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

	2004-05 Change	2005-06 Change	2006-07 Change	2007-08 Change	2004-08 Change
Primary Care	3.89%	2.03%	6.30%	2.04%	14.97%
Specialists	6.61%	1.78%	3.16%	2.19%	14.39%

Trends in Physician Compensation Models

2008 & 2009 MGMA Survey Respondents:

Productivity Measures Used in Compensation Method	2008 Practices	2008 Providers	2009 Practices	2009 Providers
Number of RVUs	17%	36%	16%	47%
Professional Collections	40%	32%	31%	29%
Gross Charges	11%	13%	9%	15%
Adjusted Charges	14%	13%	12%	11%

** Only selected categories presented*.

Trends in Physician Compensation Models

2008 & 2009 MGMA Survey Respondents:

Basis for Incentive / Bonus Used in Compensation Method	2008 Practices	2008 Providers	2009 Practices	2009 Providers
Patient Satisfaction	7%	23%	6%	20%
Peer Review	8%	4%	7%	6%
Admin/Governance Duties	11%	14%	10%	15%
Service Quality	6%	22%	6%	21%

** Only selected categories presented*.

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:

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

** 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:**

Incentive Measure – Individual Performance	PCPs	Specialists
wRVUs	58%	54%
Patient Satisfaction	42%	38%
Collections	28%	32%
Quality Measures	37%	32%
Charting	15%	19%
Collegiality	**15%**	**17%**
Patient Outcomes	15%	12%
Average Incentive Award as a % of Base Salary	**17%**	**20%**

** 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

Factor	Salary	Salary + Bonus	wRVU Based	% of Rev	PCE
Volume		Possible	Yes	Yes	Yes
Reimbursement		Possible		Yes	Yes
Overhead		Possible			Yes
Cost of Capital		Possible			Possible
MLP Earnings		Possible	Possible	Possible	Possible
Ancillary Profits		Possible			Possible
Owner Profits		Possible			Possible
Quality Measures		Possible		Possible	Possible

Setting for Physician Services

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

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

Setting for Physician Services

Practice setting impacts the dynamics of physician productivity and compensation:

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

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

Organization Ownership - 2008	MGMA Practices	MGMA Providers	AMGA Groups
Physician	56%	55%	49%
Hospital / IDS	38%	34%	44%
Other	6%	11%	7%

Group Type - 2008	MGMA Practices	MGMA Providers	AMGA Groups	AMGA Physicians
Single Specialty	70%	28%	11%	2%
Multispecialty	30%	72%	89%	98%

Profiles of Comp Survey Participants

MGMA 2008 – Group Size	Physicians
Fewer than 26	23%
26 to 75	23%
76 to 100	7%
More than 100	47%

AMGA 2008 – Group Size	Groups	Physicians
Fewer than 35	24%	3%
35 to 70	21%	6%
71 to 100	11%	5%
More than 100	44%	86%

