Presentation Outline

- Marketplace trends in physician compensation
- Regulatory requirements
- Matching compensation to services provided
- Overview and analysis of popular compensation models
- Impact of practice setting
- Common misapplications of the compensation surveys
- FMV
Market Trends & Physician Compensation

- Conflicting Long-Term Trends:
  - Aging population and population growth will increase demand for physician services.
  - Supply of physicians will not be sufficient to meet this demand.
  - For supply and demand to equalize, physician compensation should increase significantly, but...
  - Cost containment efforts as part of healthcare reform may limit or stall compensation increases.
  - So, where does the interplay of these market dynamics lead us?
Market Trends & Physician Compensation

➢ Trend towards physician employment
  ▪ Recent study by the Center for Studying Health System Change shows physician ownership in practices declined from 61.6% in 1996-97 to 54.4% in 2004-05.

➢ Trend towards hospital employment
  ▪ A recent article on medscape.com cites the president of MGMA as saying that hospitals will employ a majority of physicians within 5 years.
  ▪ 2009 Health Management Academy survey reports that 88% of responding CEOs and CMOs believe physician employment will become the dominant and permanent model for medical staff relationships.
    ▪ Some sources claim hospital employment may be driving up physician compensation.
## Market Trends & Physician Compensation

### MGMA: Change in Median Compensation

<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care</td>
<td>3.89%</td>
<td>2.03%</td>
<td>6.30%</td>
<td>2.04%</td>
<td>14.97%</td>
</tr>
<tr>
<td>Specialists</td>
<td>6.61%</td>
<td>1.78%</td>
<td>3.16%</td>
<td>2.19%</td>
<td>14.39%</td>
</tr>
</tbody>
</table>

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# Trends in Physician Compensation Models

## 2008 & 2009 MGMA Survey Respondents:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of RVUs</td>
<td>17%</td>
<td>36%</td>
<td>16%</td>
<td>47%</td>
</tr>
<tr>
<td>Professional Collections</td>
<td>40%</td>
<td>32%</td>
<td>31%</td>
<td>29%</td>
</tr>
<tr>
<td>Gross Charges</td>
<td>11%</td>
<td>13%</td>
<td>9%</td>
<td>15%</td>
</tr>
<tr>
<td>Adjusted Charges</td>
<td>14%</td>
<td>13%</td>
<td>12%</td>
<td>11%</td>
</tr>
</tbody>
</table>

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## Trends in Physician Compensation Models

### 2008 & 2009 MGMA Survey Respondents:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Satisfaction</td>
<td>7%</td>
<td>23%</td>
<td>6%</td>
<td>20%</td>
</tr>
<tr>
<td>Peer Review</td>
<td>8%</td>
<td>4%</td>
<td>7%</td>
<td>6%</td>
</tr>
<tr>
<td>Admin/Governance Duties</td>
<td>11%</td>
<td>14%</td>
<td>10%</td>
<td>15%</td>
</tr>
<tr>
<td>Service Quality</td>
<td>6%</td>
<td>22%</td>
<td>6%</td>
<td>21%</td>
</tr>
</tbody>
</table>

*Only selected categories presented.*

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Trends in Physician Compensation Models

**2008 AMGA Survey Respondents:**
- 70% of groups used market data to set physician salaries
- Groups implementing production-based comp plans:
  - Nearly 60% used Work RVUs (“wRVUs) to measure production.
  - Roughly 32% used net production.

**Other Incentives and Discretionary Compensation:**

<table>
<thead>
<tr>
<th>Incentive</th>
<th>% Using</th>
<th>Incentive</th>
<th>% Using</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Satisfaction</td>
<td>40%</td>
<td>Peer / Chart Review</td>
<td>22%</td>
</tr>
<tr>
<td>RVU Goals</td>
<td>37%</td>
<td>Market Adjustments</td>
<td>20%</td>
</tr>
<tr>
<td>Dept Budget Goals</td>
<td>32%</td>
<td>Cost Containments</td>
<td>17%</td>
</tr>
<tr>
<td>Individual Financial Goals</td>
<td>30%</td>
<td>Access</td>
<td>15%</td>
</tr>
<tr>
<td>Citizenship</td>
<td>26%</td>
<td>Call Coverage</td>
<td>13%</td>
</tr>
<tr>
<td>Additional Responsibilities</td>
<td>22%</td>
<td>Clinical Outcomes</td>
<td>12%</td>
</tr>
</tbody>
</table>

