



Fair Market Value

Compensation & Productivity Benchmark Methodology

Office of the Dean, School of Medicine
Medical College Physicians
Children's Specialty Group

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I. Preamble

MCW's Institutional faculty compensation strategy is to have an institution-wide framework to help guide the alignment of departmental and individual efforts with the priorities of the Institution which is both sustainable and market responsive. These strategies in turn lead to performance planning initiatives that can be translated into concrete and operational objectives that can be measured, communicated, and used to drive decision-making at institutional, practice, departmental and individual levels.

Historically, planning and measuring performance was based on divergent methodologies and business objectives. MCW's Institutional strategy has led to the development of a standard platform for managing business rules and information used in planning, evaluating performance and productivity, and reviewing and setting compensation.

Beginning in early 2012, MCW undertook an initiative to develop Fair Market Value (FMV) guidelines for faculty compensation. Delineating a FMV methodology is an accepted practice used across the country in academic and healthcare institutions for assessing reasonable levels of compensation and complying with regulatory requirements. FMV results are intended to serve as a standard for institutional, practice and department leadership to assess alignment of faculty compensation and business needs, while also ensuring the institution's faculty compensation is in compliance with federal regulatory requirements.

In the same timeframe that FMV was being developed, focus was placed on understanding benchmarks used for clinical productivity. MCW generally used University Health Systems Consortium (UHC) – now Vizient – as the clinical productivity benchmark.

MCW's goal, in collaboration with each Practice and academic unit leadership, is to establish a consistent set of clinical compensation and productivity benchmarks and avoid different specialty areas using disparate benchmarking data resulting in inconsistent measures and outcomes. The Medical College Physicians (MCP) clinical practice reviewed a series of surveys and standardized on Vizient for consistency except where no Vizient benchmarks are available. Currently, Vizient is also being used as the productivity benchmark for Children's Specialty Group (CSG) faculty. According to the criteria set forth in this methodology, some departments have justified specialty specific data sources for their faculty.

II. Executive Summary

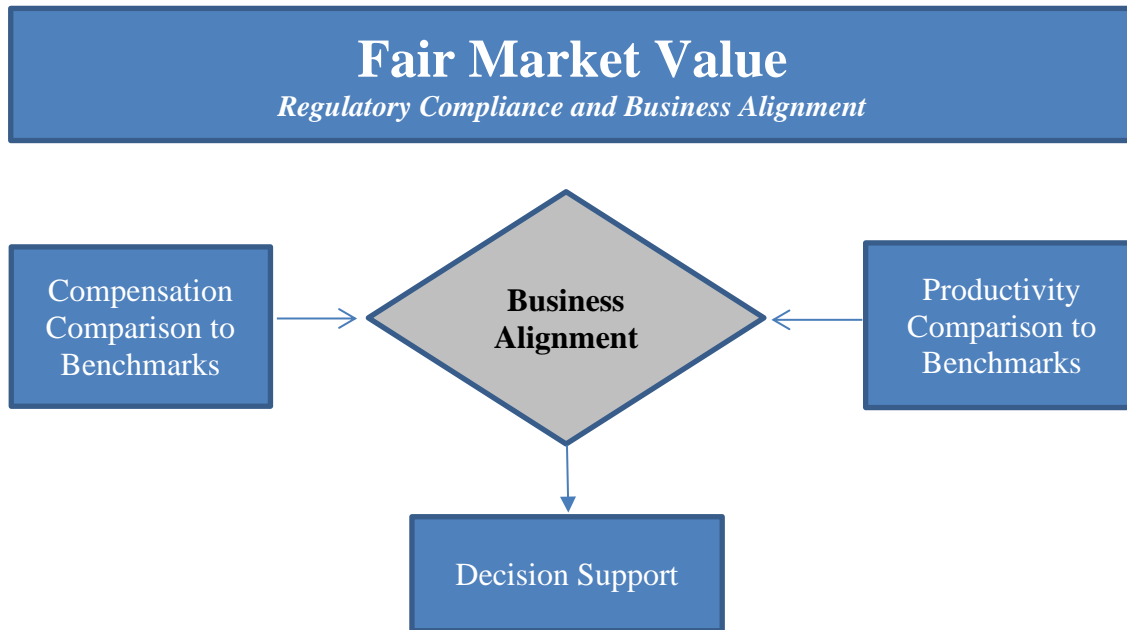
In collaboration with the Practices, this white paper describes the development of compensation and productivity benchmarks at MCW. Widespread understanding of how the benchmarks are evaluated and selected should enable faculty and institutional leaders to accept the outcomes of the FMV analyses, and, while continuing to refine departmental data upon which the analyses are based, provide a context to make leadership decisions. MCW will continue to refine its benchmark evaluation process so that the organization can continue to use those benchmarks that are the most valued and reliable.

While every attempt has been made to gather and present the best available benchmarks, not all specialties and subspecialties are represented in reliable published surveys. In these circumstances, processes are in place to work with the clinical practices and academic department leadership in defining appropriate benchmarks.

Approved benchmarks are meant to be a reliable and consistent standard which establishes guideposts to assess clinical practice, academic unit, and individual faculty compensation and productivity levels. These guideposts are intended to provide a level of alignment between compensation and productivity that will assist leadership in the decision-making process.

III. Overview

Since its initial inception at MCW in early 2012, the FMV methodology has been adjusted to reflect input from institutional, practice and academic unit leadership. The FMV methodology establishes a standard platform to review faculty compensation from a regulatory, retention, and consistency perspective. Both the business alignment and compliance components of the FMV process include compensation and clinical productivity benchmarks. The FMV methodology provides context to the alignment of compensation and productivity.



