewed also did not appear to consistently understand how the group incentive is determined. One faculty member interviewed indicated that certain quality measures were tracked by faculty member's pediatric division but that the measure did not impact the incentive. We were informed that group goals are to be developed with input from division directors and two to three goals are set for each division. However, an exception was made in to distribute the group incentive funds as if goals were met. This decision was made because Pediatrics did not have sufficient data upon which to evaluate whether group goals were met. As of March 2014, Pediatrics has more reliable data and expects that the first group incentives that include evaluation of group goals will be made for the first quarter of FY 2014.

Recommendation: It appears opportunities exist to more clearly communicate how the compensation plan works to faculty:

- To improve transparency and communication of plan implementation, Pediatrics should provide its faculty with scorecards that precede each quarterly incentive payment. The score cards should reasonably demonstrate how the incentive was calculated, the individuals wRVUs, and when ready, the attainment of divisional goals.
- To enhance clarity and facilitate faculty understanding of the plan, Pediatrics should consider including expanded, detailed examples that clearly demonstrate how quarterly incentive compensation and an annual productivity-based changes in fixed compensation would be calculated, theoretically, for a fictional faculty member for each class of faculty.

Management's Response: *Coinciding with the timing of this audit, the Department had appointed two incentive compensation committees to provide the Chair's Office with a critical appraisal of the performance in May 2014. One was comprised of elective representatives, one from each division; the other was formed by all the Division Chiefs. Both groups remarked on the need to provide individual faculty members with a more immediate account of the data and methods used to calculate their incentive payments.*

Based on the recommendations of these committees and the conclusions of the current audit, the Department has revised its incentive plan. The Department will no longer rely on the Division Directors to provide incentive payment information to faculty members. A system will be developed and implemented to distribute data directly to faculty members through statements that will be prepared at least quarterly and placed in an electronic location accessible only to the faculty member. The implementation will require some modifications in the UT Southwestern Intranet access paths for faculty housed at Children's Medical Center, and thus a start date of January 1, 2015 is planned.

In addition to direct date access, the Department has retained the services of the faculty-elected committee to function as a consultative body on a continuous basis. Details of the modifications introduced in the plan have already been presented to the faculty and will continue to be discussed in upcoming quarterly faculty meetings. Both the revised description of the plan and the presentations given in those meetings contain examples of the application of the provisions of the plan, as recommended by the auditors.

Anticipated Implementation Date: *January 1, 2015*

Clinical FTE

Clinical FTE = ((1 – (External Salary Support / Salary) – (Time in Departmentally Assigned Effort / Total Time))

Pediatrics devised a formula to determine clinical effort for each faculty member for each division. As illustrated in the formula to the right, the clinical effort represents the fraction of a faculty member's effort remaining after subtracting the portions of a faculty member's total effort that is supported by external salary contributions or assigned to functions, as determined by department leadership, to be of interest to Pediatrics or UT Southwestern. As an example, a full-time clinical faculty member who receives 20 percent salary support from a federal research grant and serves as a program director with an estimated 10 percent effort would have a cFTE of 0.70. Consequently the wRVU benchmark for this faculty member would be 0.70 times the AAAP benchmark.

As part of our work, we requested supporting documentation form Pediatrics to review incentive calculations for a sample of faculty. We found that the wRVUs used by Pediatrics to calculate incentives agreed to the wRVU information provided by MSRDP Finance and that the calculated individual incentives were mathematically accurate. However, in reviewing the most recent support for the January 2014 incentive payments, we noticed that there were some faculty members with low cFTEs that earned relatively large quarterly incentive payments.

Clinical FTE%	No. of Faculty A and B Faculty	Number that Earned Incentive	% That Earned Incentive	Incentive Earned by Group	Average Quarterly Incentive Earned for Faculty that Earned Incentive	wRVUs earned	Incentive wRVUs (Excess wRVUs over Benchmark)	$ / Incentive wRVUs
9% to 50%	37	16	43%	$89,702	$5,606	11,922	3,392	$26.44
51% to 75%	30	20	67%	$188,615	$9,431	29,718	7,528	$25.06
80%* to 99%	37	17	46%	$86,027	$5,060	41,335	3,457	$24.88
100%	48	22	46%	$98,031	$4,456	58,273	6,415	$15.28

* There were no faculty with cFTE between 76% and 79%.

As illustrated in the table to the right, we grouped the A & B faculty members into four cFTE groups. It appears that the lower the cFTE, the higher the value of the wRVUs in excess of the productivity benchmark. On average, faculty in the 51 to 75 percent cFTE group earned the highest incentive compensation. One of the faculty members we interviewed had 100% cFTE and had teaching duties. As illustrated in the cFTE formula on the previous page, there is no percent effort estimate associated for teaching. If there are clinical faculty members with teaching responsibilities that do not have external salary support or assigned administrative duties, then their cFTE may overstate their clinical effort for purposes of determining incentives.

Using the January 2014 incentive compensation supporting documentation, we reviewed A & B faculty by division. For the Emergency Medicine and the Critical Care Divisions, the higher the cFTE the higher the wRVUs generated. However, we noted that there were certain faculty members whose formula-based cFTE might not reflect their actual clinical effort. For example, we noted that one faculty member in the General Pediatric division generated the highest amount of wRVUs and had less than a 25 percent cFTE. In the cardiac division, a faculty member with less than a 45 percent cFTE had the highest quarterly incentive payment. However, this faculty member produced 48 percent less wRVUs than the most clinically productive faculty member in the division and earned significantly more quarterly incentive compensation than the top producer.

According to the Compensation Guidelines, "department incentive plans should limit incentive compensation paid to physicians who spend less than 50% of their time clinically." For high producing faculty with low cFTE, their actual wRVUs, when converted to a 1.0 cFTE basis can represent relatively high benchmark percentile. Such faculty members are paid at the same dollar-per-wRVU rate as clinical faculty members with higher cFTEs.

Consequently, it appears that Pediatrics does not have a mechanism in place to limit incentive compensation paid to positions that have less than a 50 percent clinical effort. In addition, certain faculty members with a low cFTE may have much higher actual clinical effort.