*Percentages add to more than 100% due to multiple response categories.*
## Trends in Physician Compensation Models

### 2008 SCA Survey Participants:

- 54% provide salary guarantees
- 39% have compensation plans based on wRVUs
- 70% have incentive compensation programs:

<table>
<thead>
<tr>
<th>Incentive Measure – Individual Performance</th>
<th>PCPs</th>
<th>Specialists</th>
</tr>
</thead>
<tbody>
<tr>
<td>wRVUs</td>
<td>58%</td>
<td>54%</td>
</tr>
<tr>
<td>Patient Satisfaction</td>
<td>42%</td>
<td>38%</td>
</tr>
<tr>
<td>Collections</td>
<td>28%</td>
<td>32%</td>
</tr>
<tr>
<td>Quality Measures</td>
<td>37%</td>
<td>32%</td>
</tr>
<tr>
<td>Charting</td>
<td>15%</td>
<td>19%</td>
</tr>
<tr>
<td><strong>Collegiality</strong></td>
<td>15%</td>
<td>17%</td>
</tr>
<tr>
<td>Patient Outcomes</td>
<td>15%</td>
<td>12%</td>
</tr>
</tbody>
</table>

**Average Incentive Award as a % of Base Salary**

<table>
<thead>
<tr>
<th></th>
<th>PCPs</th>
<th>Specialists</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>17%</td>
<td>20%</td>
</tr>
</tbody>
</table>

*Percentages add to more than 100% due to multiple response categories.*
Trends in Physician Compensation Models

Summary of Trends:

- wRVUs are the most popular productivity measure for incentive compensation.
- Collections runs a distant second for most common productivity measure.
- Patient satisfaction is one of the most commonly used non-productivity measures for incentive bonus pay.
- Groups use a wide variety of measures for incentive bonus pay.
Regulatory Considerations for Compensation

- Physician compensation can trigger three major sets of governmental laws and regulations:
  - Federal Anti-Kickback Statute ("AKS") and the "Stark" Law and Regulations
  - Internal Revenue Code ("IRC") related to either the tax treatment of compensation for tax "C" corps or private inurement considerations for tax-exempt entities
  - State "mini" Stark laws and tax regulations

- Each of these regulatory areas is complex: legal and tax expertise and advice is essential for full compliance (...and this presentation is not such advice...)
AKS and Stark Key Issues

AKS Considerations:
- As a criminal statute, AKS looks for intent to induce or reward referrals to prove a violation.
- AKS provides various safe harbors for compliance.
- FMV is an element in most of these safe harbors.

Stark Law & Regulations
- Strict liability statute with civil penalties for violation
- Regulates financial arrangements between physicians and entities to which they make referrals for certain healthcare goods and services, deemed “Designated Health Services” (“DHS”)
- Requires applicable arrangements to fit into exceptions, most of which require compensation to be consistent with FMV and not based on the volume or value of referrals
Stark Compensation Issues

- Prohibits referrals of DHS where financial relationships exists between providers and referral sources of DHS, unless they meet an exception.
- Stark prohibits compensation based on the value or volume of DHS referrals and requires compensation to be consistent with FMV.
- Stark exceptions affecting compensation:
  - In-Office Ancillary Services Exception (“IOAS”):
    - Solo practitioners can refer and receive compensation from in-office ancillaries but not hospital-employed solo physicians.
    - Physicians can refer DHS within their “Group Practice” (even if group is Hospital-owned) and can receive compensation indirectly related to DHS under certain specified criteria.
Stark Compensation Issues

- Stark requires physician compensation be consistent with FMV.
- In evaluating FMV compensation, Stark and AKS distinguish between clinical and administrative services provided by physicians (*but no guidance on how this affects the determination of FMV.*)
- Stark prohibits the use of market data from parties in a position to refer to one another from being used to establish FMV.
- Can use “any reasonable method” to determine FMV.
- Stark also requires arrangements to be “commercially reasonable”
Tax Compensation Issues

For practices treated as “C” corporations for income tax purposes:

- “Reasonable” compensation for personal services rendered by shareholders can be deducted as wages.
- Other amounts or compensation paid above this “reasonable” amount should generally be treated as dividend income to shareholders, i.e. double taxation.

