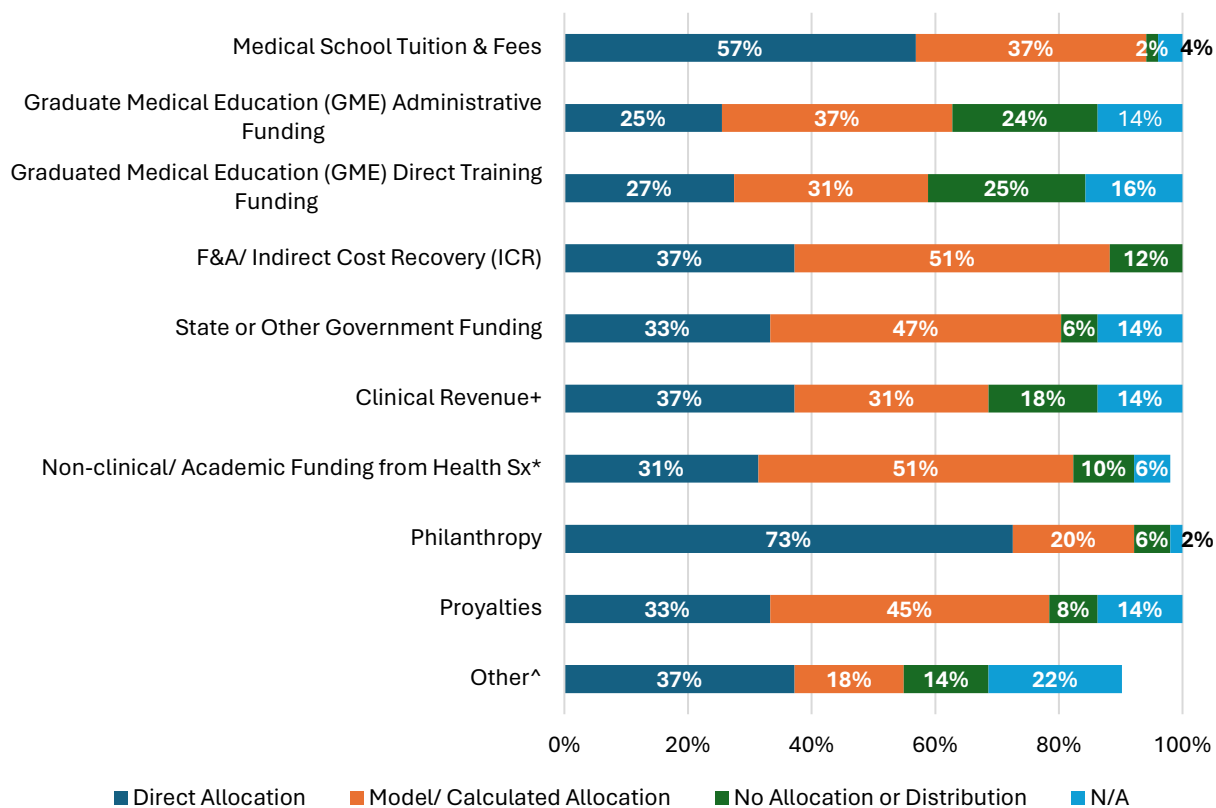


GBAnalytic #16: Funds Flow and Faculty Compensation

GBAnalytic #16 was developed by the Group on Business Affairs Data and Benchmarking Committee. The survey was sent to Principal Business Officers on February 14th, 2024, and closed on March 7th, 2024. There were 51 complete, unique, and identifiable responses to the survey.

- How are the following funds distributed from your university or health system to the medical school? Please select the option that is used the most. (Respondents could only choose a **single** response for each topic).



*Non-clinical/ academic funding from the health system includes one blank;

+Clinical revenues include fee-for-service, value-based care, clinical contract revenue;

^Other includes five blanks;

Respondents who answered “N/A” to Q1:

Our health system separates the School from GME and Research. There is no dean's tax or other transfer of clinical or research funds to or from the school. Donor funds available for operations expenses are directly allocated, but the larger percent return on the endowment is a calculated rate.

The practice plan is in the health system, so the school does not receive clinical revenues. It receives an academic transfer from the clinical revenues, by formula.

We do not receive GME funding or clinical revenue to the medical school.

Would like to caveat the clinical revenue for contracts and FFS comes directly to the medical school. The value-based care revenue is not allocated/distributed.

We receive no government support for either the university, the medical school or the health system. GME funding is retained by the university hospital, and from those revenues the hospital pays direct costs of GME (e.g., stipends to residents, educational allowance, GME office admin staff, etc.). Arguably some portion of the funds flow transfer from the hospital is for residency program directors and program coordinators, whose salaries are the medical school's responsibility. However, that portion is not defined under the current funds flow agreement and is something that will be spelled out in the development of our funds flow 2.0 agreement.

We are a stand-alone Medical School with no hospital or parent university.

Hospitals in Maryland work under a different model and do not get direct or indirect GME. We do have a service contract which funds education of residents, but not at all based on hospital GME funding.

GME Direct Funding- GME Trainees are directly funded by the hospital.

State Funding - We are not state-funded.

Royalties - we have a very poor royalty rate currently.

We do not receive state or other government funding.

I am not sure I answered this question correctly, as HMS does not own its affiliated hospitals. They earn what they earn from clinical, GME and research revenue. None is allocated to the Medical School. HMS earns tuition and fees, and except for CME courses, none of that revenue is shared with the hospitals, except to reimburse for teaching fees. We do get a small amount of support from our hospitals as direct support.

Clinical revenue is not very clear. the school of medicine only receives professional revenue.

GME direct training funding is paid from the hospital and does not pass through the school.

The only funding from the Parent for academic support are "commitments".