> **Recommendation:** To ensure equitable determination of cFTE, we encourage Pediatrics to revisit its cFTE formula and determine if there is a manner in which to provide reasonable credit for clinical faculty members' teaching efforts and to evaluate the estimates used to determine administrative time. We also encourage Pediatrics to review historical clinical productivity of faculty members with low cFTE amounts and validate whether the cFTE used to determine incentive compensation reasonably approximates a faculty member's actual clinical effort. Lastly, Pediatrics should determine whether there is an equitable manner in which to limit incentive compensation paid to faculty members who have less than 50 percent clinical effort.
>
> **Management's Response:** *Based on the recommendations of the committees appointed by the Department, a standard clinical FTE deduction of 10% of the clinical effort will be instituted to recognize clinical and administrative efforts. Historical information will be reviewed in conjunction with the Division Directors to ensure that the clinical FTE truly reflects clinical effort. Moreover, the faculty-elected committee will be asked to provide guidance regarding the equanimity and fairness of clinical FTE reductions and exceptions. Finally, incentive payments will be adjusted based on the clinical FTE to ensure that the reductions in clinical FTE do not result in disproportionate access to incentive payments*
>
> **Anticipated Implementation Date**: *Implementation of the 10% credit will be given September 1, 2014. Payout using clinical FTE that includes the 10% credit will be on June 1, 2015 for the incentive evaluation period of September 1, 2014 through February 28, 2015.*

Procedures for Determining Incentive Compensation

Pediatrics uses Microsoft Excel spreadsheets for determining incentive compensation. The spreadsheets include information obtained from different sources. For example, wRVUs are obtained from Epic information maintained by MSRDP finance. Quality and patient satisfaction information are from other sources and can include data from hospital partners. Department administrators are very familiar and know steps necessary to determine incentives. However, implementation of the compensation plan is in its initial phases and documented procedures or guidelines for administering quarterly incentive payments have not yet been developed. Over time, administrators assigned to determine incentives can change. Well-written procedures should be independent of individuals performing assigned functions, include clearly defined roles and responsibilities, and provide clear instructions on what needs to be done. Written procedures also reduce the risk of errors, and can help ensure consistent application of processes over time.

> **Recommendation:** Pediatrics should develop written procedures for administration of incentive compensation.
>
> **Management's Response:** *Agreed, formal written procedures will be developed for administering incentive compensation.*
>
> **Anticipated Implementation Date:** *December 1, 2014 – The First Incentive Date of FY 2015*

True-Up of Incentives Earned and Paid

The underlying assumption for the individual component for class A and B pediatrics faculty is that their incentive is achieved when they exceed their wRVU benchmark. If the percent clinical effort does not change during the year, A and B faculty members are accountable for exceeding that annual benchmark. As illustrated in

the table on the following page, a pediatrics faculty member could earn incentive payments for Q1 and Q4. This would result in in overpayment for 200 wRVUs for the entire fiscal year. If incentive were trued-up during the year, then the risk of overpayment could be limited to Q1 only. The compensation plan does suggest a mechanism that could limit the downside risk of over overpayment. According to the department's plan, 20 percent of earned incentive is to be paid in quarters 1, 2 and 3, while 40 percent of annual incentive would be paid in the fourth quarter. As documented in the plan, "by reserving the largest distribution for October 15, the Department can make final adjustments in the total incentive payments based on actual financial performance for the fiscal year, thereby preventing excessive or insufficient incentive distributions." Based on our testing, it appears Pediatrics has not yet implemented this mechanism as described in its compensation plan.

FY Quarter	Actual wRVU	Benchmark wRVU	wRVU for Incentive
1	600	500	100
2	500	500	0
3	300	500	(200)
4	600	500	100
Totals	**2,000**	**2,000**	**0**

Recommendation: Pediatrics should, as described in its plan, implement a true-up mechanism to reduce the risk of excessive or insufficient incentive distributions.

Management's Response: *As per the plan, only budgeted amounts of incentive will be distributed so excessive or insufficient distributions will not be made in total. To mitigate individual variances by quarter, the committees have recommended a return to biannual incentive payments.*

Anticipated Implementation Date: *December 1, 2014 – The First Incentive Date of FY 2015*

<u>Missing Required Compensation Plan Disclosures</u>

Section VI of the Compensation Guidelines states that the department incentive plans must clearly state the following six items:

G. Incentive Compensation is paid to incentivize future performance. Therefore, to receive Incentive Compensation, a faculty member must be an employee of UT Southwestern on the date of payment.

H. Incentive Compensation is not eligible for inclusion in the formula for contributions to the mandatory retirement programs, but is subject to all deductions required by state and federal law.

I. Incentive Compensation can only be made to MSRDP faculty with an active signed MSRDP agreement.

J. Incentive compensation earned by individual faculty members requires compliance with baseline expectations of MSRDP policies for:
1. Timely completion of medical records (inpatient and outpatient) within 7 days or less;
2. Timely submission of professional billings within 7 days or less;
3. Billing compliance training and adherence to billing guidelines;
4. Appropriate coverage of expected amounts of night and weekend call coverage;
5. Adherence to clinic session scheduling and cancellation policies; and
6. Patient satisfaction evaluations at the minimum expectations for the practice.

E. The upper limits of Incentive Compensation (as a % of Total Compensation) for which members are eligible should be stated, and the Departmental Incentive Plans should indicate how payments will be reduced if the total Incentive Compensation calculated to be paid is greater than available departmental profit or reserves.

F. Fees for all court appearances, depositions, expert testimony, or legal consultations are deposited into the departmental fund, and the percent distribution is determined and approved prospectively in the Departmental Incentive Plans.

We compared the Pediatrics compensation plan to the Compensation Guidelines. The Pediatrics compensation plan did not include disclosures of items A., B, C, and D.6 only.

Recommendation: Pediatrics should update its plan to include the disclosures required by the Compensation Guidelines.

Management's Response: *The revised plan contains a point-by-point account of university guidelines and regulations.*

Anticipated Implementation Date: *September 1, 2014*

Required Compensation Guidelines Compliance Elements

In accordance with the MSRDP Compensation Guidelines, "incentive compensation earned by individual faculty members requires compliance with baseline expectations of MSRDP policies for:

1. Timely completion of medical records within days or less;
2. Timely submission of professional billings (7 days or less);
3. Billing compliance training and adherence to billing guidelines;
4. Appropriate coverage of expected amounts of night and weekend call coverage;
5. Adherence to clinic session scheduling and cancellation policies; and
6. Patient satisfaction evaluations at the minimum expectations for the practice"

The interviews suggest that faculty members understood that open encounters should be closed within 7 days or less. In Pediatrics, if a clinical faculty member has open encounters, the incentive payment can be held until the applicable faculty member takes appropriate action to enclose the encounter. However, it appears that non-compliance with the other five baseline expectations is not currently considered as part of the determination of incentive compensation.

Recommendation: As part of determining periodic incentives payments, Pediatrics should verify, at least annually, whether faculty members who have earned incentive compensation have met the applicable baseline MSRDP expectations at least annually. If certain applicable requirements are not met (some of which may be division specific), Pediatrics should consider different options, such as determining whether adequate correction action was taken or reducing incentives to be paid.