For practices organized as tax-exempt [501(c)(3)] entities:

- Compensation paid must be “reasonable” and consistent with FMV.
- Compensation must be consistent with a non-profit mission as evaluated using criteria in the regulations.
Matching Compensation to Services Provided

Services provided by physicians can vary:

- **Physician services**
  - Clinical: patient care
  - Administrative: medical director, consultant, expert
  - Supervision: “incident to”, mid-level providers (“MLP”), in-office ancillaries
  - Other: call coverage, teaching, research

- **Entrepreneurial or business owner services:**
  - Owning/managing a business, *i.e.* a physician practice
  - Providing capital or investment to the practice
  - Being at-risk for the earnings of the practice
Matching Compensation to Services Provided

- Marketplace compensation varies by type of service.
  - Services vary in terms of the tasks, requirements, risks, levels of physical and mental effort, hours worked, and scope of responsibility entailed in the service.
  - Unique market factors affect the level or structure of pay for certain services.
    - Examples: wRVU rates, on-call pay, pharma vs. hospital hourly rates for directorships

- Key step in developing a physician compensation plan is matching compensation to the services provided.

- Federal regulators are focused on this issue!
Matching Compensation to Services Provided

- **Example #1** - Neurosurgeon in private practice seeks employment based on a wRVU model.
  - He currently receives $2,000 per shift for call coverage.
  - Should the physician continue to receive the on-call pay as compensation under employment?

- **Example #2** – Internist in private practice seeks employment under a base salary and incentive bonus model commensurate with her current pay.
  - She currently makes around $400,000 per year from her practice that includes several MLPs who all generate twice their salary and benefits cost in collections.
  - What should her compensation level be under employment?
Popular Compensation Models

- Fixed or flat salary
- Base salary + incentive/productivity bonus
  - Incentives can be tied to non-production related measures, such as patient satisfaction, quality or charting
  - Bonus based on professional revenues, wRVUs, or profits
- wRVU-based
  - Fixed comp rate per wRVU
  - Graduated scale comp rates
- % of Revenue
  - Based on professional revenues (charges or collections)
Popular Compensation Models

- % of Pre-Compensation Earnings (“PCE”)
  - PCE is defined as practice revenues less expenses, excluding physician compensation.
  - Stark prohibits PCE from including ancillary earnings for solo hospital-employed physicians.
  - Stark allows PCE to include ancillary profits if they meet the Group Practice definition and IOAS exception criteria.

- Hybrid / Mix and Match
  - Varying comp pools that are compensated using various measures or benchmarks
  - Greater of up to three different models
  - Varying methods for allocating revenues, costs and profits
Evaluating Compensation Models

- Recent studies on pay-for-performance measures indicate that performance outcomes are more likely to be achieved when significant levels of compensation are tied to the achievement of those outcomes.
- In other words, you get what you pay for!
- What are the right outcomes to pay for?
  - Depends on the organization and its goals.
  - For most practices, however, productivity, revenue generation, and cost management are three key objectives for sustaining long-run economic practice viability.
Evaluating Compensation Models

Evaluation Tools:

- **Performance-based Pay Analysis:**
  - What services are the physician responsible for providing?
  - What resources are the physician responsible for managing?
  - Is compensation tied to outcomes for these areas of responsibility?

- **“Eat What You Treat” model as a tool for baseline economic analysis of compensation models**
  - Allows for identification and analysis of the full spectrum of economic drivers of compensation.
  - Allows adjustments from this baseline analysis for particular arrangements and organization goals.
Evaluating Compensation Models

Potential Economic Factors in Compensation:

- **Revenue Factors:**
  - Volumes
    - Individual physician productivity and practice style
    - Demand in the local market
  - Payor mix
  - Market reimbursement levels
  - Procedure / case mix
  - Hours worked
  - Mix of admin and clinical duties
Evaluating Compensation Models

- Overhead / cost structure factors:
  - Local market factors
  - Organization-specific factors
  - Physician-specific factors
  - Technology and equipment utilization
  - Staffing levels

- Other factors:
  - Ancillary earnings: revenues less costs
  - MLP earnings
  - Other revenue sources: on-call pay, medical directorships, drug studies, etc.
Evaluating Compensation Models

- **Factors in Owner Compensation:**
  - Profits from non-shareholder physicians and MLPs
  - Ancillary profits
  - Ownership in healthcare provider facilities, e.g. ASCs or specialty hospitals
- **Distribution methods:**
  - Productivity-based
  - Equality-based
  - Hybrid
  - Other criteria
# Evaluating Compensation Models