We do not currently have royalties

KPSOM does not charge tuition, we don't have GME, don't receive any state or government funding as we are private, and we don't have any philanthropy or royalties.

School does not have a health system (hospital)

GME Admin/Direct Funding - School receives an allocation from the state in support of GME programs administered by and affiliated with our school

We do not have royalties or other revenue to report

We do have Other Government Funding like Federal Clinical Subsidies which are a Direct Allocation, our State Funding is a model.

The health system oversees Graduate Medical Education and there is no direct cost or revenue associated with the School of Medicine.

While part of a public university, the School of Medicine receives no government funding.

There are currently no royalties derived from the School of Medicine to be allocated.

There are no other revenue streams currently for the School of Medicine. The primary non-tuition/fees revenue stream is listed with Clinical Revenue.

Clinical revenue would be allocated to practice plan.

Clinical Rev - remains w/ the Physician Group Practice in our Clinic which is a separate entity and is not part of the medical school.

Respondents who answered "Other" to Q1:

Earnings on total SOM reserves (invested by the University), strategic funding from university reserves.
Facilities usage and parking revenue.

Any revenue generated by locally managed fee-for-service activities (e.g., user fees for core facilities, conference dues for CME programs, contract revenue, etc.) are retained by the responsible unit to offset the costs of those specific programs.

Contract, sales, state special funding initiatives.

CME, all contractual arrangements.

Direct contracts.

Fixed price residuals, service centers, other income such as VA IPA.

We have a margin sharing arrangement with our primary academic affiliate.

Interest Earnings.

Investment income.

Parking proceeds.

Leasehold income from medical school owned properties, shared resource income to internal and external users.

Residuals from fixed contracts (such as many clinical trials)

An HMS Support payment, needed because we do not benefit from clinical revenue or grateful patient donations.

Fee for service on research activities.

Fee for Service or explicit commitments.

investment income on school reserves.

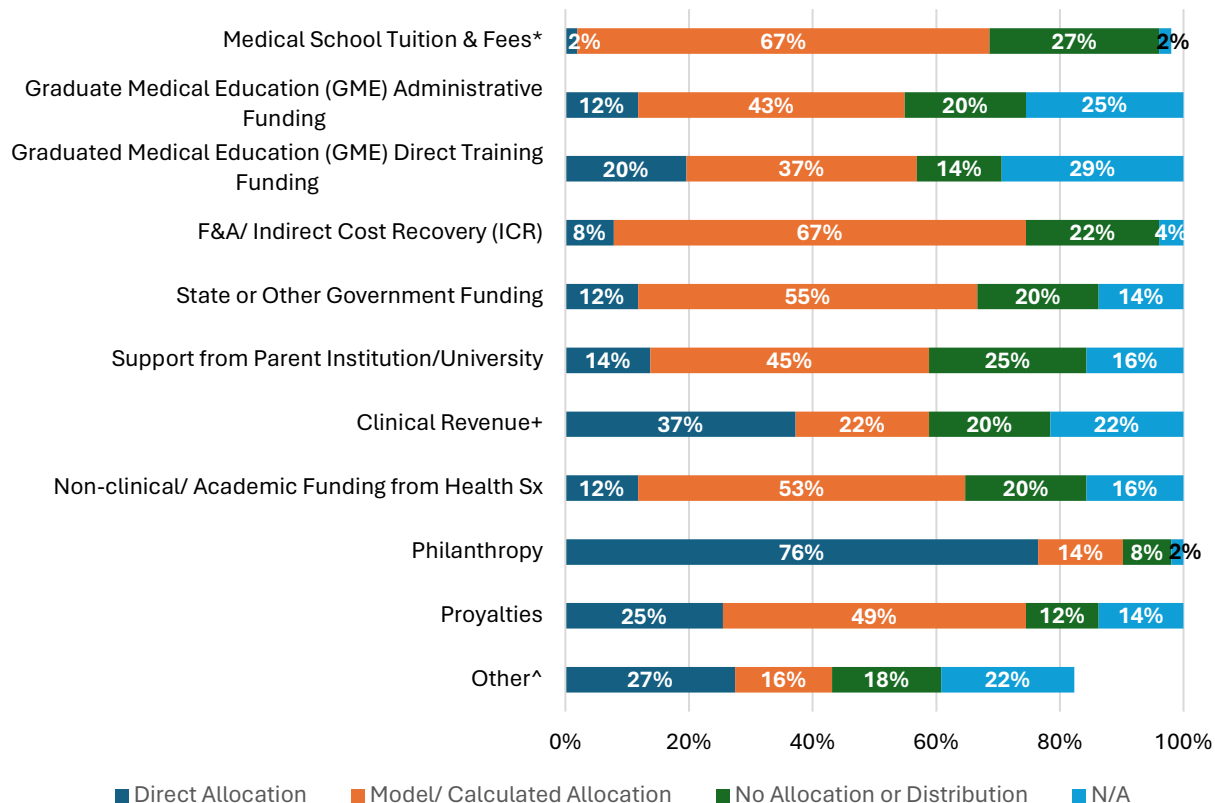
Investment income on the medical school investable balance and payout of endowment income.

Interest from endowments.

University foundation funding

Other Revenues include transfers in from university entities for the support of department, faculty and student curriculum as well as revenue from labs, consulting, registries, fees, and other miscellaneous revenue.

2. How are the following funds distributed from the medical school to departments? Please select the option that is used the most. (Respondents could only choose a **single** response for each topic).



*Medical School Tuition & Fees includes one blank;

+Clinical revenues include fee-for-service, value-based care, clinical contract revenue;

^Other includes nine blanks;

Respondents who answered “N/A” to Q2:

Our "departments" lie entirely within the school. There is no overlap between the academic and clinical departments. The school receives all funds and pays all expenses, though each division of the school does draft and adhere to an annual budget. The school receives no GME or research funds.