The results from FMV compensation and productivity analysis are not only used in decision support for institutional, practice and academic unit leadership, but also provides a single source of information used in Performance Metrics, Financial and Budget Forecasting, Affiliate Hospital Funds Flow, and other initiatives.

IV. Benchmark Selection Criteria and Guidelines

This section provides criteria to ensure selected benchmark data are both compliant with applicable legislation and reflective of accepted practices. These guidelines allow various sources of available data, including individually reported professional association data, ad hoc, unpublished, or 'park bench' data points to be validated on a consistent basis. Because validating individual sources of data requires an investment of time and resources the following guidelines provide a threshold that benchmark data must meet to be considered.

The Sherman Anti-Trust Act of 1890, passed by Congress and signed into law by President Benjamin Harrison, is the foundation for how compensation survey data are governed. This Act, along with supporting legislation of 1904, ensured a competitive business environment by discouraging the formation of monopolies. The Act also has been used to ensure competitive wage levels through the elimination of anti-competitive price fixing. The Act and its effect on the way compensation data are now reported in surveys was brought to light and clarified through significant court cases and continues to be

the standard regulating modern day compensation survey publishing. The guidelines stipulated in this legislation are commonly referred to as Survey Safe Harbor Guidelines. These guidelines are as follows:

- Survey data must be conducted by an independent third party
- Reported data must be at least three months old
- Each disseminated statistic must have five companies reporting data
- No individual company’s information can represent more than 25 percent of each disseminated statistic

The following criteria establish reliable data and should characterize accepted survey data:

- In compliance with the Sherman Anti-Trust Act
- Survey must have an adequate sample size
- No secrets about the data or methodology
- Survey sources and sample sources always identified
- Data are timely, up-to-date, and effective date of the data are well-defined
- Job matching standards are clear
- Competitive marketplace from which they are drawn is understood

Best practices related to survey selection suggest the following characteristics to be sought or avoided to assist with maintaining consistent business rules and data continuity from year to year:

What to Look For	What to Avoid
Surveys that follow survey safe harbor guidelines	Surveys that report any data in violation of Survey safe harbor guidelines
Surveys conducted by firms that take care to clean and analyze data	Surveys conducted by firms that do not clean or analyze participant data
Surveys that have a consistent level of participation year over year	Surveys with wild fluctuations in participation year over year

The benchmarks selected for MCW FMV calculations also consider survey methodology, who reported the data and how it was collected. It is most desirable to have data reported by institutional personnel and collected through a method that is reliable and as error-proof as possible. When appropriate, we also consider who is reviewing and aggregating the data and find out whether data anomalies are confirmed with participants.

V. Compensation Methodology and Benchmarks

MCW typically competes nationally in the academic medicine and health care market. FMV methodology is reviewed on annual basis to ensure our methodology is market competitive to recruit and retain. Please reference Appendix A for our current FMV methodology rules. FMV typically blends total compensation benchmark data from academic and administrative leadership survey sources into a single composite value, weighting data based on reported allocations of effort for each faculty member. This is an accepted practice used in justifying compensation for federal regulatory and compliance purposes and is used by a number of academic medical institutions and health systems for benchmarking complex positions with distributed effort.

The following nationally recognized compensation survey sources are available for reliable comparisons:

1. Clinical surveys:

- American Medical Group Association (AMGA): Medical Group Compensation and Financial Survey. Includes data from 260 medical groups representing more than 92,621 providers.
- Medical Group Management Association-Physician Practice (MGMA-Physician): Physician Compensation and Production Survey. Includes data from more than 3,847 medical practices representing over 80,000 physicians and non-physician providers.
- SullivanCotter and Associates, Inc.: Physician Compensation and Productivity Report (includes data from health care organizations representing more than 135,000 physicians, PhDs, residents, advanced practice providers, and medical group executives).
- Department validated survey data

2. Academic Surveys:

- Association of Administrators in Academic Pediatrics (AAP): Faculty Compensation and Productivity Survey. Includes data from over 100 institutions representing 10,120 faculty.
- Association of Administrators in Academic Radiology (AAARAD): Faculty Salary and Productivity Survey. Includes data from over 90 institutions representing 4,569 faculty.
- Association of American Medical Colleges (AAMC): Report on Medical School Faculty Salaries. Includes data from all of the 144 accredited medical schools in the U.S. representing over 110,281 full-time faculty.
- Medical Group Management Association-Academic (MGMA-Academic): Academic Practice Compensation and Production Survey for Faculty and Management. Includes data from 616 clinical science departments representing over 20,876 faculty physicians and non-physician providers.

3. Administrative Leadership Surveys:

- Association of American Medical Colleges (AAMC): Dean's Office Staff Survey
- Association of Administrators in Academic Pediatrics (AAP)
- Sullivan Cotter and Associates, Inc.: Physician Compensation and Productivity Report (includes data from health care organizations representing more than 135,000 physicians, PhDs, residents, advanced practice providers, and leadership roles).

References to clinical, academic and administrative leadership work effort reflect the following:

- Clinical: Activities that focus directly on inpatient or outpatient services for which a professional fee to a patient can be generated – regardless of whether or not it is billed.
- Academic: Time spent on organized basic, clinical or translational research activities funded by extramural or internal sources, efforts supporting the education and community engagement missions. It may include other academic activities such as writing articles; serving as a visiting professor; participating in a national conference; and the like.
- Administrative: Leadership responsibilities and supervision of clinical programs (e.g., Medical Director; Program Director; Department Chair; faculty practice or department administration; and/or academic program administration).

The full set of business rules for FMV calculations are found in APPENDIX A. Note: For specialties in the Department of Pediatrics, the AAP benchmark is prioritized over AAMC and if the data is not available, AAMC is used.