Management's Response: *The Department will monitor adherence to guidelines within the limitations imposed by the data provided by Children's Medical Center and Parkland Hospital in the pertinent areas.*

Anticipated Implementation Date: *September 1, 2015*

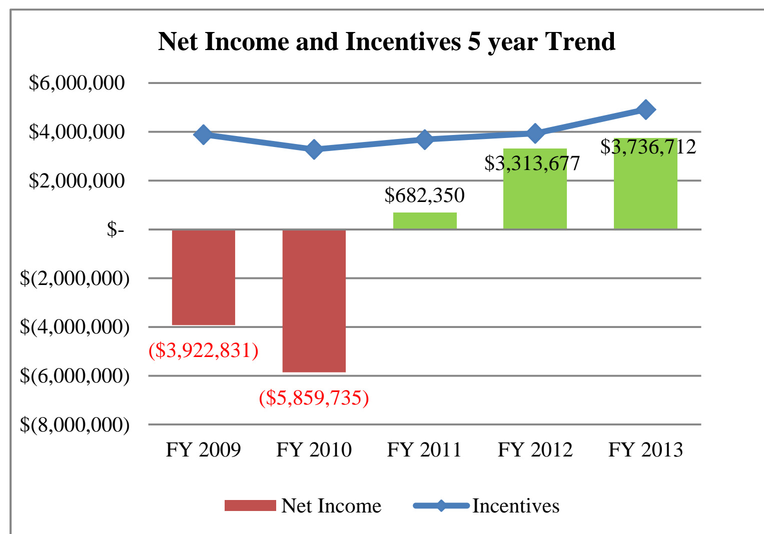
Summary Trends

As part of this engagement, we trended faculty compensation, incentive payments, wRVUs, billed collections, total clinical revenue, and other metrics for the period from FY 2009 to FY 2013. As illustrated in the table to the right, faculty salaries (including supplemental administrative compensation) have increased by 40 percent while the MSP full time equivalent increased 39 percent and incentive compensation increased by 26 percent. Over this a same period, total billed collection (which includes Parkland Memorial Hospital Epic billed collections) have increased from $29.6 million to $48.2 million, or 63 percent, while total clinical revenue has increased from $49.4 million to $84.0 million, or 70 percent. Work RVUs have also increased over the last five fiscal years—from 653,054 to 859,856, or 32 percent. In addition, billed collections per FTE have increased from $181 thousand to $212 thousand, or 17 percent.

Compensation Type	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 09 – FY 13 % Change
Faculty Salaries + Supplemental Admin. Compensation	$26,420,210	$29,374,520	$33,998,353	$35,728,309	$37,081,113	40%
Incentive compensation	$3,885,724	$3,279,118	$3,682,113	$3,935,946	$4,914,350	26%
Total Faculty Compensation	$30,305,934	$32,653,638	$37,680,466	$39,664,255	$41,995,463	39%
All Department Compensation and Benefits*	$40,536,398	$43,464,325	$50,267,040	$53,938,854	$62,255,616	54%
Incentives / Total Faculty Compensation	12.8%	10.0%	9.8%	9.9%	11.7%	-9%
MSP Full Time Equivalent	164	165	186	211	227	39%
wRVUs	653,054	682,211	754,797	785,974	859,856	32%
Billed Collections	$29,648,794	$34,156,465	$38,939,373	$41,053,429	$48,235,441	63%
Contractual Revenue + UPL+ Other	$19,726,491	$20,265,321	$ 27,466,179.00	$ 32,549,208.00	$35,742,380	81%
Total Clinical Revenue	$49,375,115	$54,421,785	$66,405,552	$73,602,637	$83,977,821	70%
Collections/FTE	$180,637	$206,883	$209,520	$194,195	$212,070	17%
Net Income	($3,922,831)	($5,859,735)	$682,350	$3,313,677	$3,736,712	195%

* Includes faculty and non-faculty

In FY 2009, Pediatrics experienced a deficit of $3.9 million that increased to $5.9 million in FY 2010. However, net income became positive in FY 2011 and the positive trend continued for FY 2012 ($3.3 million) and FY 2013 ($3.7 million). Overall, net income has a net positive change of over $7.6 million from FY 2009 to FY 2013.



As previously mentioned, total incentives paid have increased by 26 percent over the last five fiscal years from $3.9 million to $4.9 million. Like net income, incentives paid decreased from FY 2009 to FY 2010 and then increased each year from FY 2011 to FY 2013 as net income improved. Though total incentive payments have increased, they have decreased as a percentage of total faculty compensation—from 12.8 percent to 11.7 percent.

Appendix G – Department of Radiology

BACKGROUND

The University of Texas (UT) Southwestern Medical School's Department of Radiology's mission is "to grow and sustain a world-class radiology department, characterized by its ability to translate innovations in imaging, information technologies, and image-guided therapies to optimize patient outcomes." The department is led by Neil M. Rofsky, M.D., who became chair of the department in September 2010.

The chair, in coordination with departmental leadership, developed the incentive plan that was implemented in 2012, with some modifications made since then. The chair did not want to base incentive compensation on clinical productivity alone. Consequently, other mission-based goals were incorporated as factors in determining incentive compensation, including academic productivity, citizenship, and a discretionary component to reward activities that do not fit into one of the other categories. As illustrated in the table to the right, a faculty member could, in theory, earn up to 50 points under the Radiology plan. Points are converted to incentive dollars based on predefined ranges. For fiscal year (FY) 2013, the ranges for semiannual incentive payments were as follows: $0 for 5 points or lower, $2,000 for 5 – 11 points, $4,000 for 12 – 26 points, $6,000 for 27 – 34 points, and $9,000 for 34 points or higher.

Incentive Element	Maximum Points
Individual Clinical Productivity (wRVU-based)	10 (20%)
Divisional Clinical Productivity (wRVU-based)	10 (20%)
Citizenship	10 (20%)
Academic Productivity	15 (30%)
New Innovator (Chair's Discretion)	5 (10%)
Total Points (%)	**50 (100%)**

RESULTS

The Radiology incentive compensation plan was reviewed and approved by the faculty compensation committee and approved by the provost/dean as well as the executive vice president for health system affairs. In accordance with the UT Southwestern *Compensation Guidelines for the Medical Service, Research, and Development (MSRDP) Faculty Practice Plan*, includes both individual and group incentive goals. In general, it appears the Radiology plan is achieving its objective to reward clinical productivity. Our testing also indicated that incentive payments were appropriately authorized. However, we identified opportunities to enhance administration of the incentive plan. Our observations and recommendations are detailed below and are made with the acknowledgement that the Radiology department is still in process of fully implementing its incentive plan and is making revisions as needed.

Department Chair's Incentive

During FY 2013, the department chair participated alongside other departmental faculty members in the incentive plan. According to the Compensation Guidelines, separate incentive plans for department chairs should be devised and amounts of incentive compensation approved are the responsibility of the provost/dean and the Executive Vice President for Health System Affairs, subject to the approval of the president. Of the departments reviewed, only the Radiology chair participates in the same incentive plan as faculty. The chair was a primary author of the department's plan and there are subjective elements within the incentive plan that is subject to the chair's discretion. In addition, the chair has the ability to make final adjustments to faculty members' score, including his own. Because of potential conflicts of interest in the plans structure and administration, the chair should not participate alongside eligible Radiology faculty. We were informed that executive vice president for health system affairs and the provost/dean are in process of developing incentive plans for clinical department chairs. Ideally, the chairs incentives should be based upon overall departmental performance instead of same individual performance criteria in place for faculty.