The medical school does not receive GME funding or clinical revenue.

No academic funds are provided to medical school from the health system. GME Direct training funds flow from the health system to the medical school/university to support the salaries of the trainees. These funds do not go to departments.

We do not receive support from the government nor from our parent university.

As previously noted, GME funding is retained by the university hospital. To the extent that we have programs with community-based hospitals, those revenues do flow directly to the departments involved.

We do not have a parent university nor hospital.

GME is directly funded by Hospital. State Funding - there is no state funding. Support from university - all funds are generated within the SOM or funded by the hospital (no university funds provided).

We either do not receive this type of funding (e.g., support from university) or we distribute funding to departments but not according to a model and not directly (e.g., academic funding from health system).

We do not receive GME revenues (retained 100% by health system).

Distribution is negotiated.

As stated in the previous question, this is being answered from HMS's perspective only. Our affiliated hospitals may allocate their revenue to their depts. Most of our funding is not allocated directly to departments unless it is restricted for their use.

GME direct training funding is paid from the hospital and does not pass through the school.

The only funding from the parent for academic support are "commitments".

Graduate medical education revenue stays at the health system

No Royalties.

N/As are areas where we don't receive funds for.

Note: PhD programs run by departments receive a direct allocation of tuition and fee revenue. We are a private institution, so I am considering state or other government funding in this case to be grant funding.

Texas A&M does not have a Health (Hospital) system.

The medical school does not collect GME revenue, F&A/ICR, state/government funding, or royalties.

We do have other government funding like federal clinical subsidies which are a direct allocation, our state funding is a model.

Departments earn their own clinical revenue from professional fees; the school does not allocate clinical revenue to the departments.

Clinical Rev - remains w/ the physician group practice in our clinic which is a separate entity and is not part of the medical school.

Respondents who answered "Other" to Q2:

Earnings on reserves becomes part of the general pool of funds distributed by budget to the departments.

Facilities usage and parking that goes to medical school's facilities department to offset costs.

We provide operating stipend funds (from practice plan revenues) and a small amount of flexible leadership funds (from health system).

Again, this is referring to fee-for-service activities.

Sales, contract, state special funding initiatives.

Other revenues are based on types of contacts and distributed to where to the department providing services.

Special earmarks, etc.

Fixed price residuals, service centers, other income such as VA IPA.

Dean's Office seed and start up fund.

Interest income.

Fee for service activity for research work.

Fee for service and explicit commitments.

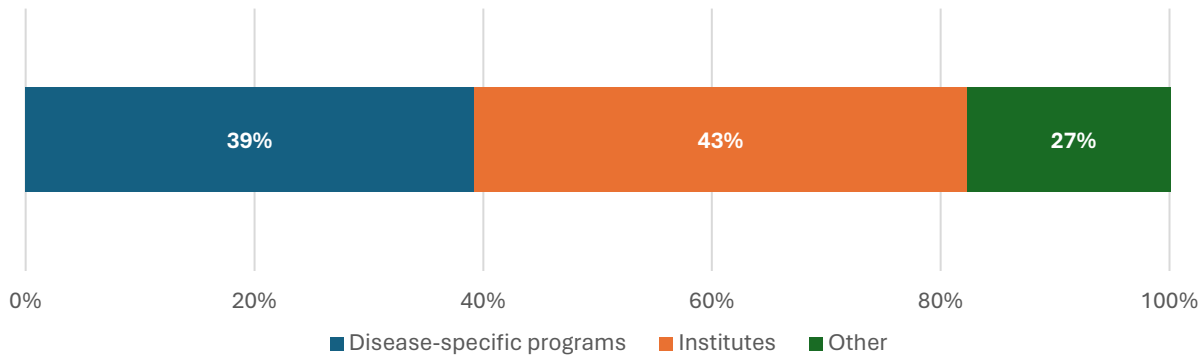
Clinical Trial Revenue is booked directly in departments.

Service Centers (Cores).

Interest from Endowments.

Other Revenues include transfers in from university entities for the support of department, faculty and student curriculum as well as revenue from labs, consulting, registries, fees, and other miscellaneous revenue.

3. Do you receive strategic support or revenue from your health system and/or university in support of any of the following? (Respondents were allowed to choose **multiple** responses)



Respondents who answered “Other” to Q3:

All support is general.

Data science, strategic high-profile science recruitments.

Psychiatry research.

Dean support for development of the college and recruitment of chairs.

Academic support as well as department-based initiatives.

Recruitments.

University provides the school state funding for support of education and research.

PI commitments.

We receive revenue as part of an affiliation agreement with the hospital, support for GME, as well as strategic funds for specific joint initiatives, program and recruitments.