VI. Clinical Productivity Methodology and Benchmarks

The wRVU productivity measure continues to be the predominant benchmark for clinical productivity in published survey sources. Established definitions for quality and population health productivity measures used in benchmarking are beginning to emerge. Allowing that there is some variability in the market, a general national definition of clinical effort, defined as nine half days, is being used by a preponderance of published surveys. This is the standard that MCW utilizes, but will assess and evolve in line with market.

The following nationally recognized productivity survey sources are available and were reviewed by the MCW Practices in determining the best representative source of meaningful and reliable benchmark and productivity data:

- Vizient: An alliance of 120 academic medical centers and 300 of their affiliated hospitals representing the nation's leading academic medical centers.
- American Medical Group Association (AMGA)
- Medical Group Management Association-Physician Practice (MGMA-Physician)
- SullivanCotter and Associates, Inc.
- Association of Administrators in Academic Pediatrics (AAP)
- Department specific data sources, as requested.

Just as all compensation data reported in benchmark surveys is annualized, each clinical productivity benchmark survey has its own methodology to determine annualized wRVU benchmarks. The Clinical Work Week (CWW) value provided for each clinical faculty member is utilized to adjust the wRVU benchmark in the same way the clinical FTE is used to weight the blend of clinical compensation survey data.

Below are the definitions of Clinical Work Week used by MCP Practice:

	Weekly Effort for full time Clinical	CWW Value/Unit	Full time CWW
E&M Based			
E&M Based - Academic Standard	8 half days	1 half day = 0.111	0.89
E&M Based - Academic Community Standard	9 half days	1 half day = 0.111	1.00
Inpatient/Critical Care			
Note: Inpatient work expectations vary widely based on specialty. Departments should define expectations for a full time equivalent for inpatient work based on nuances of the specialty and determine effort based on that full time effort equaling 0.90.			
Procedural			
Procedural - Academic Standard	36 hours	1 hour = 0.025	0.90
Procedural - Academic Community Standard	40 hours	1 hour = 0.025	1.00
Radiology			
Radiology - Academic Standard	36 hours	1 hour = 0.025	0.90
Radiology - Academic Community Standard	40 hours	1 hour = 0.025	1.00
Emergency Medicine			
Emergency Medicine - Academic Standard	30 hours	1 hour = 0.0286	0.86
Emergency Medicine - Academic Community Standard	35 hours	1 hour = 0.0286	1.00
Anesthesia			
Anesthesia - Academic Standard	36 hours	1 hour = 0.025	0.90
Anesthesia - Academic Community Standard	40 hours	1 hour = 0.025	1.00
Pathology			
Pathology - Academic Standard	36 hours	1 hour = 0.025	0.90
Pathology - Academic Standard	40 hours	1 hour = 0.025	1.00

In assessing productivity benchmark data, wRVUs are normalized to a clinical workweek to have a common basis of comparison. This methodology is not consistently applied between the benchmark sources referenced above. Therefore, MCW took steps to determine which survey uses the most reliable methodology and align our comparisons to it, knowing that no single available source is “perfect.”

MCP and CSG Practices review the best available clinical productivity data sources for use as the standard productivity benchmarks. Based on reasons discussed below, MCP has selected Vizient as the primary source for clinical productivity benchmark data. Currently, Vizient is being used as the productivity benchmark for CSG; however, the Practice is evaluating the suitability of the Vizient benchmark. Note, for a few specialties, where Vizient benchmarks were unavailable, the Practice and academic unit leadership agree upon an alternate benchmark source.

On this basis, MCP has selected Vizient as the primary source for clinical productivity benchmarks for the following reasons:

1. Vizient Benchmarks are developed exclusively from other academic medical institutions.
2. MCW is currently submitting productivity data for both MCP and CSG to Vizient and clarity exists around the business rules in how the data are collected and reported.
3. Vizient does not use a “survey approach.” They utilize detailed data submitted by member organizations using structured business rules in providing productivity benchmarks based on a “study approach.”
 - a. Robust methodology for developing benchmarks includes a consistent methodology to measure wRVU’s/production across institutions.
 - b. Detail data submission from institutions allows in-depth analysis of benchmarks and development of custom benchmarks when necessary through the use of CPT codes.
4. Vizient productivity is normalized to one clinical work week (cFTE).

Conclusion MCP / Adult Specialty

The wRVU productivity differential between Vizient and the other clinical productivity surveys is due to the emphasis on cFTE adjustment of the productivity data. The other commercial surveys in general do not adjust, or even require cFTE data from submitting organizations and average in all data submitted. The statistical analysis demonstrates with a high degree of reliability the three main commercial surveys are within an acceptable statistical confidence interval. Vizient, whose methodology is documented above, is accounting for the time the other surveys allow to blend into their published results. By doing so, Vizient productivity data are more finely tuned to the actual time spent in clinical work, supported by the billing data provided by member institutions.

Conclusion CSG / Children’s Specialty.

The wRVU productivity differential between Vizient and the AAAP surveys is due to the emphasis on cFTE adjustment of the productivity data. Although there is limited information on the AAAP survey it does align with Vizient and is utilized to assess productivity measures for CSG.

Considerations for Benchmark Application

The directional accuracy of the benchmark data provides guidance to the decision-making process. Even though there will be some inconsistencies or issues, in most cases they are immaterial and still provide

value. Given the issues we know of, use caution and bear in mind the following:

- Many leading pediatric centers do not participate in the Vizient data collection.
- A limited number of pediatric specialty benchmarks exist. We have worked aggressively with Vizient to create “custom” benchmarks for additional specialties by drilling down and stratifying their existing data.
- For specialties where no Vizient benchmark exists, MCW has elected to use General Pediatrics or the adult benchmarks. Caution must be exhibited when analyzing the productivity measures for these specific sections.
- Advanced Practice Providers (APP’s) contribute significantly to the clinical effort. But their activities may be rolled into the physician productivity. Equally, they may be engaged in clinical activities that are not billable but free up physician time. This is an area needing further refinement by Vizient and other survey publishers, i.e. whether the APP generated RVUs are consistently included or excluded from the submitted physician data.
- For Faculty that have dual specialties, we do not currently have a way to weight or pull multiple specialties. This can cause discrepancies in the data and what their actual benchmarks should be.