Profiles of Comp Survey Participants

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

** Percentages add to more than 100% due to multiple response categories*.

Common Misapplications of the Comp Surveys

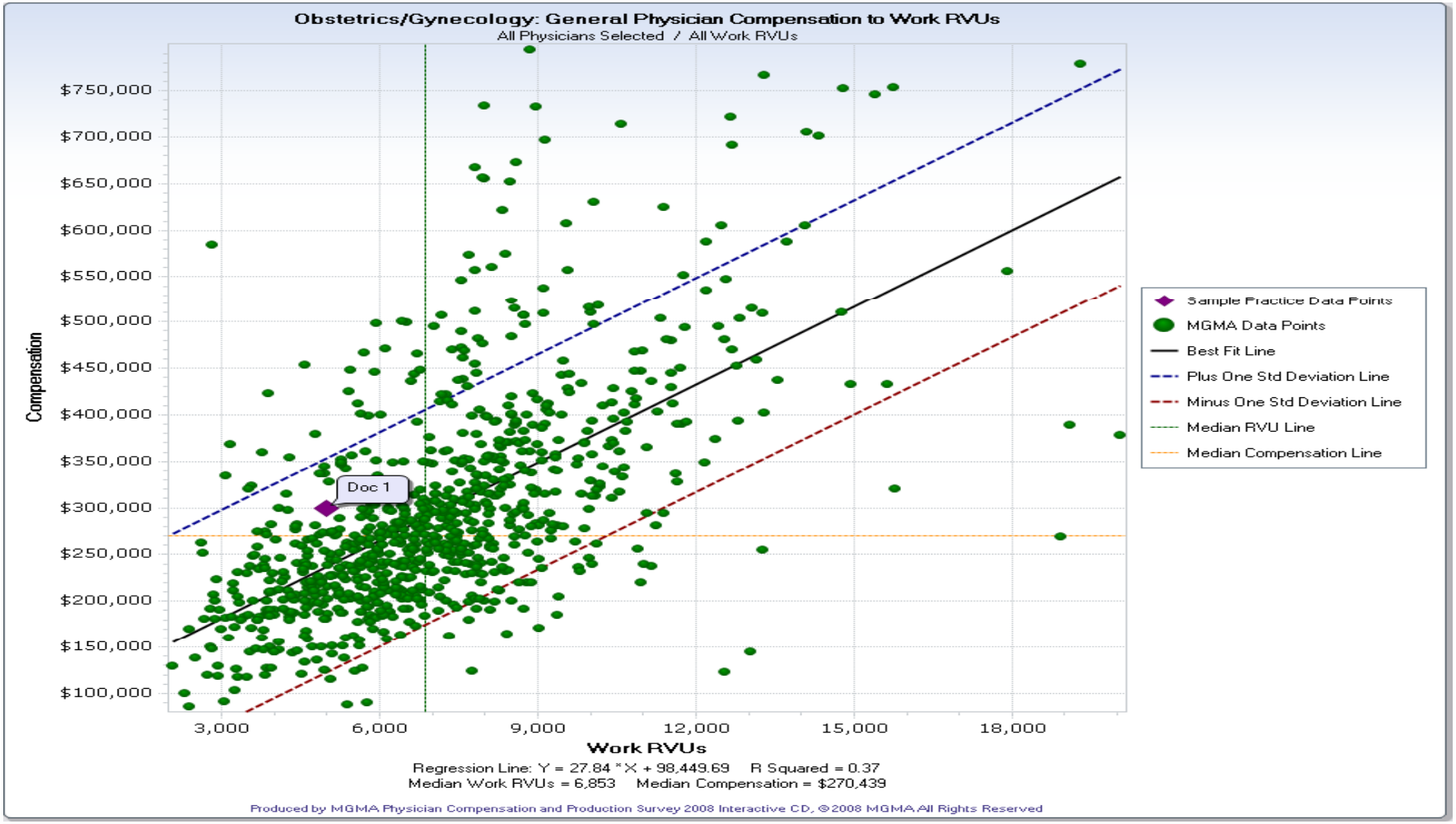
- **#3 – The comp surveys are the best indication of what should be paid for employing a physician to provide clinical services.**
  - **The comp surveys generally report total compensation, *i.e.*, compensation from all sources.**
  - **MGMA and AMGA necessarily reflect some level of owner compensation.**
  - **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