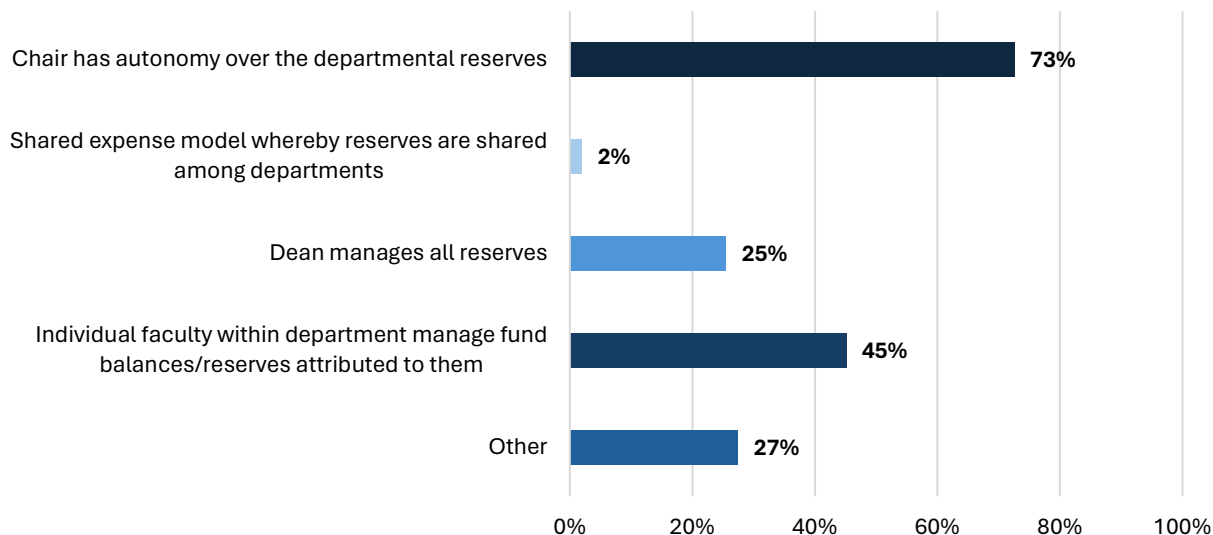
Operating subsidy.

Enterprise funding - support and growth initiatives.

Margin share, hospital contract.

Funding for academic enrichment fund, chair dev pkgs, strategic initiatives, etc.

4. How are departmental reserve funds managed? (Respondents were allowed to choose **multiple** responses).



Respondents who answered “Other” to Q4:

Our school’s departments are 100% academic (not clinical) and academic chairs do not manage the school’s operation.

Limited fund sources which can build as reserves are retained at the department level - but now reserves exist with state funds or through the practice group.

Chair has autonomy but with oversight by faculty practice leadership & CFO.

Chair autonomy with dean approval (perhaps that is implied in option 1).

Yeah, I'd say we have all of this :)

We are trying to change our culture and move away from the silos where the chair has autonomy. Dean pledges dept reserves for new chair hires to force spending on strategic items, before dean supports with commitments. Also new comp plan.

our institution does not allow reserves.

Reserves are in the departments; however, they require approval to use.

Service lines manage all reserves.

Departments have discretion over funds; however, at year end clinical department reserves are swept centrally.

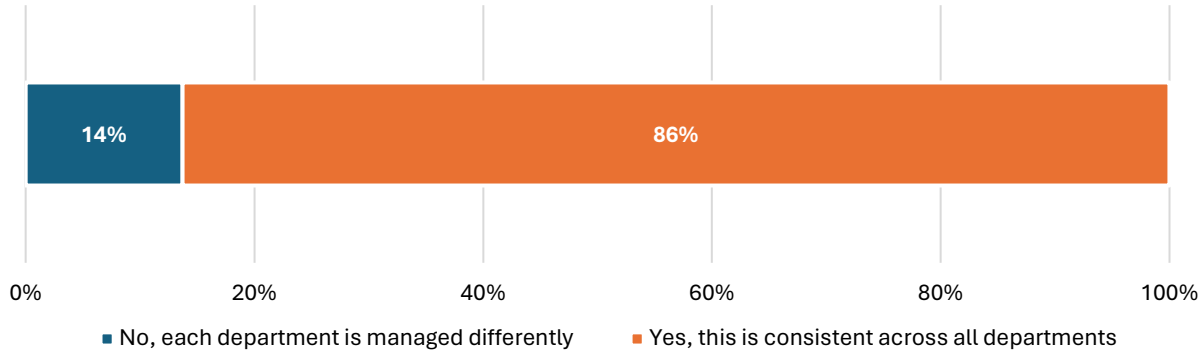
Chair has autonomy with dean approval.

Departments do not receive reserve funds unless the source is philanthropy.

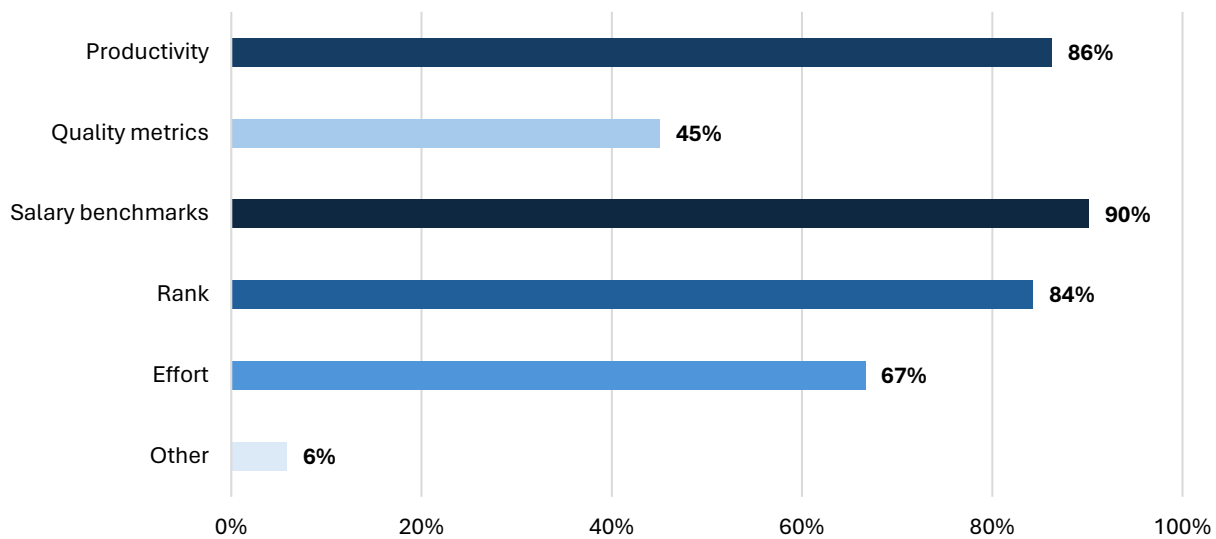
Reserves held at university level.