> **Recommendation:** Until development and approval of department chairs' incentive plans are completed, the department chair should discontinue participation in the department's incentive plan. Alternatively,

the chair may participate in the department's incentive plan if the chairs' incentive is determined outside of the department and reviewed and approved by the dean's office.

Management's Response: *Dr. Rofsky is looking forward to the implementation of an incentive plan for department chairman. Dr. Rofsky will no longer participate in the Radiology Department Incentive Plan.*

Anticipated Implementation Date: *September 2014*

Eliminate Discretionary Scoring of Individual Productivity Component

Radiology's incentive plan states that the "basis of the Individual Clinical Component of the Physician Incentive Plan is the Physician work relative value unit (wRVU), which is reflective of clinical productivity." Productivity above the 50th percentile of the Association of Administrators in Academic Radiology (AAARAD) benchmark is eligible for incentive. The criteria used are objective metrics. The point scale for the various benchmark percentiles is shown in the table to the right. However, we were informed that because there was not yet sufficient source data for the "24 Hour Turnaround >80%" element in FY 2013, all 10 points were wRVU-based.

wRVUs to Benchmark	Points
<25%	0
25%-49%	0
50%-74%	5
75%-89%	8
>90%	9
24 Hour Turnaround >80%	1
Maximum Points	**10**

Upon reviewing the detailed supporting data for the point scoring of the individual productivity component, we observed apparent inconsistencies in the way the actual points were awarded. For example, in the table below, Person C had wRVUs in the 75th-89th percentile and was awarded 10 points, while Persons E and G both had wRVUs above the 90th percentile but only received nine points. Additionally, some of the points awarded do not correspond with a value in the point scale, which may indicate potential discretionary adjustments. This could potentially affect the final dollar amount of incentive payment for those plan participants who are near a threshold in the calculation of total points. For example, someone with 34 total points would earn $6,000, but someone with 35 points would earn $9,000.

Plan Participant	Subspecialty/ Division	CFTE	Actual wRVUs March - August 2013	wRVUs Adjusted for 100% CFTE	AAARAD Benchmark Percentile (Prorated for 6 Months)	Actual Points Awarded	Expected Points Earned*
Person A	Magnetic Resonance Imaging (Abdominal/Body)	0.035	191	5,466	75%-89%	7	9
Person B	Abdominal/Body	0.6	3,484	5,807	75%-89%	9	9
Person C	General Imaging	0.3	1,879	6,263	75%-89%	10	9
Person D	Neuroradiology	0.8	4,643	5,804	50%-74%	7	6
Person E	Neuroradiology	0.25	2,561	10,246	>90%	9	10
Person F	Vascular Interventional	0.8	4,901	6,126	75%-89%	9	9
Person G	Vascular Interventional	0.53	5,189	9,790	>90%	9	10

*Note: This example assumed that the one point for "24 Hour Turnaround >80%" was awarded to all plan participants in FY 2013.

Recommendation: Objective criteria, such as wRVUs and other quantifiable metrics, should be determined in a formulaic manner. For example, points could be assigned either by range or sliding scale

for wRVUs produced by faculty and without judgmental adjustment of points. Judgmental adjustment of points with respect to wRVU productivity could result in inconsistent application and over time.

Management's Response: *There is rigor and formulas for all the calculations. We have assigned points for each element of the plan. The issue is that this is a newly implemented plan and there has been some trial and error involved. It has continued to iterate and be improved over time. We have also changed back to a consistent biannual payment schedule with the same elements to be evaluated for each payment, which will eliminate ambiguity.*

Anticipated Implementation Date: *September 2014*

Communication of Clinical FTE and Incentive Calculations

In addition to their clinical work, Radiology faculty members may have various academic, research, and administrative responsibilities. Since each plan participant's actual wRVUs are converted to a 100 percent clinical FTE's (cFTE) equivalent wRVUs, the cFTE is an important factor in measuring clinical productivity. The cFTE is determined by the actual scheduled time that the faculty member is working on clinical activities. While the department does not currently maintain formal documentation of communicating the assigned cFTE to faculty members, the department chair indicated that a letter with this information will be provided to faculty members in the future.

Also, the chair expressed interest in conducting a survey of faculty members to measure understanding of the departmental compensation plan. From the limited number of interviews we conducted, faculty members expressed varying degrees of understanding of the incentive plan. They generally knew that incentive compensation was a function of productivity, but those interviewed indicated that more information could enhance transparency of how the amount of incentive compensation is actually computed. Each faculty member receives a letter with their incentive payment showing the components on which the incentive is based and how many points were earned in each component. The letter also has an award scale that translates the total number of points earned to the actual dollar amount of the incentive payment. However, the detailed information used to arrive at the points is not shown on the letter.

Recommendation: We encourage the department to implement its plan to formally communicate to faculty members their assigned cFTEs and conduct a survey to assess faculty awareness of the Radiology plan as it deems appropriate. Part of this communication could include examples of how incentive points are earned for model employees. To enhance transparency and understanding, Radiology should consider providing more detailed information about how points for incentive are earned as part of each actual incentive award letter.

Management's Response: *Assignment of total professional effort, including amount of assigned clinical effort (cFTE), is reviewed for all faculty at the time of annual evaluation. Each faculty member signed an evaluation form detailing their assigned cFTE this spring as part of their annual evaluation. A new management report has been developed by the Dean's Office and Health System to review high levels of incentive payment for faculty with < 50% assigned cFTE, and the Radiology department will be participating in this review process.*

Anticipated Implementation Date: *September 2014*

Procedures for Determining Incentive Compensation

Radiology uses Microsoft Excel spreadsheets for determining incentive compensation. The spreadsheets include information obtained from different sources. For example, wRVUs are obtained from Epic information

maintained by MSRDP finance. Quality and patient satisfaction information are from other sources and can include data from hospital partners. Department administrators are very familiar and know steps necessary to determine incentives. However, implementation of the Radiology plan is its initial phases and documented procedures or guidelines for administering quarterly incentive payment program are in progress but have not yet been fully developed. Over time, administrators assigned to determine incentive compensation can change, and well-written procedures are independent of individuals performing assigned functions, include clearly define roles and responsibilities, and provide clear instructions on what needs to be done. Well-written procedures also reduce the risk of errors and can help ensure consistent application of processes over time.

Recommendation: To reduce the risk of error and ensure consistent administration of incentive compensation over time, Radiology should complete development of written procedures for administration of incentive compensation.

