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# The Power of the MGMA Pay to Production Plotter

AN MGMA DATADIVE RESOURCE

**MGMA**<sup>®</sup>

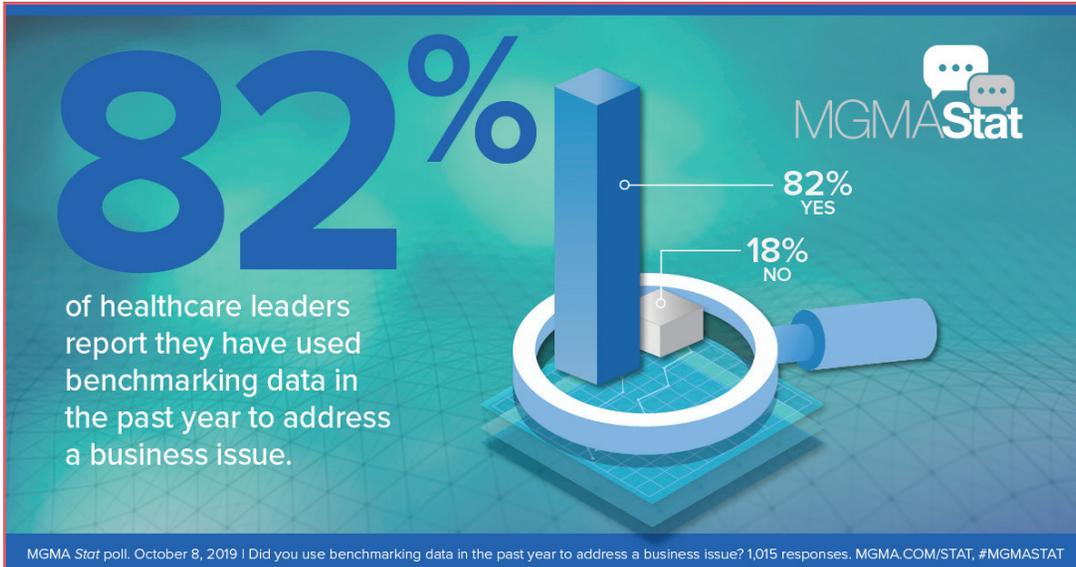
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# Introduction

According to a recent **MGMA Stat poll**, 82% of healthcare leaders reported using benchmarking data in the past year to address a business issue. Respondents identified compensation and productivity as the two most utilized benchmarking areas in their practices.



The combination of compensation and productivity benchmarking is crucial in setting up a physician compensation strategy. “Building a successful compensation plan is not an easy process and has the added peril of creating real or perceived inequities among the practice’s providers. There is a very complex relationship between incentives and compensation levels; only examining median information provides a very limited view,” says David N. Gans, MSHA, FACMPE, senior fellow, MGMA.

One tool to simplify the complexity of provider compensation data is the **MGMA DataDive Pro Report Builder’s Pay to Production Plotter**, which displays the actual distribution of the database on two axes, showing each provider’s compensation and work RVU (wRVU) production.

**Watch this three-minute overview of the Pay to Production Plotter tool at [mgma.com/powerptpp](https://mgma.com/powerptpp).**

This report will help you gain a deeper understanding of the relationship between provider compensation and productivity through using MGMA DataDive’s Pay to Production Plotter. After exploring a case study and a few use cases, your organization will be ready to get the most out of this powerful tool.

**Gans says: “One of the principles of evidence-based management is that good decisions are based on good data. The interrelationship of provider production and their compensation is extremely complex, and a healthcare executive wanting to better understand the dynamic requires substantial information from within the practice as well as external benchmarks. Fortunately, with the right tools and data reports it is possible to view the big picture and to understand and manage even the most complex problem.”**

## CASE STUDY

### DETERMINING THE RIGHT FIT FOR COMPENSATION

#### PROFILE

A physician-owned group that maintained a robust private (outpatient) practice but also provided hospitalist coverage to a local hospital.

#### CHALLENGE

**Interested parties within the physician group were reviewing ways to streamline how providers were compensated for work provided in the private practice and for time spent covering hospital shifts.** To do this, they brought in an outside party, Luis Argueso, partner, Healthcare Appraisers Inc., Denver, to help determine the best fit for their practice.