Medical Group managed by Health System.

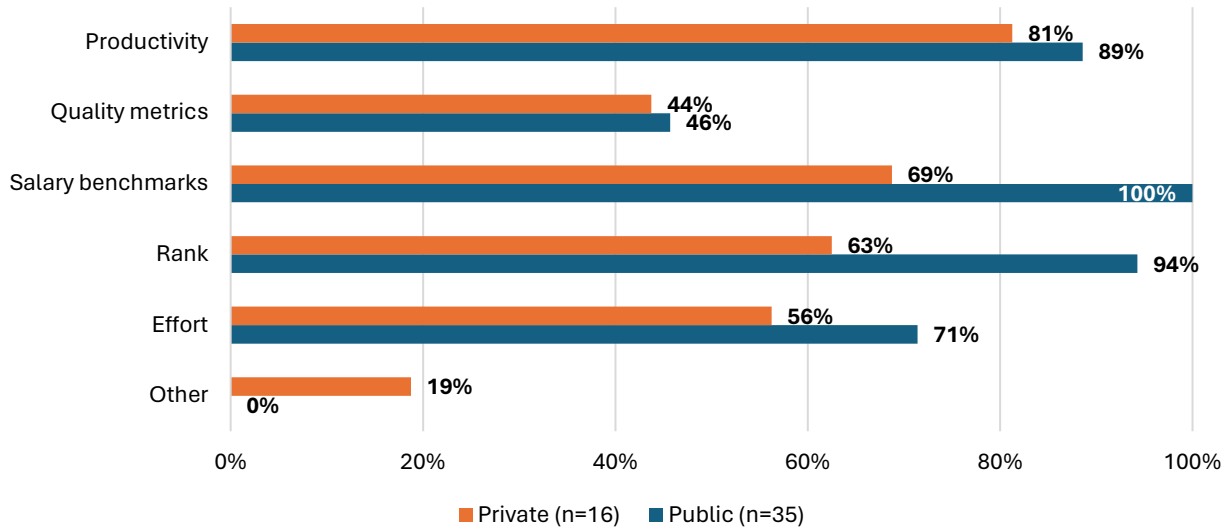
5. Is this consistent across all departments? (Respondents could only choose a **single** response).



6. How is clinical faculty compensation determined? (Respondents were allowed to choose **multiple** responses).



Question 6 by Public and Private schools. Percentages are out of the total number of respondents from each school type.



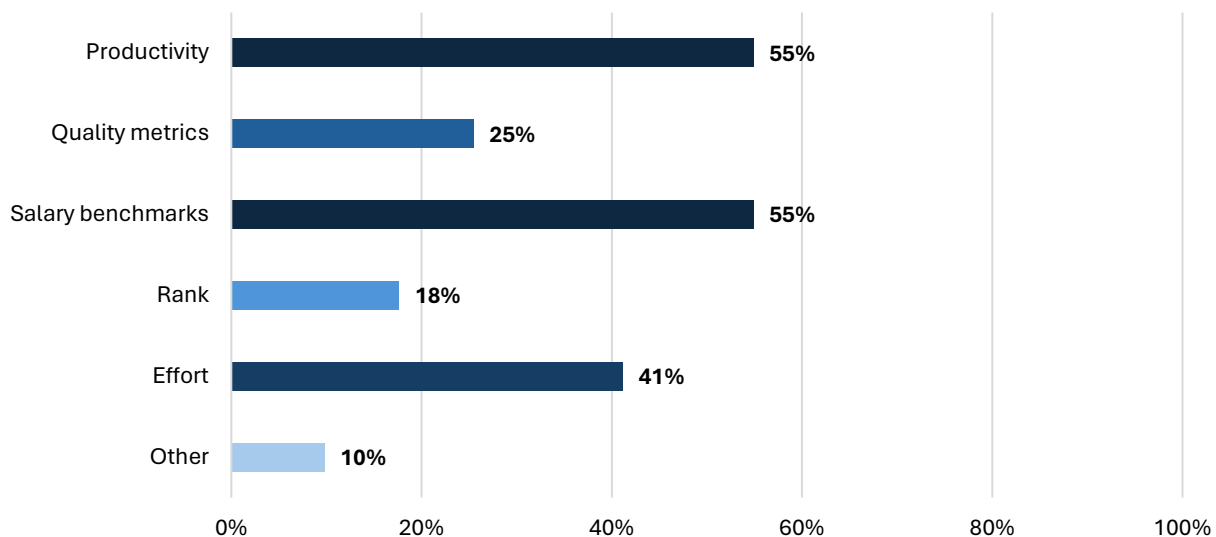
Respondents who answered “Other” to Q6:

The physician enterprise assesses and manages clinical compensation. We are working to include a standard 'carve-out' for classroom teaching time.