Management's Response: *Standard Operating procedures are being developed and approved before the next incentive payment.*

Anticipated Implementation Date: *September 2014*

True-Up of Incentives Earned and Paid

The underlying assumption for the clinical productivity components is that incentive is earned when faculty members exceed their wRVU benchmarks. If the cFTE percentage does not change during the fiscal year, then faculty members are accountable for exceeding that annual benchmark. As illustrated in the table to the right, a faculty member could earn incentive payments for Q1 and Q4. This would result in an overpayment for 200 wRVUs for the entire fiscal year. If incentive were trued-up during the year, then the risk of overpayment could be limited to Q1 only.

FY Quarter	Actual wRVU	Benchmark wRVU	wRVU for Incentive
1	600	500	100
2	500	500	0
3	300	500	(200)
4	600	500	100
Totals	**2,000**	**2,000**	**0**

Recommendation: Radiology should implement a true-up mechanism to reduce the risk of excessive or insufficient incentive distributions.

Management's Response: *The conversion to a biannual plan will provide more data to be integrated over a longer period of time, which will eliminate these irregularities.*

Anticipated Implementation Date: *September 2014*

Administration of Incentive Over 30 Percent of Total Compensation

We were informed that faculty members who earn incentive compensation that accounts for over 30 percent of their total compensation for the fiscal year have the excess incentive redirected to an account for applicable faculty members to use towards professional development expenses. This process affects the amount of incentive compensation that a faculty member could receive. However, the Compensation Guidelines do contain a provision for paying earned incentive in excess of the 30 percent threshold with the approval of the provost/dean and executive vice president of health system affairs. We were informed that Radiology staff was not unaware of the exception approval process.

Recommendation: When applicable, Radiology should seek approval from the provost/dean and executive vice president of health system affairs to pay incentive compensation if it exceeds 30 percent of

a faculty member's total annual compensation. If Radiology would like to provide alternatives for handling incentives above 30%, Radiology should seek approval from the dean/provost and executive vice president for health system affairs of the alternative process. If approved, Radiology should update its plan to describe this alternative, and, if approved, should provide applicable faculty members the option of receiving the excess or setting it aside for professional development.

Management's Response: *The Radiology Department is aware of the option to request payment of incentives > 30% of total compensation and in the future will review such cases for consideration for letters of request from the Radiology Department Chair to the provost/dean and executive vice president of health system affairs.*

Anticipated Implementation Date: *September 2014*

Summary Trends

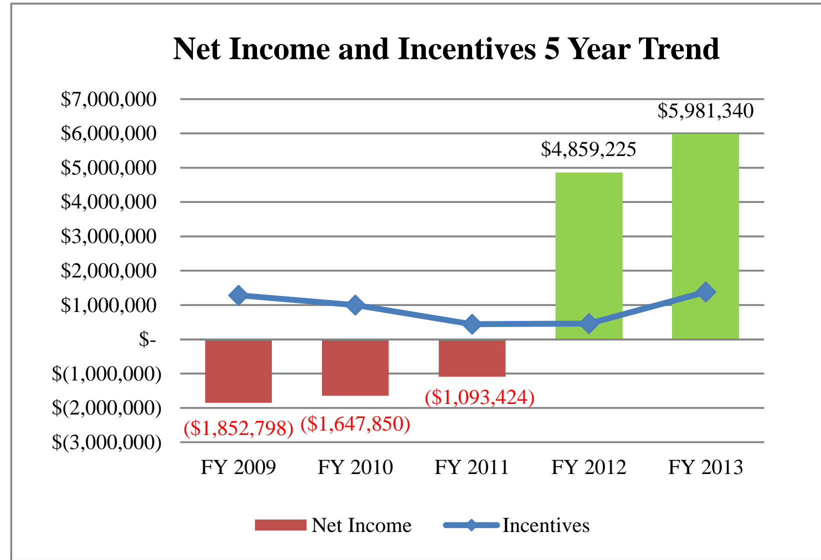
As part of this engagement, we trended faculty compensation, incentive compensation, wRVUs, billed collections (which includes Parkland Memorial Hospital Epic billed collections), total clinical revenue, and other metrics for the period from Fiscal Year (FY) 2009 to FY 2013. As illustrated to the right, faculty salaries (including supplemental administrative compensation) have increased by 15 percent and incentive compensation increased by 8 percent. Over this same period, total billed collections have increased from $22.1 million to $32.6 million, or 48 percent, while total clinical revenue has increased from $42.5 million to $44.0 million, or 4 percent. Work RVUs have also increased over the last five fiscal years—from 463,678 to 552,005, or 19 percent. In addition, billed collections per FTE have increased from $251,458 to $369,083, or 47 percent.

Compensation Type	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 09 – FY 13 % Change
Faculty Salaries + Supplemental Administrative Compensation	$27,889,204	$28,363,180	$30,737,145	$29,105,586	$31,973,411	15%
Incentive Compensation **	$1,283,183	$998,506	$439,377	$457,167	$1,380,730	8%
Total Faculty Compensation	$29,172,387	$29,361,686	$31,176,522	$29,562,753	$33,354,141	14%
All Department Compensation and Benefits	$38,920,314	$39,125,251	$42,264,306	$40,641,701	$43,071,342	11%
Incentives / Total Faculty Compensation	4.4%	3.4%	1.4%	1.5%	4.1%	-6%
MSP Full Time Equivalent	88	66	71	79	88	0%
wRVUs	463,678	494,792	483,023	537,757	552,005	19%
Billed Collections	$22,050,625	$28,260,596	$29,554,120	$31,371,986	$32,601,122	48%
Contractual Revenue + UPL+ Other	$20,437,717	$13,397,381	$12,612,613	$12,053,709	$11,392,906	-44%
Total Clinical Revenue	$42,488,342	$41,657,977	$42,166,733	$43,425,695	$43,994,028	4%
Collections/FTE	$251,458	$431,278	$419,044	$396,976	$369,083	47%
Net Income with Profit Sharing	($1,852,798)	($1,647,850)	($1,093,424)	$4,859,225	$5,981,340	N/A*

*Percent change not applicable when the beginning and ending year are not both positive and both negative. The change from FY 2012 to FY 2013 was 23%.

** Incentives paid in FY 2011 and FY 2012 was limited to funds guaranteed by one of Radiology's hospital partners. Otherwise, incentives were not paid to faculty in either fiscal year.

In FY 2009, Radiology experienced a deficit of $1.9 million that decreased to $1.1 million by FY 2011. Net income became positive in FY 2012 and was almost $6.0 million in FY 2013. Overall, net income has increased by $7.8 million from FY 2009 to FY 2013.



As previously mentioned, total incentives have increased by 8 percent over the last five fiscal years from $1.3 million to $1.4 million. Incentives paid decreased as net deficits decreased, and then they started increasing in FY 2012 as net income improved. Though total incentive payments have increased, they have decreased as a percentage of total faculty compensation—from 4.4 percent to 4.1 percent.