Customized benchmarks

If there is a need for a customized benchmark, the department should partner with the Faculty Compensation Team to come up with the appropriate custom/blended benchmark based on the faculty role.

VII. Research Productivity

It is important to evaluate research productivity using criteria based upon the goals and ideals of the Institution. Measurements of research productivity continue to be a topic of discussion among academic medical centers at a national level as well as local to MCW. Certain metrics such as levels of grant funding, number and quality of publications, citation counts, national conference presentations, scholarly awards, recognition and prestige, as well as mission goals set by the Senior Associate Dean, provide context to research productivity, as assessed by the academic unit leadership. Due to the uniqueness of each individual research program, benchmarks still require individual context. In considering these benchmarks it is important to realize that each individual should be compared against peers within the same field of biomedical research.

VII. Evolution of FMV Benchmark Resources

How academic medical centers measure success will continue to evolve, driving the creation of new measures which will be needed to assess performance. The rigorous examination of benchmark sources currently used needs to continue as we adopt new measures for our business. As we evolve, a healthy balance must be found between using standard and consistent benchmarks versus managing “one off” and special case scenarios.

Appendix A: Fair Market Value (FMV) Business Rules

Faculty Compensation - Faculty Market Value (FMV)

Business Rule effective dates: To create standards and consistency in FMV year over year, the effective date of benchmark updates will be applied retroactively to the earliest date reflected in the BI systems (e.g. if there is a benchmarking change in 2025, it will be applied retroactively to the data in the BI system in year’s prior).

Faculty Survey Ranks:

- Instructor: rank in Oracle
- Assistant Professor: rank in Oracle, unless can be classified as Chief or Chair based on the Position Title
- Associate Professor: rank in Oracle, unless can be classified as Chief or Chair based on the Position Title
- Professor: rank in Oracle, unless can be classified as Chief or Chair based on the Position Title; excludes titles for Vice Chairs
- Chief: determined by position title that contains the word “Chief”
 - *Note: As of 7/1/2024, titles containing “Vice Chair” or “Associate Chair will no longer be classified using the faculty survey rank of “Chief” and will default to their rank in Oracle.*
- Chair: determined by position title that contains word “Chair”, unless can be classified as a Chief; excludes titles for Chief Officers

Compensation Survey Benchmark	Rules	Notes
AAMC (Compensation)	<p>*Used only for faculty without a AAAP specialty assigned in Oracle (e.g. MCP and NA faculty, or CSG faculty when there is no AAAP specialty available. Does not apply to approved exceptions (see Addendums for approved benchmark exceptions)</p> <p>Degree</p> <ul style="list-style-type: none"> • MD or equivalent • PhD or equivalent <p>Specialty</p> <ul style="list-style-type: none"> • Mapping from Oracle, plus historical specialty crosswalk by faculty by year <p>Rank</p> <ul style="list-style-type: none"> • Assistant Professor • Associate Professor • Professor • Chief (Special case for Neurology Chief with PhD being mapped to Professor benchmark – Dr. Sara Swanson) • Chair – use 3 year rolling average, All Schools <p>Other conditions</p> <ul style="list-style-type: none"> • Faculty only • Exclude faculty in Visiting positions • See Table 1 (below) for mapping to All Schools vs. Private Schools <p><i>Exclude: Instructor rank faculty, faculty with grades F207 and between F217- F227</i></p>	<p><u>Note:</u></p> <p><i>*Clinical specialties are mapped to “Private Schools”</i></p> <p><i>*Basic Science/ Non-clinical specialties are mapped to “All Schools”</i></p> <p><i>*Chairs mapped to “All Schools”</i></p>

<p>AAAP (Compensation and Productivity)</p>	<p>*Used only for CSG Practice faculty, or NA Practice faculty in the Department of Pediatrics (00350), when there is a AAAP specialty assignment in Oracle that corresponds to a AAAP Survey specialty</p> <p>Degree</p> <ul style="list-style-type: none"> • MD or equivalent • PhD or equivalent <p>Rank (AAAP Rank is based on academic ranks only)</p> <ul style="list-style-type: none"> • Assistant Professor • Associate Professor • Professor <p>Specialty: Mapping from Oracle effective 7/1/2023</p> <ul style="list-style-type: none"> • Mapping from Oracle (if AAAP specialty is listed in Oracle), plus historical specialty crosswalk by faculty by year. <p>Other conditions</p> <ul style="list-style-type: none"> • Faculty in CSG Practice only • Include faculty in “NA” Practice within the Department of Pediatrics • Chiefs with PhD or Equivalent Degree that meet conditions of CSG practice or “NA” faculty within the Department of Pediatrics • <i>(If no AAAP benchmark listed in Oracle AAAP specialty field, default to AAMC specialty benchmark)</i> • Exclude faculty in Visiting positions • <i>Exclude faculty: Instructor rank faculty, faculty with grades F207 and between F217- F227</i> • <i>Exclude MCP faculty</i> 	<p><i>Note: only Total Compensation benchmark is used.</i></p>
<p>AAAP Leadership (Compensation)</p>	<p>* Used only for CSG Chiefs and Chiefs within the Department of Pediatrics and Practice of NA</p> <p>Degree</p> <ul style="list-style-type: none"> • MD or equivalent only <p>Rank (AAAP Rank is based on academic ranks only)</p> <ul style="list-style-type: none"> • Assistant Professor • Associate Professor • Professor <p>Specialty: Mapping from Oracle effective 7/1/2023</p> <ul style="list-style-type: none"> - Mapping from Oracle (if there is a AAAP specialty in Oracle), plus historical specialty crosswalk by faculty by year. <i>Previously was mapped according to specialty crosswalk by faculty member by year.</i> <p>Other conditions</p> <ul style="list-style-type: none"> • CSG Faculty Only <i>(if there is no AAAP benchmark available, default to AAMC)</i> • Exclude faculty in Visiting positions <p><i>Exclude: Instructor rank faculty, faculty with grades F207 and between F217- F227, PhD or Equivalent Degree</i></p>	<p><i>Note: only Total Compensation benchmark is used.</i></p> <p><i>Only Applies to MD or Equivalent Degree. PhD or Equivalent Degree will default to AAAP Compensation above.</i></p>
<p>MGMA (Acad) <i>Noted for historical/future for Compensation benchmarking use. No specialties are currently</i></p>	<p>Degree</p> <ul style="list-style-type: none"> • MD or equivalent • PhD or equivalent <p>Specialty: <i>Mapped according to specialty crosswalk by faculty member by year</i></p> <p>Rank</p> <ul style="list-style-type: none"> • Assistant Professor • Associate Professor 	