## Performance & Compensation Analysis Table

<table>
<thead>
<tr>
<th>Factor</th>
<th>Salary</th>
<th>Salary + Bonus</th>
<th>wRVU Based</th>
<th>% of Rev</th>
<th>PCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Volume</td>
<td>Possible</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Reimbursement</td>
<td>Possible</td>
<td></td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Overhead</td>
<td>Possible</td>
<td></td>
<td></td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Cost of Capital</td>
<td>Possible</td>
<td></td>
<td></td>
<td></td>
<td>Possible</td>
</tr>
<tr>
<td>MLP Earnings</td>
<td>Possible</td>
<td>Possible</td>
<td>Possible</td>
<td>Possible</td>
<td>Possible</td>
</tr>
<tr>
<td>Ancillary Profits</td>
<td>Possible</td>
<td></td>
<td></td>
<td></td>
<td>Possible</td>
</tr>
<tr>
<td>Owner Profits</td>
<td>Possible</td>
<td></td>
<td></td>
<td></td>
<td>Possible</td>
</tr>
<tr>
<td>Quality Measures</td>
<td>Possible</td>
<td></td>
<td></td>
<td></td>
<td>Possible</td>
</tr>
</tbody>
</table>
Setting for Physician Services

Setting of physician services significantly affects the dynamics of physician work and productivity:

<table>
<thead>
<tr>
<th>Factor</th>
<th>Hospital-Based</th>
<th>Practice-Based</th>
</tr>
</thead>
<tbody>
<tr>
<td>Source of Patient Base</td>
<td>Hospital</td>
<td>Physician practice</td>
</tr>
<tr>
<td>Service Context</td>
<td>• Staffing of hospital unit, function, or service line</td>
<td>Physician service is sole or primary element of patient care</td>
</tr>
<tr>
<td></td>
<td>• Provides resource input to larger service</td>
<td></td>
</tr>
<tr>
<td>Productivity</td>
<td>Limited by volumes and case acuity of facility</td>
<td>Mainly driven by individual physician efforts</td>
</tr>
<tr>
<td>Work Hours</td>
<td>Shift-based: 12 or 24 hour coverage</td>
<td>Physician’s practice schedule</td>
</tr>
</tbody>
</table>
Setting for Physician Services

Practice setting impacts the dynamics of physician productivity and compensation:

<table>
<thead>
<tr>
<th>Hospital-Based Physicians</th>
<th>Practice-Based Physicians</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual physician efforts have reduced impact on productivity</td>
<td>Individual physician efforts generally drive productivity</td>
</tr>
<tr>
<td>Shift coverage may be necessary regardless of patient volumes</td>
<td>Work hours and productivity generally correlate: work hours drive productivity</td>
</tr>
<tr>
<td>Revenues and earnings to support physician compensation may be limited by factors unrelated to physician efforts</td>
<td>Revenues and earnings to support physician compensation can be directly affected by physician efforts</td>
</tr>
</tbody>
</table>

Implication: physician compensation plans should address the dynamics of practice setting.
Common Misapplications of the Comp Surveys

- Use of the various physician compensation surveys is very common in the marketplace by physician groups, hospitals, consultants and appraisers.
- Users often view the survey data as definitive record of physician compensation in the marketplace.
- Many users, however, have critical misunderstandings about the survey data.
- As a result, survey data are frequently misapplied and misused in setting physician compensation.
Common Misapplications of the Comp Surveys

#1 – The surveys are the definitive snapshot of physician compensation in the marketplace.

- The participants in the surveys are not based on statistical sampling methods.
- They represent the compensation for those physicians and groups who elected to participate.
- The surveys reflect the profiles of the groups who participate in the surveys and/or are involved with the organizations who produce the surveys.
- Not all respondents provide data for all the questions asked. The data reported is not a complete picture of all the respondents.
Common Misapplications of the Comp Surveys

#2 – The survey with the highest number of respondents is most representative of the marketplace.