Appendix H – Department of Surgery

BACKGROUND

The University of Texas (UT) Southwestern Medical School's Department of Surgery consists of eight surgical divisions whose mission is "to address a constellation of medical problems that frequently require operative management for emergency and non-emergency treatment and to disseminate information, deliver medical care to patients, and develop new knowledge regarding surgical diseases." Michael A. Choti, M.D., is the department's chairman (chair) and has been serving in this capacity since October 2013. Dr. Choti did not participate in the development of the current incentive compensation plan, which was implemented during FY 2013.

<table>
<tr><th>Division</th><th>Individual Incentive</th><th>Group Incentive</th></tr>
<tr><td>Burn, Trauma, Critical Care (BTCC)</td><td>75% of incentive pool that is allocated by individual % of divisional gross charges</td><td rowspan="6">25% of incentive pool with individual allocation based upon achievement on divisional specific goals.</td></tr>
<tr><td>GI Endocrine</td><td rowspan="4">75% of incentive pool based upon exceeding benchmark wRVUs. Benchmark is product of clinical FTE % multiplied by the applicable MGMA standard.</td></tr>
<tr><td>Oral and Maxillofacial Surgery</td></tr>
<tr><td>Surgical Oncology</td></tr>
<tr><td>Vascular Surgery</td></tr>
<tr><td>Surgical Transplant Surgery</td><td>75 % of individual incentive dependent upon number of organ procurements performed relative to total divisional procurements and amounts collected by the division.</td></tr>
<tr><td>Pediatric Surgery</td><td>None</td><td>None</td></tr>
<tr><td>Emergency Medicine</td><td>None</td><td>None</td></tr>
</table>

Surgery incentives are paid semiannually and according to the Surgery compensation plan, a faculty member's incentive should be 75 percent for individual performance and 25 percent for group performance. As illustrated in the table above, division-specific incentives have both individual and group components. Because of significant differences between the services provided, unique, division-specific plans are described within the department's incentive compensation plan. For example, individual incentives are not determined in the same manner for each division, and division-specific group goals are to be set annually with input from division chiefs.

RESULTS

According to Section IV of the MSRDP Compensation Guidelines, "department incentive plans must be reviewed by each clinical department every two years and sent for review by the provost/dean and executive vice president of the health system for approval by the president." The Surgery incentive compensation plan was reviewed and approved by the faculty compensation committee and approved by the dean/provost as well as the executive vice president for health system affairs. In accordance with the MSRDP Compensation Guidelines, the department's incentive compensation plan encourages prospective performance that appears to lead to growth in clinical volumes and income and includes group incentives to encourage improvement in patient satisfaction and compliance with baseline compensation guideline expectations.

The department chair indicated that he intends to revise the current incentive compensation plan. For this revision, the chair plans to seek faculty support, implement a transparent process that may involve creation of an elected committee, and provide faculty members an opportunity to vote on the plan. The chair may also look at other compensation plan models and work with senior administration on developing revisions. He estimates this process may take two years to complete—one year to design the plan and another to model it. Consequently, the current plan, or some version of it, may be in place until full implementation of the revised plan.

Though it appears that the current incentive compensation plan is achieving its objective to reward individual productivity and achievement of group goals, we identified opportunities to improve communication, transparency, and plan administration as detailed below:

Emergency Medicine and Pediatric Surgery

As illustrated within the first table in the background section of this report, there are two divisions within surgery that currently do not have incentive plans—Emergency Medicine and Pediatric Surgery. In FY 2015, Emergency Medicine will become a distinct clinical department with a separate department chair. During the audit, UT Southwestern completed its recruitment of and hired a department chair. Executive management indicated that a key expectation for UT Southwestern's first chair of Emergency Medicine is development of an incentive compensation plan in alignment with the MSRDP Compensation Guidelines. Pediatric Surgery also does not have an incentive plan. We were informed that UT Southwestern is working with Children's Medical Center on a new contract. After an agreement is reached, development of a Pediatric Surgery incentive plan will be considered.

Communication of the Surgery Plan and Feedback to Faculty

According to the MSRDP Compensation Plan Guidelines, "the metrics and calculations to be used in determining incentive compensation should be presented to faculty prospectively in a written and understandable format." In addition, "a copy of the Department Incentive Plan should be included, as an appendix, with each memorandum of appointment and should be provided to all MSRDP faculty members eligible for Incentive Compensation at the time of approval of any changes to the Departmental Incentive Plans."

During this audit, we interviewed the department chair, key departmental administrators, and a small sample of faculty members. We were informed that the Surgery plan was made available to division chiefs and that the division chiefs were to communicate the compensation plan to faculty. Individual faculty members were not provided copies of the plan, and it is not available on an intranet site. Faculty interviewed did not consistently recall whether they had received the department's incentive compensation plan and indicated that understanding of the plan and incentive pay amongst faculty is low. However, faculty members interviewed appeared to understand that wRVUs are a key factor in determining incentive compensation. This may be attributed to expectation letters provided to faculty members that define their annual productivity benchmarks. Faculty members are also provided scorecards with information on individual and group incentives earned. However, opportunities exist to enhance the scorecards to more clearly demonstrate how the individual and group components are determined. Faculty members interviewed also expressed interest in knowing and understanding the formulas to calculate individual and group incentives. Lastly, the incentive compensation plan describes the frequency of incentive payments as semiannual, but it does not specify the months in which incentive payments should be expected. Testing indicated that semiannual incentive payments are distributed in May and November. Other clinical department plans included the months in which faculty can expect to receive incentive payments.

> **Recommendation**: Surgery should provide each faculty member a copy of the current compensation plan and consider making the plan available on an intranet site. Surgery should also ensure that all division chiefs clearly understand how their respective division plans function. To improve faculty understanding of their respective divisional plans, the division chiefs should meet with their respective faculty and clearly explain how both the individual and group incentives are determined. As a supplement to the current plan, Surgery should consider including expanded, detailed examples that demonstrate how incentive compensation payments and annual productivity-based changes in fixed compensation would be calculated, in theory, for a fictional faculty member for each division. The scorecards can also help facilitate faculty understanding of how incentives are determined and can be updated to more clearly demonstrate how incentives are determined. Lastly, the Surgery plan should be updated to include dates on which faculty can expect semiannual incentive payments.
>
> **Management's Response:** *The department is in the process of developing a website for a variety of department policies and procedures; a PDF of the current plan will be one of those documents. The Chairman is in process of defining and clarifying some ambiguities of the plan to ensure everyone understands the logic used to administer the plan, including how effort is distributed and defined.*

Specific examples will be generated for the faculty. This first year we plan to use a fictional example. Going forward in future years, we plan to use individual targets, current salary data, and multiple performance scenarios (e.g., under target 20%, at target, over target 20%) to demonstrate impact. We will modify the current plan to include dates that incentive payments will be distributed.