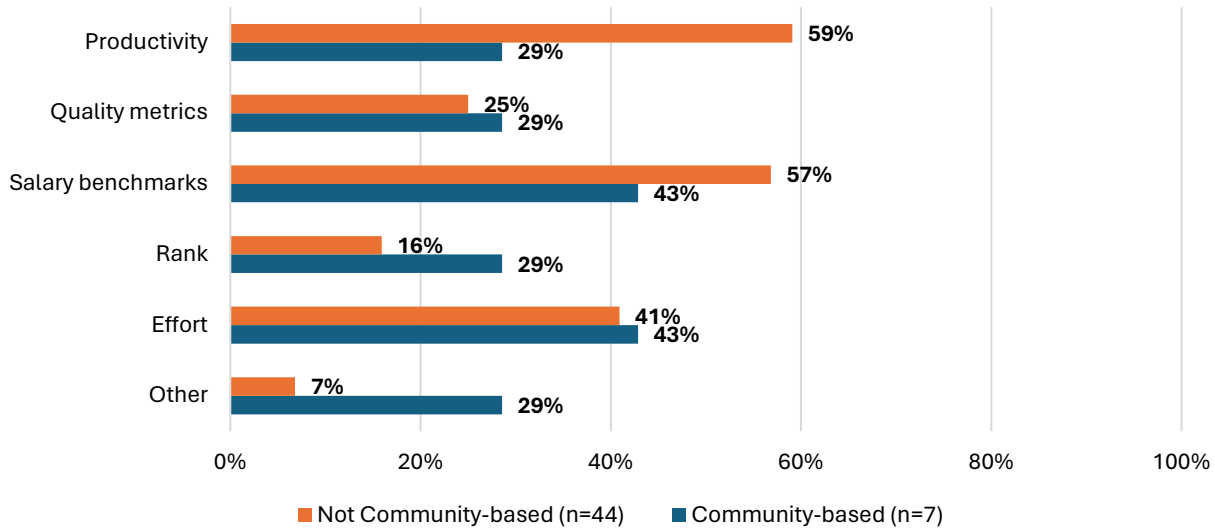
Each chair/department has a unique compensation plan with metrics that pertain to their business, so it really depends, but includes many of the metrics listed above.

Department chair recommendation.

7. How is community-based faculty compensation determined? (Respondents were allowed to choose **multiple** responses)



Question 7 by community-based and not community-based schools. Percentages are out of the total number of respondents from each school type.



Respondents who answered “Other” to Q7:

We do not pay for Community/Volunteer Faculty.

Each chair/department has a unique compensation plan with metrics that pertain to their business.

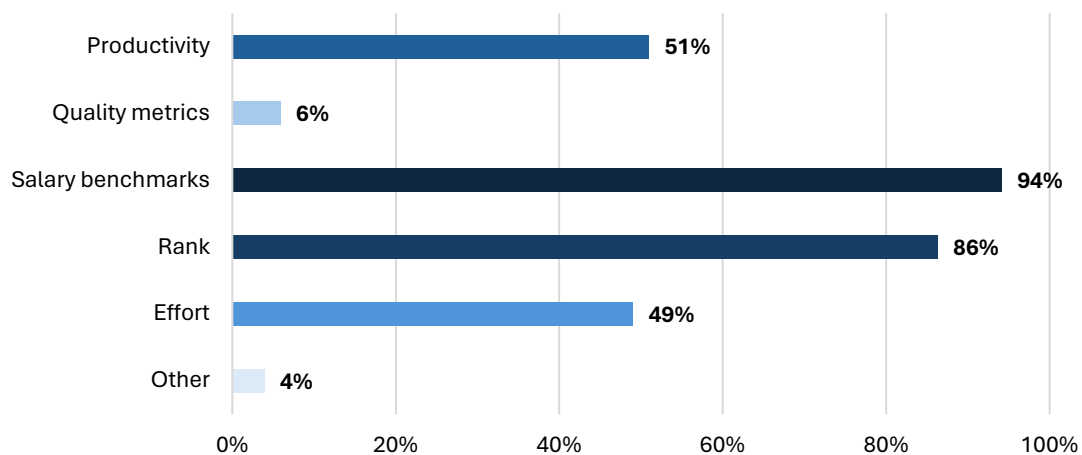
Community based faculty are affiliate faculty and not directly employed by the school. We contract with the community health system for physician participation in the education of medical students.

Compensation to faculty is determined by employer.

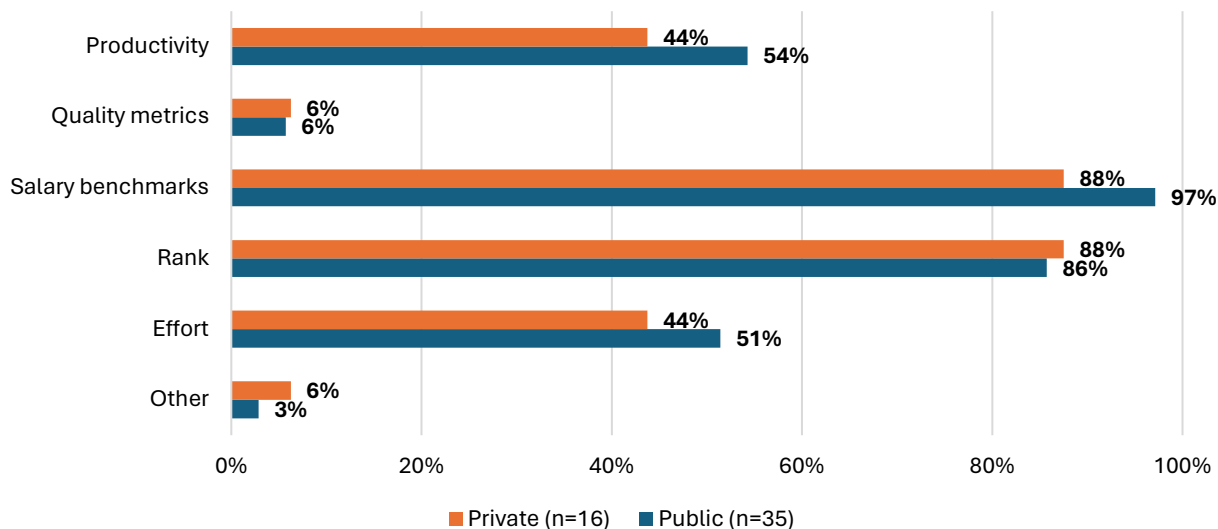
Faculty appointment and privileges.