- Each survey tends to represent a different segment of the physician marketplace.
  - AMGA: large multispecialty groups over 100
  - SCA: hospital/health system and teaching institutions
  - MGMA: cross section of small to large groups, mostly multispecialty
- The number of respondents may simply provide a wider look at the type of practices represented in the survey.
Profiles of Comp Survey Participants

**MGMA and AMGA**

<table>
<thead>
<tr>
<th>Organization Ownership - 2008</th>
<th>MGMA Practices</th>
<th>MGMA Providers</th>
<th>AMGA Groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician</td>
<td>56%</td>
<td>55%</td>
<td>49%</td>
</tr>
<tr>
<td>Hospital / IDS</td>
<td>38%</td>
<td>34%</td>
<td>44%</td>
</tr>
<tr>
<td>Other</td>
<td>6%</td>
<td>11%</td>
<td>7%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Group Type - 2008</th>
<th>MGMA Practices</th>
<th>MGMA Providers</th>
<th>AMGA Groups</th>
<th>AMGA Physicians</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single Specialty</td>
<td>70%</td>
<td>28%</td>
<td>11%</td>
<td>2%</td>
</tr>
<tr>
<td>Multispecialty</td>
<td>30%</td>
<td>72%</td>
<td>89%</td>
<td>98%</td>
</tr>
</tbody>
</table>

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## Profiles of Comp Survey Participants

### MGMA 2008 – Group Size

<table>
<thead>
<tr>
<th>Group Size</th>
<th>Physicians</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fewer than 26</td>
<td>23%</td>
</tr>
<tr>
<td>26 to 75</td>
<td>23%</td>
</tr>
<tr>
<td>76 to 100</td>
<td>7%</td>
</tr>
<tr>
<td>More than 100</td>
<td>47%</td>
</tr>
</tbody>
</table>

### AMGA 2008 – Group Size

<table>
<thead>
<tr>
<th>Group Size</th>
<th>Groups</th>
<th>Physicians</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fewer than 35</td>
<td>24%</td>
<td>3%</td>
</tr>
<tr>
<td>35 to 70</td>
<td>21%</td>
<td>6%</td>
</tr>
<tr>
<td>71 to 100</td>
<td>11%</td>
<td>5%</td>
</tr>
<tr>
<td>More than 100</td>
<td>44%</td>
<td>86%</td>
</tr>
</tbody>
</table>

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Profiles of Comp Survey Participants

<table>
<thead>
<tr>
<th>SCA – Types of Organizations</th>
<th>2008 *</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital / Medical Center</td>
<td>68%</td>
</tr>
<tr>
<td>Teaching Institutions</td>
<td>49%</td>
</tr>
<tr>
<td>Trauma Centers</td>
<td>40%</td>
</tr>
<tr>
<td>Group Practice</td>
<td>20%</td>
</tr>
<tr>
<td>Integrated Delivery System</td>
<td>18%</td>
</tr>
<tr>
<td>Faculty Practice Plan</td>
<td>4%</td>
</tr>
<tr>
<td>PHO</td>
<td>3%</td>
</tr>
<tr>
<td>HSO</td>
<td>2%</td>
</tr>
<tr>
<td>MSO</td>
<td>2%</td>
</tr>
</tbody>
</table>

* Percentages add to more than 100% due to multiple response categories.
#3 – The comp surveys are the best indication of what should be paid for employing a physician to provide clinical services.

- The comp surveys generally report total compensation, *i.e.*, compensation from all sources.
- MGMA and AMGA necessarily reflect some level of owner compensation.
- Compensated call coverage is included to some degree.
- Medical directorship fees are included to some degree.
- Conclusion: There is noise in the survey data when evaluating compensation for clinical services only!
Common Misapplications of the Comp Surveys

- #4 – Regional or state data better reflect my local marketplace.
  - Regional data may be concentrated from respondents in a small number of states or even a single state.
  - State data may reflect participant concentrations in a few locales. Each location may have differing market dynamics.
  - Further study and review of the data are needed to evaluate whether regional or state data are more applicable for a specific market.
  - State data often has an extremely limited of respondents, depending on the state, which limits its reliability; regional data might not have any respondents from certain states in the region.
Common Misapplications of the Comp Surveys

#5 – Compensation and productivity always correlate in the survey data.

- The 2008 MGMA compensation and productivity data do not always show a strong correlation between the two variables. See Tables 1 to 3 in the supplemental materials.
- In Table 3, hospital-based physicians tend to show little correlation between wRVU or professional collections and compensation.
- Tables 1 and 2 indicate there is less correlation between wRVUs and compensation than between professional collections and compensation.
Anesthesiology Physician Compensation vs. Work RVUs

All Physicians Selected / All Work RVUs

Regression Line: Y = -8.23 * X + 449,254.34  R Squared = 0.13
Median Work RVUs = 5,357  Median Compensation = $386,000

Sample Practice Data Points
MGMA Data Points
Best Fit Line
Plus One Std Deviation Line
Minus One Std Deviation Line
Median RVU Line
Median Compensation Line

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Common Misconceptions of the Comp Surveys

#6 – The compensation per wRVU rate should correlate with the level of wRVU productivity of the physician.