Anticipated Implementation Date: *The website will be launched by **January 2015**. Plan clarifications and example of payment distribution will be completed by **October 2014**. We anticipate that plan education will be ongoing, and has already commenced with the Division Chiefs.*

Incentive Plan Methodology

During our testing, we observed elements of plan implementation that were either not included or clearly described in the in divisional plans, specifically for the Burn, Trauma and Critical Care (BTCC), Gastrointestinal and Endocrine (GI Endocrine), Vascular, and Surgical Transplant Surgery divisions.

The BTCC divisional plan describes an individual incentive (75 percent of the incentive pool), based on the ratio of the individual's billing to the division's total billing. In practice, there is also a second individual incentive that is mentioned but not clearly described in the plan. This second individual incentive is allocated based upon contractual income earned by an individual that is attributable to their shift work, coverage weeks in the Intensive Care Unit (ICU), and midlevel weeks for services provided at Parkland Memorial Hospital (PMH). The current allocation for this portion of individual incentive also includes income related to administrative pay for faculty. There were five members of the BTCC team that earned administrative compensation for their roles at PMH. Because certain members of the BTCC team are compensated for their administrative roles, the effect is that that these members of the BTCC team are earning a portion of their incentive based on compensated administrative duties. The BTCC plan also does not describe the allocation for the two individual components. For the May 2013 payment, 75 percent of the individual portion of the incentive pool was based upon billed gross charges and 25 percent based upon PMH contractual income. For the November 2013 payment, it was 70 percent for billed gross charges and 30 percent for PMH contractual income. We requested approval for the change in the split and were informed that the change was discussed with the department chair; however, that approval was not documented nor was it clear whether members of the BTCC were informed of the change. Changing from a 75/25 split to a 70/30 split affects the allocation of individual incentive pool because faculty members without administrative compensation can get a lower proportion of the incentive pool if the split changes.

BTCC also has a group incentive. According to the plan, it is 25 percent of the incentive pool and is to be distributed in proportion to individual faculty member's FTE. Distribution of the group incentive is dependent upon achievement of five divisional goals. In May 2013, BTCC met four of five goals. The BTCC team would have earned more for the group incentive had all five goals been met. This reduction mechanism is in accordance with the plan; however, in November 2013, BTCC faculty members were not paid a group incentive. Consequently, it appears that faculty members were not evaluated for achievement of group goals for the second half of FY 2013.

GI Endocrine, Vascular, Oral, and Surgical Oncology Surgery have similar methodologies for determining the group incentives. Each describes between six and eight group requirements that must be met in order to earn incentive related to a particular goal. Each requirement has a different weight ranging from 2.5 percent to 7.5 percent and each is clearly defined in the plan for each division. Eligible faculty members who achieve the group goals are to be awarded group incentives proportionally based upon their clinical FTE. In practice, the weights can change from one pay period to the next. The weight can and should change if the division believes it does not have sufficient data for a particular requirement to measure goal attainment. In addition, weights can change if a greater emphasis is needed on a behavior that needs to be modified. However, we noticed that the relative weights for the remaining requirements were not maintained and were provided equal weight. We also noted changes in weights from one pay period to the next even if the group goal elements did not change. Currently, the

plan does not clearly describe how weights can or should change, including any requisite approval requirements if certain requirements are not reasonably measurable or whether certain requirements can or should be modified to incent desired behaviors.

Opportunities also exist for improving the clarity of the Surgical Transplant Surgery plan. Its plan states that 50 percent of organ procurement collections, net of institutional taxes, are available for incentive payments—75 percent of the pool for individual incentive and 25 percent for the group incentive. The plan also states that the individual incentive will be based on the number and reimbursement of organ donor procurements in each six month period divided by the number of providers. We were informed that the transplant program is relatively new and the volume of cases is still growing and that work relative value units (wRVUs) are not a good metric for individual incentives. In practice, the incentive methodology is similar to what is described in the plan, but it is more clearly described as number of individual procurements by a faculty member divided by total procurements performed by the group multiplied by 50 percent of total procurement collections. The division's plan also includes requirements that must be met for a group incentive. No group incentives were paid for FY 2013.

Recommendation: Though the current Surgery plan will likely change in the upcoming years, Surgery should ensure that the division plans more clearly describe how incentives are calculated. In coordination with the department chair, the BTCC division should re-examine the inclusion of the administrative compensation element for determining the individual portion of incentive income that is attributable to an individual's days of shift work, coverage weeks in the ICU, and midlevel weeks for services provided at PMH. BTCC should also clearly define the allocation between both individual incentive components. Any changes to the allocation percentage should have the approval of the department chair, the division chief, and concurrence of affected faculty. For group incentives, the Surgery incentive plan should clearly describe the approval process necessary to make changes to plan and the degree of affected faculty input.

Management's Response: *The Chairman and BTCC Division Chief will review the administrative compensation element and define the allocation between individual incentive components. The department accepts the recommendation that changes to the allocation percentage should have the approval of the Chairman, the Division Chief, and concurrence of affected faculty. Additionally, group incentive approval process will be clearly defined in plan modifications.*

Anticipated Implementation Date: *The BTCC incentive plan will be revised to reflect these clarifications/changes by **January 2015**.*

True-Up of Incentives Earned and Paid

For several divisions within Surgery, the individual component of incentive compensation is determined by wRVU. The underlying assumption for the individual component is that their incentive is achieved when they exceed their wRVU benchmark. If the percent clinical effort does not change in the year, a faculty member is accountable for exceeding that benchmark. As illustrated in the table to the right, a Surgery faculty member could, in theory, earn an individual incentive payment for the second semiannual payment period. This would result in an overpayment since, in this example, the faculty member did not exceed the benchmark for the entire fiscal year. Including limitations on the first incentive payment (e.g., payment of 70 percent of incentive earned over the evaluation period) could limit the downside risk of overpayment in the second period if, for whatever reason, the faculty member was unable to meet his or her annual productivity benchmark. Currently, the Surgery plan does not include or describe a true-up mechanism to ensure that total incentive payments are based on actual clinical productivity for the entire fiscal

FY Semi-Annual Period	Actual wRVU	Benchmark wRVU	wRVU for Incentive
1	700	1,000	(300)
2	1,200	1,000	200
Totals	**1,900**	**2,000**	**(100)**

year. Implementation of a true-up mechanism could prevent or minimize the risk of overpaying incentives for the fiscal year.

> **Recommendation:** Surgery should implement a true-up mechanism of incentive payments to prevent or minimize the impact of overpaying incentive distributions from the available pool of funds.
>
> **Management's Response:** *The department is currently evaluating a true-up versus an annual, one-time incentive payment.*
>
> **Anticipated Implementation Date:** ***January 2015***

Actual and Potential Compensation Errors

During testing, we noted the following errors and potential errors:

SAC Computation Error

The chair receives supplemental administrative compensation (SAC). As previously mentioned, Dr. Choti began his appointment in October 2013. We recalculated the chair's pro-rated SAC and found that he was underpaid for the first six-month period. Surgery agreed and will work with the dean's office to make the correction.