Community based are not usually compensated.

8. How is non-clinical faculty (research, teaching) compensation determined? (Respondents were allowed to choose **multiple** responses)



Question 8 by Public and Private schools. Percentages are out of the total number of respondents from each school type.



Respondents who answered “Other” to Q8:

Each chair/department has a unique compensation plan with metrics that pertain to their business/initiatives.

9. When research faculty grant revenue is below expectations, what measures are in place to bridge the resulting salary gap?

Use of Reserves and Discretionary Funds:

Faculty discretionary reserves are used first, followed by department reserves, and then Dean's reserves.

Departments may use their operating support and wealth for bridge funding.

Departments and faculty can use reserve balances for bridge funding.

Departments and faculty benefit from reserve funds based on established incentive plans.

Departments may cover gaps with bridge funding, sometimes requesting support from the dean.

Departments must fund through state appropriations or other departmental sources.

Departments manage grant revenue and salary gaps using available funds, including clinical reserves or university funds.

Departments are responsible for bridging the resulting salary gap.

Institutional Support and Bridge Funding Programs:

Institutional bridge funding programs are managed by faculty committees.

There are formal bridge funding programs supported by various levels of administration (Chancellor, Dean, Departments).

The VC for Research may have a bridge funding program, and department chairs also set funds aside for bridge funding.

Some institutions use education and general funds or funds allocated to department revenue for bridge funding.

Bridge funding request processes exist for time-limited funding for eligible faculty.

Adjustment of Faculty Salary and Effort:

Salary scales may be adjusted based on lower salary recovery, with any gap in salary coming from department discretionary funding.

Non-tenure system research faculty are reappointed annually, and tenure system faculty may have a portion of their salary at risk tied to grant funding.

Salary reductions may occur over time based on contract terms.

Faculty salary or FTE may be reduced in some cases.

Specific Departmental Strategies:

Clinical departments must use clinical revenues, while basic science departments may use savings from faculty with higher grant salary support.

Most department salary plans specify bridge funding for a limited time period.

Each department manages grant revenue and salary gaps using a combination of available funds, F&A, clinical reserves, or university funds.

Departmental resources may be used, or faculty salary may be reduced to cover the gap.

Each department determines how to cover the gap through their compensation plans.

10. What financial support is available for faculty engaged in Undergraduate Medical Education (UME) teaching?

Faculty Compensation and Resource Allocation Models:

Support from Dept. of Medical Education for FTE/salary dedicated to teaching UME modules.
Funding provided per hour for teaching.

Direct salary support to departments from the medical school.

Salary support for education leadership designated roles, teaching allocation for clinical faculty at discretion of department chair.

Salary support for a limited % of FTE, not providing specific salary for specialty.

Support for a % of salary provided to faculty engaged in UME teaching from the Dean's office.

Dean's office provides financial support for faculty engaged in UME.

Major roles in UME teaching curriculum have funds available to protect their time.

Incentive program for faculty physicians directly involved in education and instruction of students enrolled in the UME Program.

Direct funds from the medical school based on effort and some funds from GME.

Medical School funds the department for faculty who teach, with support allocated up to a salary cap.

School funding to departments includes calculations related to UME teaching and prep time.

Allocation of tuition revenue based on faculty effort in teaching medical students.

Department allocation prescribed by the SOM, with certain roles paid directly by the Med Ed unit.

Line-item salary support for specific classes and roles.

Funds flow formula for faculty teaching, flowing to the department to support faculty member effort.

School distributes funds to departments based on metrics of UME quantity and quality.

Funds allocated to departments based on mission/effort driven allocation model.

Financial support provided to departments from the Dean's for UME teaching and for preceptors.

Institutional Funding Sources:

State, parent, and hospital support as directed by the Dean.

Many UME roles funded directly by Academic Affairs, while departments fund other academic activities.

State appropriation distribution model considers UME activity.

State funds and MD tuition used to transfer support to department for faculty serving in UME core faculty roles.

USF uses E&G dollars from the state to fund UME teaching through an EVU model.

Financial support provided to departments from the Dean's for UME teaching and for preceptors.

Specialized Models and Programs:

Almost all faculty have part of their total compensation covered by a tuition revenue allocation from the college.

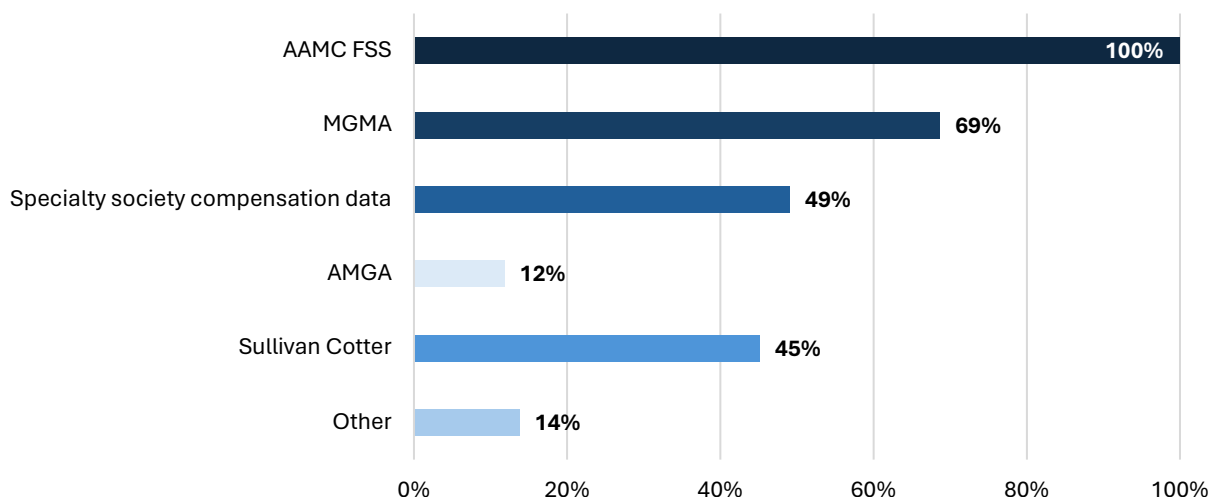
"High intensity teaching" funding model supported by funds from the Dean's office and a tax on departments, where roles > 10% effort receive salary support.