<p><i>benchmarked to this survey.</i></p>	<ul style="list-style-type: none"> • Professor • Chief (mapped to “Division Chair/Chief” in the survey) • Chair (mapped to “Department Chair” in the survey) <p>Other conditions</p> <ul style="list-style-type: none"> • Faculty only; exclude faculty in Visiting positions • Exclude all Basic Science departments <p><i>Exclude: Instructor rank faculty, faculty with grades F207 and between F217- F227</i></p>	
<p>MGMA (Physician Comp and Productivity)</p>	<p>Degree</p> <ul style="list-style-type: none"> • MD or equivalent • PhD or equivalent <p>Specialty: <i>Mapped according to specialty crosswalk by faculty member by year</i></p> <p>Other conditions</p> <ul style="list-style-type: none"> • Must have clinical FTE or external FTE • Include Staff Physicians • Exclude faculty in Visiting positions • <i>Exclude faculty: Instructor rank faculty, faculty with grades F207 and between F217- F227</i> 	
<p>Sullivan Cotter (Comp and productivity)</p>	<p>Degree</p> <ul style="list-style-type: none"> • MD or equivalent • PhD or equivalent <p>Specialty: <i>Mapped according to specialty crosswalk by faculty member by year</i></p> <p>Clinical Benchmark Position Level</p> <ul style="list-style-type: none"> • MDs mapped to “Staff Physician” • Chiefs mapped to “Med. Director/Div. Chief” • PhDs with MCW specialties listed above mapped to “Clinician/Researcher” <p>Other conditions</p> <ul style="list-style-type: none"> • Exclude faculty in Visiting positions <p><i>Exclude: Instructor rank faculty, faculty with grades F207 and between F217- F227</i></p>	<p><u>Note:</u> *National data only *Use “Physicians” tab for MDs *Use “Total Cash Compensation” values</p>
<p>AMGA (Productivity Only)</p>	<p>Degree</p> <ul style="list-style-type: none"> • MD or equivalent • PhD or equivalent with MCW specialties listed above <p>Specialty / Specialty Group</p> <ul style="list-style-type: none"> • MDs are mapped to specialties in Medical, Surgical, and Radiology/ Anesthesiology/ Pathology groups • PhDs are mapped to Midlevel Provider group <p>Other conditions</p> <ul style="list-style-type: none"> • Include Staff Physicians • Exclude faculty in Visiting positions <p><i>Exclude: Instructor rank faculty</i></p>	

Benchmark	Rules
Vizient (UHC) Productivity	Sub-Specialty: <i>Mapped based on entries in Oracle</i> Other conditions <ul style="list-style-type: none"> Several custom sub-specialties have been developed over the years and are governed by MCP or CSG. <i>Exclude: Instructor rank faculty</i>
AAAP Productivity	Sub-Specialty: <i>Mapped according to entries in Oracle.</i> Other conditions <ul style="list-style-type: none"> CSG Faculty Only Exclude faculty in Visiting positions <i>Exclude: Instructor rank faculty</i>
AAARAD Productivity	Sub-Specialty: <i>Mapped according to MCW specialty related to radiology.</i> Degree: M.D. only Other conditions <ul style="list-style-type: none"> Benchmarks supplied by the Department of Radiology <i>Exclude: Instructor rank faculty</i>
Other mapped productivity benchmarks	AMGA, MGMA Physician, Sullivan Cotter (clinical) – see mapping rules in the compensation section of this document. Sullivan Cotter Productivity Benchmarks <ul style="list-style-type: none"> Faculty within the Department of Ophthalmology (318) and with an MCW specialty of “Ophthalmology-Medical Retina” should use “Ophthalmology – Medical Retina” benchmark <i>Exclude: Instructor rank faculty</i>

Table 1. AAMC Survey Table Mapping

As a general rule, clinical faculty/providers are benchmarked against “Private Schools” AAMC benchmarks, whereas academic faculty are benchmarked against “All Schools.”