Potential Incentive Computation Error

We were informed that the BTCC division chief earned incentive compensation in excess of incentive paid and that he had elected to receive a lower amount. However, supporting documentation provided did not demonstrate how the higher incentive amount was determined and indicated that the incentive paid would have been much lower had the incentive been determined in a similar manner to other faculty within the division. With the November incentive payment, the chief earned incentive in the same manner as faculty in the BTCC division.

> **Recommendation:** Surgery should ensure that the chair is paid the correct SAC amount. In addition, Surgery should verify the incentive the BTCC chief actually earned for the May 2013 incentive payment and determine whether any adjustments to incentive payments need to be made to the chief and the other members of the BTCC team.
>
> **Management's Response:** *The department leadership changed in October 2013 (Chairman) and March 2014 (Administrator). Significant changes in management and oversight have and are occurring. These changes should resolve this specific error.*
>
> **Anticipated Implementation Date:** *No additional action required.*

Procedures for Determining Incentive Compensation

Surgery uses Excel spreadsheets for determining incentive compensation. The spreadsheets include information obtained from different sources. For example, wRVUs are obtained from Epic information maintained by MSRDP finance. Quality and patient satisfaction information are from other sources and can include data from hospital partners. Department administrators are very familiar and know steps necessary to determine incentives. However, documented procedures or guidelines for administering the quarterly incentive payment program have not yet been developed for each division. Over time, administrators assigned to determine incentive compensation can change. Well-written procedures should be independent of the individuals performing assigned functions, include clearly defined roles and responsibilities, and provide clear instructions on what needs to be done.

Recommendation: Surgery should ensure that written procedures for administration of incentive compensation are developed for each division to reduce the risk of errors and ensure consistent application of processes over time.

Management's Response: *The department is in full agreement with this recommendation and is in the process of developing written procedures for the administration of the incentive compensation.*

Anticipated Implementation Date: ***January 2015***

Missing Required Compensation Plan Disclosures

Section VI of the MSRDP Compensation Guidelines states that the department incentive plans must clearly state the following six items:

A. Incentive Compensation is paid to incentivize future performance. Therefore, to receive Incentive Compensation, a faculty member must be an employee of UTSW on the date of payment.

B. Incentive Compensation is not eligible for inclusion in the formula for contributions to the mandatory retirement programs, but is subject to all deductions required by state and federal law.

C. Incentive Compensation can only be made to MSRDP faculty with an active signed MSRDP agreement.

D. Incentive compensation earned by individual faculty members requires compliance with baseline expectations of MSRDP policies for:
   1. Timely completion of medical records (inpatient and outpatient) within 7 days or less;
   2. Timely submission of professional billings within 7 days or less;
   3. Billing compliance training and adherence to billing guidelines;
   4. Appropriate coverage of expected amounts of night and weekend call coverage;
   5. Adherence to clinic session scheduling and cancellation policies; and
   6. Patient satisfaction evaluations at the minimum expectations for the practice.

E. The upper limits of Incentive Compensation (as a % of Total Compensation) for which members are eligible should be stated, and the Departmental Incentive Plans should indicate how payments will be reduced if the total Incentive Compensation calculated to be paid is greater than available departmental profit or reserves.

F. Fees for all court appearances, depositions, expert testimony, or legal consultations are deposited into the departmental fund, and the percent distribution is determined and approved prospectively in the Departmental Incentive Plans.

We compared the Surgery incentive compensation plan to the MSRDP Compensation Guidelines. The incentive compensation plan did not include disclosures for items A, B, C, and F. With respect to item D, most divisions included the six elements as applicable. However, we noted that D.3, billing compliance training and adherence to billing guidelines, was not included as a baseline expectation for Surgical Transplant Surgery.

Recommendation: Surgery should update its plan to include the disclosures required by the MSRDP Compensation Guidelines.

Management's Response: *The department will include disclosures required by the MSRDP Compensation Guidelines.*

Anticipated Implementation Date: ***January 2015***

Summary Trends

As part of this engagement, we trended faculty compensation, incentive compensation, wRVUs, billed collections (which includes Parkland Memorial Hospital Epic billed collections), total clinical revenue, and other metrics for the period from FY 2009 to FY 2013. As illustrated in the table to the right, faculty salaries (including supplemental administrative compensation) increased by 42 percent while the MSP full-time equivalent increased 10 percent and incentive compensation increased by 23 percent. Over this same period, billed collections increased from \$19.3 million to \$41.7 million, or 117 percent, while clinical revenue increased from \$50.3 million to \$65.6 million, or 30 percent. Work RVUs have also increased over the last five fiscal years—from 492,687 to 645,375, or 31 percent. In addition, billed collections per FTE have increased from \$200 thousand to \$394 thousand, or 97 percent.

Compensation Type	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 09 – FY 13 % Change
Faculty Salaries + Supplemental Admin. Compensation	\$22,629,862	\$24,025,623	\$27,267,757	\$30,714,081	\$32,056,607	42%
Incentive Compensation	\$1,612,307	\$2,489,383	\$3,168,551	\$2,150,176	\$1,980,144	23%
Total Faculty Compensation	\$24,242,169	\$26,515,006	\$30,436,308	\$32,864,257	\$34,036,751	40%
All Department Compensation and Benefits	\$35,760,168	\$38,010,018	\$43,339,585	\$46,926,796	\$49,188,329	38%
Incentive / Total Faculty Comp.	6.7%	9.4%	10.4%	6.5%	5.8%	-13%
MSP Full Time Equivalent	96	81	95	107	106	10%
wRVUs	492,687	509,668	582,416	611,894	645,375	31%
Billed Collections	\$19,262,358	\$30,768,933	\$33,266,388	\$38,789,606	\$41,721,697	117%
Contractual Revenue +UPL+Other	\$31,029,526	\$21,846,362	\$21,092,239	\$22,065,056	\$23,844,932	-23%
Total Clinical Revenue	\$50,291,844	\$52,615,295	\$54,358,617	\$60,854,662	\$65,566,629	30%
Billed Collections/FTE	\$200,243	\$379,567	\$351,697	\$362,436	\$393,878	97%
Net Income	\$2,489,811	\$1,671,209	(\$1,066,394)	\$1,166,850	\$2,662,812	7%

Over the last five fiscal years, surgery's net income increased by 7 percent. However, as illustrated in the graph at the right, net income decreased from FY 2009 to FY 2011—from \$2.5 million to a negative \$1.1 million. A positive trend emerged during FY 2012 and continued through FY 2013. Between FY 2011 and FY 2013, net income increased \$3.7 million. As previously mentioned, total incentives increased by 23 percent over the last five fiscal years from \$1.61 million to \$1.98 million. Unlike net income, incentives paid increased from FY 2009 to FY 2011 and then decreased from FY 2011 to FY 2013 to become more aligned with net income. Though total incentive payments have increased, they have decreased as a percentage of total faculty compensation—from 6.7 percent to 5.8 percent.