Dean's Office charges Dean's Tax to departments and uses those funds for faculty and staff effort for major roles.

Support only for UME leadership roles.

Full or partial FTE for defined roles such as course directors, clerkship directors, with an imperfect model for funding contact hours.

11. What sources do you use to measure faculty compensation benchmarks? (Respondents were allowed to choose **multiple** responses).



Respondents who answered “Other” to Q11:

CUPA.

ECG.

Proprietary blend of local, regional, and national private practice compensation.

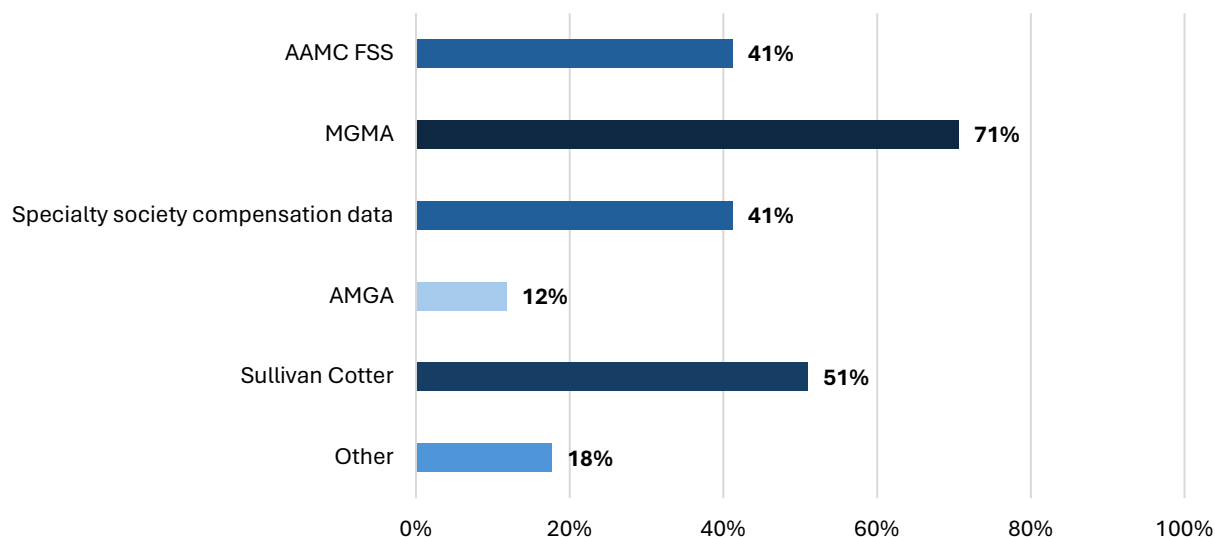
We use Sullivan Cotter or MGMA for APPs.

VMG.

The Health System uses Proprietary Benchmarks obtained from a consulting firm.

AAAP, AUPO (Ophthalmology), AAARAD.

12. What sources do you use to measure clinical productivity benchmarks? (Respondents were allowed to choose **multiple** responses).



Respondents who answered “Other” to Q12:

The physician enterprise manages all clinical compensation.

Health Systems use a variety of measures that the dean or dean's office does not participate.

Vizient.

Vizient.

Proprietary blend of local, regional, and national private practice RVU data.

Sullivan Cotter.

For APPs we use internal expectations.

Sullivan Cotter and VMG.

The Health System uses Proprietary Benchmarks obtained from a consulting firm.

AAAP, AAARAD.



Participating Institutions:

Donald and Barbara Zucker School of Medicine at Hofstra/Northwell

Duke University School of Medicine

Eastern Virginia Medical School

Emory University

Geisel School of Medicine at Dartmouth College

Hackensack Meridian School of Medicine

Harvard Medical School

Johns Hopkins School of Medicine

Kaiser Permanente Bernard J. Tyson School of Medicine

Kirk Kerkorian School of Medicine at UNLV

Loyola University Chicago

LSU Health Sciences Center School of Medicine - New Orleans

MCW

Medical College of Georgia at Augusta University

Mercer University School of Medicine

MUSC

NEOMED

New York Medical College

Northwestern University Feinberg School of Medicine

Oakland University William Beaumont SOM

Ohio State University

Oregon Health & Science University

Penn State College of Medicine

Rutgers New Jersey Medical School

Texas A&M School of Medicine

UAB Heersink School of Medicine

UC San Francisco

UNC-Chapel Hill

University of Maryland

University of Chicago

University of Cincinnati

University of Hawaii, John A Burns School of Medicine

University of Illinois

University of Kansas Medical Center

University of Kentucky

University of Michigan Medical School

University of Minnesota

University of Missouri School of Medicine

University of North Dakota School of Medicine & Health Sciences

University of Tennessee Health Science Center

University of Texas at Tyler School of Medicine

University of Toledo

University of Utah School of Medicine

USF Morsani College of Medicine

UT Health San Antonio

UT Southwestern Medical Center

UTRGV School of Medicine

UVA

UW Madison School of Medicine and Public Health

Washington University School of Medicine in St. Louis

For questions, please contact gba@aamc.org