Department Type	Degree	AAMC Specialty Grouping	AAMC School Subset
Clinical	MD or equivalent	Clinical	<i>Private Schools</i>
Clinical	MD or equivalent	Non-clinical/Basic Science	<i>All Schools</i>
Clinical	PhD or equivalent	Clinical	<i>Private Schools</i>
Clinical	PhD or equivalent	Non-clinical/Basic Science	<i>All Schools</i>
Non-Clinical	MD or equivalent	Clinical	<i>All Schools</i>
Non-Clinical	MD or equivalent	Non-clinical/Basic Science	<i>All Schools</i>
Non-Clinical	PhD or equivalent	Clinical	<i>All Schools</i>
Non-Clinical	PhD or equivalent	Non-clinical/Basic Science	<i>All Schools</i>
Department Chairs	MD or equivalent	Clinical Non-clinical/Basic Science	<i>All Schools</i>
Department Chairs	PhD or equivalent	Clinical Non-clinical/Basic Science	<i>All Schools</i>

Compensation Benchmarks Value Comparisons

Benchmark	Calculations
Chairs	<p>* Calculated for all Chairs <i>Note: use aged 3 year rolling average</i> Benchmark: AAMC benchmark, All Schools, x Total FTE Rank: Chair</p>
Chiefs	<p>*Calculated for Pediatric Cardiothoracic Surgery Chiefs with MD degree in Department of Surgery (000302) Benchmark: Sullivan Cotter Medical Director/Division Chief x Total FTE</p> <p>*Calculated for Pediatric Neurosurgery Chiefs with MD degree in Department of Neurosurgery (000340) Benchmark: Sullivan Cotter Medical Director/Division Chief x Total FTE</p> <p>*Calculated for Pediatric Ophthalmology Chiefs with MD degree and MCW Specialty of “Pediatrics-Ophthalmology” in the Department of Ophthalmology (000318) Benchmark: Sullivan Cotter Medical Director/Division Chief x Total FTE</p> <p>*Calculated for CSG Practice Chiefs with PhD Degree with a MCW Specialty of Pediatrics – Neuropsychology in the Department of Neurology (000313) or Psychology (000326) Benchmark: AAMC benchmark x Total FTE Rank: Chief</p> <p>*Calculated for Pediatric Physical Medicine and Rehabilitation Chiefs with MD degree in Department of Physical Medicine and Rehabilitation (000325) Benchmark: AAMC benchmark x Total FTE Rank: Chief</p> <p>*Calculated for Pediatric Psychologist Chiefs with PhD degree with MCW Specialty of Psychologist-Child/Adolescent across all departments Benchmark: AAMC benchmark x Total FTE Rank: Chief</p> <p>* Calculated for Chiefs with MD Degree in Practice of CSG and Department of Pediatrics with practice of NA: exclude CSG Cardiothoracic Surgery Chiefs with MD Degree in the Department of Surgery (000302), exclude CSG Neurosurgery Chiefs with MD in Department of Neurosurgery (000340), exclude CSG Ophthalmology Chiefs with MD in department of Ophthalmology (000318), exclude CSG Physical Medicine and Rehabilitation Chiefs with MD in department of Physical Medicine and Rehabilitation (000325) Benchmark: AAAP Leadership benchmark x Total FTE. If AAAP is not available, AAMC benchmark x Total FTE</p> <p>* Calculated for Chiefs: excluding all Chiefs noted above; <i>Note: includes specialty benchmark exceptions utilizing MGMA or Sullivan Cotter</i> Benchmark: AAMC benchmark x Total FTE Rank: Chief</p>

Anesthesiology	<p>*Calculated for faculty members in the Department of Anesthesiology (305) with a MCW Specialty of “Anesthesiology-Cardiac” and with MD Degree Benchmark: Sullivan Cotter: (aged, raw survey values, + rank adjustment if applicable) Anesthesiology – Cardiovascular x Total FTE Rank: Associate Professor, Professor ranks: aged, raw survey values Assistant Professor rank: adjusted benchmark for Assistant Professor</p> <p>*Calculated for faculty members in the Department of Anesthesiology (305) with a MCW Specialty of “Anesthesiology-Community” and with MD Degree Benchmark: MGMA Physician: (aged, raw survey values, with no rank adjustment) Anesthesiology x Total FTE Rank: All ranks: aged, raw survey values</p>
Dermatology	<p>*Calculated for faculty members in the Department of Dermatology (328) with a MCW Specialty of “Dermatopathology” and with MD Degree Benchmark: MGMA Physician: (aged, raw survey values, + rank adjustment if applicable) Dermatology: Dermatopathology x Total FTE Rank: Associate Professor, Professor ranks: aged, raw survey values Assistant Professor rank: adjusted benchmark for Assistant Professor</p>
Emergency Medicine	<p>* Calculated for faculty members in the Department Emergency Medicine (000342) with a MCW Specialty of “Emergency Medicine - Hybrid” and with MD Degree Benchmark: 50% AAMC Emergency Medicine + 50% MGMA Physician Rank: AAMC: use rank adjustment MGMA Physician: (aged, raw survey values, with no rank adjustment)</p> <p>* Calculated for faculty members in the Department of Emergency Medicine (000342) with a MCW Specialty of “Emergency Medicine – Community” and with MD Degree Benchmark: MGMA Physician: (aged, raw survey values, with no rank adjustment) Emergency Medicine x Total FTE Rank: All ranks: aged, raw survey values</p>
Ophthalmology Dept.	<p>*Calculated for faculty members in the Department of Ophthalmology (318) with a MCW Specialty of “Optometrist” Benchmark: MGMA Physician Optometrist x Total FTE Rank: Associate Professor, Professor ranks: aged, raw survey values Assistant Professor rank: adjusted benchmark for Assistant Professor</p> <p>*Calculated for faculty members in the Department of Ophthalmology (318) with a MCW Specialty of “Ophthalmology” and with MD Degree Benchmark: MGMA Physician: Ophthalmology x Total FTE Rank: Associate Professor, Professor ranks: aged, raw survey values Assistant Professor rank: adjusted benchmark for Assistant Professor</p> <p>*Calculated for faculty members in the Department of Ophthalmology (318) with a MCW Specialty of “Ophthalmology-Cornea” and with MD Degree Benchmark: MGMA Physician: (aged, raw survey values, + rank adjustment if applicable) Ophthalmology: Cornea and Refractive Surgery x Total FTE</p>