- Example: 90th percentile wRVUs should be compensated at the 90th percentile comp/wRVU rate.
- Compensation per wRVU does not correlate with the physician’s wRVU productivity.
- For MGMA, the compensation rate per wRVU actually decreases with increasing wRVU levels. The higher rates are for lower wRVU levels (reverse correlation). See pp. 9-10 of the 2009 survey.
- Rule of Thumb / Reality Check: Frequently, median comp w/RVU is the best “explanatory” rate for compensation based on wRVU productivity.
### MGMA National Productivity Data - 2008 Report based on 2007 Data

<table>
<thead>
<tr>
<th>Surgery: General</th>
<th>n=</th>
<th>25th %tile</th>
<th>Median</th>
<th>75th %tile</th>
<th>90th %tile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compensation</td>
<td>1,024</td>
<td>$251,361</td>
<td>$316,909</td>
<td>$396,004</td>
<td>$499,180</td>
</tr>
<tr>
<td>wRVUs</td>
<td>568</td>
<td>5,792</td>
<td>7,170</td>
<td>8,843</td>
<td>10,964</td>
</tr>
<tr>
<td>Comp/wRVU</td>
<td>556</td>
<td>$37.44</td>
<td>$45.42</td>
<td>$55.72</td>
<td>$74.23</td>
</tr>
</tbody>
</table>

### Compensation Calculated using Reported Comp/wRVU Rates & wRVU Levels

<table>
<thead>
<tr>
<th>Comp/wRVU Rate</th>
<th>25th %tile</th>
<th>Median</th>
<th>75th %tile</th>
<th>90th %tile</th>
</tr>
</thead>
<tbody>
<tr>
<td>wRVUs</td>
<td>5,792</td>
<td>7,170</td>
<td>8,843</td>
<td>10,964</td>
</tr>
<tr>
<td>25th Percentile</td>
<td>$37.44</td>
<td>$216,852</td>
<td>$268,445</td>
<td>$331,082</td>
</tr>
<tr>
<td>Median</td>
<td>$45.42</td>
<td>$263,073</td>
<td>$325,661</td>
<td>$401,649</td>
</tr>
<tr>
<td>75th Percentile</td>
<td>$55.72</td>
<td>$322,730</td>
<td>$399,512</td>
<td>$492,732</td>
</tr>
<tr>
<td>90th Percentile</td>
<td>$74.23</td>
<td>$429,940</td>
<td>$532,229</td>
<td>$656,416</td>
</tr>
</tbody>
</table>
Thoughts on the Use of Comp Surveys:

- The comp surveys are excellent tools when understood and used appropriately!
- Recognize their strengths and limitations.
- Time invested in understanding how the survey is compiled and reported will pay large returns for your organization.
- Note that the surveys are not the only tools in the toolbox for determining FMV compensation:
  - Historical analysis
  - Pro forma analysis
FMV of Physician Compensation

- The valuation body of knowledge recognized by all appraisal disciplines is based on the three approaches to value:
  - Market
  - Cost
  - Income

- FMV is not simply the compensation from the surveys.
- FMV is not simply what’s being paid in the market.
- FMV is not simply what the group or hospital down the street is paying its physicians.
FMV of Physician Compensation

- From the standpoint of the professional practice of appraisal, FMV is determined based on the consideration of all three approaches to value.
- FMV for Stark compliance purposes, however, can be based on “any reasonable method.”
  - Thus, the “Stark Appraisal Conundrum” for healthcare appraisal professionals
- Specific methods and techniques for valuing physician compensation are generally tailored to the economics of the type of physician service being appraised.
Presentation Takeaways

“You Get What You Pay For”

- Does your compensation plan match pay to the services provided?
- Does your compensation plan reward performance in the areas that are important to your organization?
- Does your compensation plan pay for productivity or performance in areas over which a physician has control or impact?
- Has your organization invested sufficient time in research and analysis to use the compensation tools in its toolbox effectively to promote the organization’s goals?
Questions?