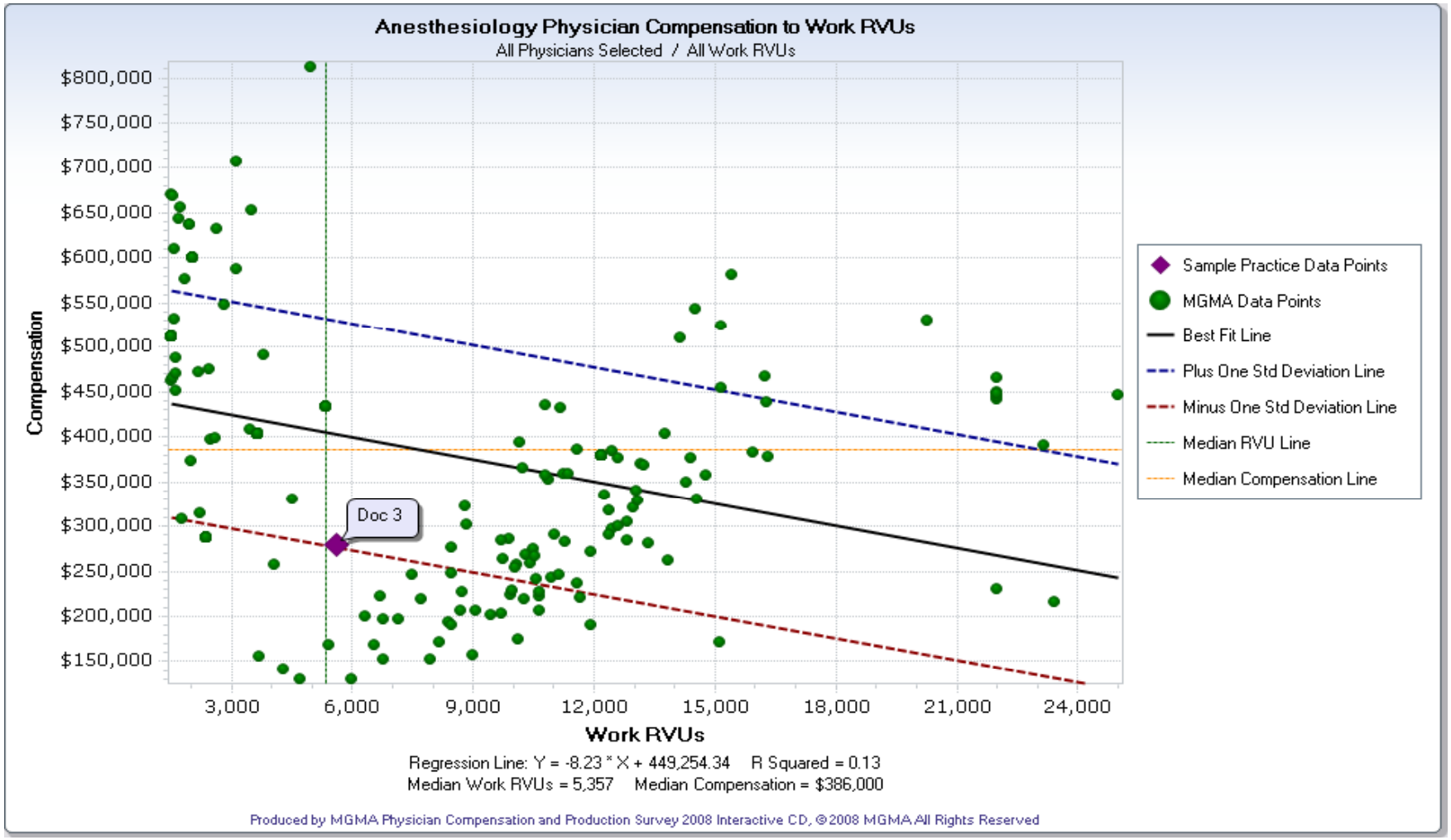
- **#4 – Regional or state data better reflect my local marketplace.**
  - **Regional data may be concentrated from respondents in a small number of states or even a single state.**
  - **State data may reflect participant concentrations in a few locales. Each location may have differing market dynamics.**
  - **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 an 2 indicate there is less correlation between wRVUs and compensation than between professional collections and compensation.**



Data used with permission from the Medical Group Management Association, 104 Inverness Terrace East, Englewood, CO 80112
877.ASK.MGMA. www.mgma.com. Copyright © 2008.



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.**

Common Misconceptions of the Comp Surveys

MGMA National Productivity Data - 2008 Report based on 2007 Data

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

Compensation Calculated using Reported Comp/wRVU Rates & wRVU Levels

Comp/wRVU Rate		25th %tile	Median	75th %tile	90th %tile
wRVUs		5,792	7,170	8,843	10,964
25th Percentile	$37.44	$216,852	$268,445	$331,082	$410,492
Median	**$45.42**	**$263,073**	**$325,661**	**$401,649**	**$497,985**
75th Percentile	$55.72	$322,730	$399,512	$492,732	$610,914
90th Percentile	$74.23	$429,940	$532,229	$656,416	$813,858

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?