Rank:	Associate Professor, Professor ranks: aged, raw survey values Assistant Professor rank: adjusted benchmark for Assistant Professor
*Calculated for faculty members in the Department of Ophthalmology (318) with a MCW Specialty of “Ophthalmology-Glaucoma” and with MD Degree	
Benchmark:	Sullivan Cotter: Staff Physician (aged, raw survey values, + rank adjustment if applicable) Ophthalmology – Glaucoma x Total FTE
Rank:	Associate Professor, Professor ranks: aged, raw survey values Assistant Professor rank: adjusted benchmark for Assistant Professor
*Calculated for faculty members in the Department of Ophthalmology (318) with a MCW Specialty of “Ophthalmology-Medical Retina” and with MD Degree	
Benchmark:	Sullivan Cotter: Staff Physician (aged, raw survey values, + rank adjustment if applicable) Ophthalmology – Medical Retina x Total FTE
Rank:	Associate Professor, Professor ranks: aged, raw survey values Assistant Professor rank: adjusted benchmark for Assistant Professor
*Calculated for faculty members in the Department of Ophthalmology (318) with a MCW Specialty of “Ophthalmology-Medical” and with MD Degree	
Benchmark:	Sullivan Cotter: Staff Physician (aged, raw survey values, + rank adjustment if applicable) Ophthalmology – Medical x Total FTE
Rank:	Associate Professor, Professor ranks: aged, raw survey values Assistant Professor rank: adjusted benchmark for Assistant Professor
*Calculated for faculty members in the Department of Ophthalmology (318) with a MCW Specialty of “Ophthalmology-Neuro” and with MD Degree	
Benchmark:	Sullivan Cotter: Staff Physician (aged, raw survey values, + rank adjustment if applicable) Ophthalmology – Neuro-Ophthalmology x Total FTE
Rank:	Associate Professor, Professor ranks: aged, raw survey values Assistant Professor rank: adjusted benchmark for Assistant Professor
*Calculated for faculty members in the Department of Ophthalmology (318) with a MCW Specialty of “Ophthalmology-Oculoplastics” and with MD Degree	
Benchmark:	Sullivan Cotter: Staff Physician (aged, raw survey values, + rank adjustment if applicable) Ophthalmology – Oculoplastic Surgery x Total FTE
Rank:	Associate Professor, Professor ranks: aged, raw survey values Assistant Professor rank: adjusted benchmark for Assistant Professor
*Calculated for faculty members in the Department of Ophthalmology (318) with a MCW Specialty of “Ophthalmology-Surgical Retina” and with MD Degree	
Benchmark:	MGMA Physician: (aged, raw survey values, + rank adjustment if applicable) Ophthalmology: Retina x Total FTE

	<p>Rank: Associate Professor, Professor ranks: aged, raw survey values Assistant Professor rank: adjusted benchmark for Assistant Professor</p> <p>* Calculated for faculty members in the Department of Ophthalmology (318) with a MCW Specialty of “Pediatrics-Ophthalmology” and with MD Degree</p> <p>Benchmark: Sullivan Cotter: (aged, raw survey values, + rank adjustment if applicable) Pediatrics: Ophthalmology x Total FTE</p> <p>Rank: Associate Professor, Professor ranks: aged, raw survey values Assistant Professor rank: adjusted benchmark for Assistant Professor</p>
OB/GYN Dept	<p>*Calculated for faculty members in the Department of Obstetrics and Gynecology (316) with either a MCW Specialty of “OB/GYN-MIGS” OR “OB/GYN-Urogynecology” and with MD Degree</p> <p>Benchmark: MGMA Physician: (aged, raw survey values, + rank adjustment if applicable) OB/GYN: Urogynecology x Total FTE</p> <p>Rank: Associate Professor, Professor ranks: aged, raw survey values Assistant Professor rank: adjusted benchmark for Assistant Professor</p>
Pathology	<p>*Calculated for faculty members in the Department of Pathology (322) with a MCW Specialty of “Pathology-Community” and with MD Degree</p> <p>Benchmark: MGMA Physician: (aged, raw survey values, with no rank adjustment) Pathology: Anatomic x Total FTE</p> <p>Rank: All ranks: aged, raw survey values</p>
Pediatrics	<p>* Calculated for faculty members in the Department of Pediatrics (000350) with an MCW Specialty of Pediatrics-Neonatology-Community and with MD Degree</p> <p>Benchmark: MGMA Physician: (aged, raw survey values, with no rank adjustment) Pediatrics: Neonatal Medicine x Total FTE</p> <p>Rank: All ranks: aged, raw survey values</p> <p>* Calculated for faculty members in the Department of Pediatrics (000350) MCW Specialty of Pediatrics-Hospitalist-Community and with MD Degree</p> <p>Benchmark: MGMA Physician: (aged, raw survey values, with no rank adjustment) Pediatrics Hospitalist x Total FTE</p> <p>Rank: All ranks: aged, raw survey values</p>
Psychology (all departments)	<p>* Calculated for faculty members with an MCW Specialty of Psychologist-Child/Adolescent with PhD Degree across all departments</p> <p>Benchmark: AAMC: Psychology-Peds., Private Schools x Total FTE</p>
Physical Medicine & Rehabilitation	<p>* Calculated for faculty members in the Department of Physical Medicine and Rehabilitation (000325) and the Division of Pediatric (000358) with MD Degree</p> <p>Benchmark: AAMC: Physical Medicine and Rehabilitation, Private Schools x Total FTE</p>
Neuropsychology (all departments)	<p>* Calculated for faculty members in CSG Practice with a MCW Specialty of Pediatrics – Neuropsychology with PhD Degree</p> <p>Benchmark: AAMC: Neurology (PhD), Private Schools x Total FTE</p>
Neurosurgery	<p>*Calculated for faculty members in the Department of Neurosurgery (340) with a MCW Specialty of “Neurosurgery-Community” and with MD Degree</p>

	<p>Benchmark: MGMA Physician: (aged, raw survey values, with no rank adjustment) Surgical: Neurological x Total FTE Rank: All ranks: aged, raw survey values</p> <p>* Calculated for Pediatric Neurosurgery faculty in Department of Neurosurgery (00340) and with MD Degree Benchmark: Sullivan Cotter Pediatric – Neurological Surgery x Total FTE Rank: Associate Professor, Professor ranks: aged, raw survey values Assistant Professor rank: adjusted benchmark for Assistant Professor</p>
Radiation Oncology	<p>* Calculated for faculty members in the Department of Radiation Oncology (335) with a MCW Specialty of “Radiation Oncology Physics” Benchmark: American Association of Physicists in Medicine Survey (aged, raw survey values), PhD Degrees – With Certification Rank: Apply AAPM Survey rank</p>
Surgery	<p>* Calculated for faculty members in the Department of Surgery with a MCW Specialty of Surgery -Thoracic and with MD Degree Benchmark: MGMA: (aged, raw survey values, + rank adjustment if applicable) Surgery: Thoracic (Primary) x Total FTE Rank: Associate Professor, Professor ranks: aged, raw survey values Assistant Professor rank: adjusted benchmark for Assistant Professor</p> <p>* Calculated for CSG Practice Pediatric Cardiothoracic Surgery faculty with Department of Surgery (000302) and with MD Degree Benchmark: Sullivan Cotter Pediatrics Cardiothoracic Surgery x Total FTE Rank: Associate Professor, Professor ranks: aged, raw survey values Assistant Professor rank: adjusted benchmark for Assistant Professor</p>
Neurology	<p>* Calculated for faculty members in the Department of Neurology (000313) with a MCW Specialty of Neurology-Oncology and with MD Degree Benchmark: SC: (aged, raw survey values, + rank adjustment if applicable) Oncology – Neuro-Oncology x Total FTE Rank: Associate Professor, Professor ranks: aged, raw survey values Assistant Professor rank: adjusted benchmark for Assistant Professor</p>
All Others	<p>* Calculated for all MD & PhD faculty; excludes Chiefs, Chairs, and groups of faculty named above AAAP Benchmark: AAAP benchmark x Total FTE. If AAAP is not available, default to AAMC Benchmark below AAMC Benchmark: AAMC benchmark x Total FTE <i>Note: faculty outside of CSG practice with a pediatric specialty should be benchmarked against AAMC</i></p>
Total Comp/ FMV	<p>Faculty actual total comp: Base Compensation (includes Base, Supplemental, Premium Pay) + Incentives (includes incentive payments, bonuses) + External Pay Benchmark: Total Compensation benchmark FTE: Total FTE (includes Clinical + Research + Education + Community Engagement + Departmental FTE)</p>

Productivity Benchmarks

Benchmark	Calculations
Productivity Units	<p>Faculty actual (Anesthesiology, excluding Anesthesiology-Pain Management): AVUs Faculty actual (non-Anesthesiology, except Anesthesiology-Pain Management): wRVUs</p> <p>Typical productivity benchmark calculation: cFTE Prod x Vizient (UHC) benchmark by specialty</p>

	<p>Exceptions:</p> <ul style="list-style-type: none"> Benchmark MCP (MDs in Anesthesiology and PhDs in Psychology specialties): cFTE Prod X Average Units (AMGA + MGMA-Physician + Sullivan Cotter clinical) <i>Exception within the group: Faculty with Vizient (UHC) specialties “Psychology: Inpatient Consult” and “Neuropsychology” (Neuropsychology effective FY 2022) are benchmarked against Vizient instead of benchmark blend</i> Benchmark for CSG faculty within AAAP benchmark listed in Oracle, this includes CSG PhD Psychology: cFTE Prod x AAAP benchmark by sub-specialty Benchmark for CSG faculty with MCW specialty of Pediatric-Anesthesiology: cFTE Prod x AMGA specialty by sub-specialty Benchmark for department of Radiology (000330): cFTE Prod x AAARAD benchmark by sub-specialty Benchmark for department of Ophthalmology (000318) with MCW specialty of “Ophthalmology-Medical Retina”: cFTE Prod x Sullivan Cotter benchmark of “Ophthalmology – Medical Retina”
Payments	<p>Faculty actual: Payments Benchmark: Average Payments (AMGA + MGMA-Physician + Sullivan Cotter clinical) x Clinical Work Week</p>

Appendix B: Revision History

Date	Author	Change Reason
10/1/13	Kevin Eide, Jeff Morrow	Original Draft
11/15/13	Kevin Eide, Jeff Morrow	Added benchmark statistics
12/21/13	Kevin Eide	Minor editorial revisions from Executives
1/6/14	Kevin Eide, Jeff Morrow	Additional benchmark statistical edits and formatting
4/2/14	Kevin Eide	Edits from Drs. Raymond and Kerschner
11/25/14	Kevin Eide	Incorporate significant edits from CSG, Research, and ICC
02/16/15	Lorie Howard	Edits to FMV comp benchmark calculation for Chairs
09/27/18	Compensation Team	Annual Review; updated language throughout document.
07/07/2021	Compensation Team	Annual Review; updated language and business rules
1/23/2025	Faculty Compensation Team	Add Ophthalmology department business rules (approved by ICC), update AAAP business rules (assigned in Oracle vs. Crosswalk), remove departmental FMV benchmarking methodology for Vice Chairs and Associate Chairs
8/1/2025	Faculty Compensation Team	Added practice and ICC approved benchmark exceptions business rules