“In their private practice, the physicians were used to being paid on a production-basis because they had sufficient volume to keep themselves busy and were able to manage the schedules of their private practice. However, when they provided coverage to the hospital, these same factors no longer applied — the majority of their work was unscheduled, and they had to remain at the hospital regardless of the patient volume at a given time,” Argueso said.

The providers had traditionally been compensated on a per-wRVU basis for both cases: work in the clinic and work in the hospital rather than a per-shift basis for hospital shifts and a per-wRVU basis for work in the clinic. **The providers advocated to keep a per-wRVU basis for compensation for both situations, due to the fact that they often rotated between outpatient and hospital care settings.**

Argueso noted that the wRVU basis made sense in the outpatient setting because the work was scheduled rather than emergent but questioned whether the wRVU basis made sense in the hospital scenario.

“It’s not usual for this specialty to be compensated like this, as the work performed on a hospitalist’s shift is difficult to schedule, and engagements with patients are often emergent,” Argueso said. “The parties wanted to offer fair compensation for the hospital-based services and originally started by considering a production-based compensation plan for the work done at the hospital. However, neither party could agree on a rate of compensation per wRVU.”

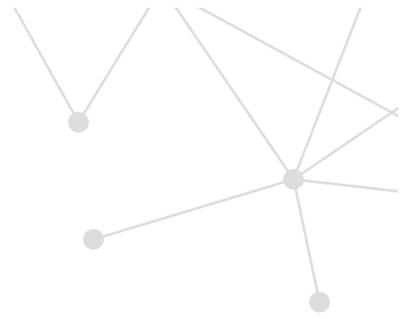
**Argueso decided to analyze the pros and cons of modifying the providers’ compensation plans.**

#### SOLUTION

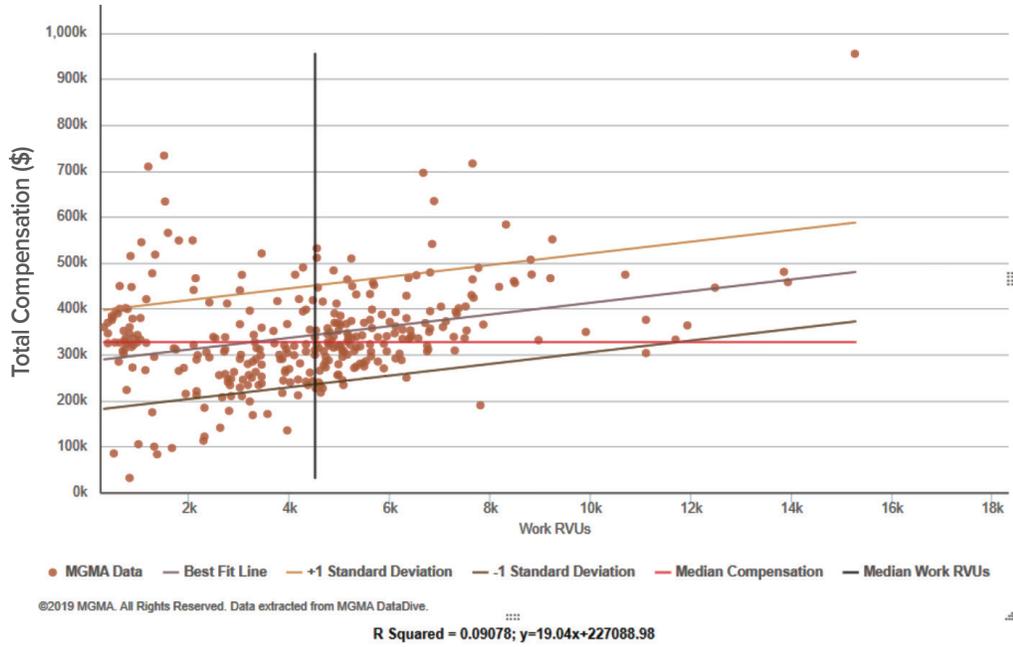
**To illustrate the difference between how the two care settings are compensated, Argueso used the MGMA Pay to Production Plotter to show the client the scatter plots for two differing specialties: hospitalist medicine and orthopedic surgery.**

**When they looked specifically at hospitalist data, there was almost no correlation between compensation and production.** This is because for hospitalists, compensation is tied to how many shifts providers work. On the other hand, orthopedic surgery shows a very strong correlation in that compensation tends to increase as production increases.

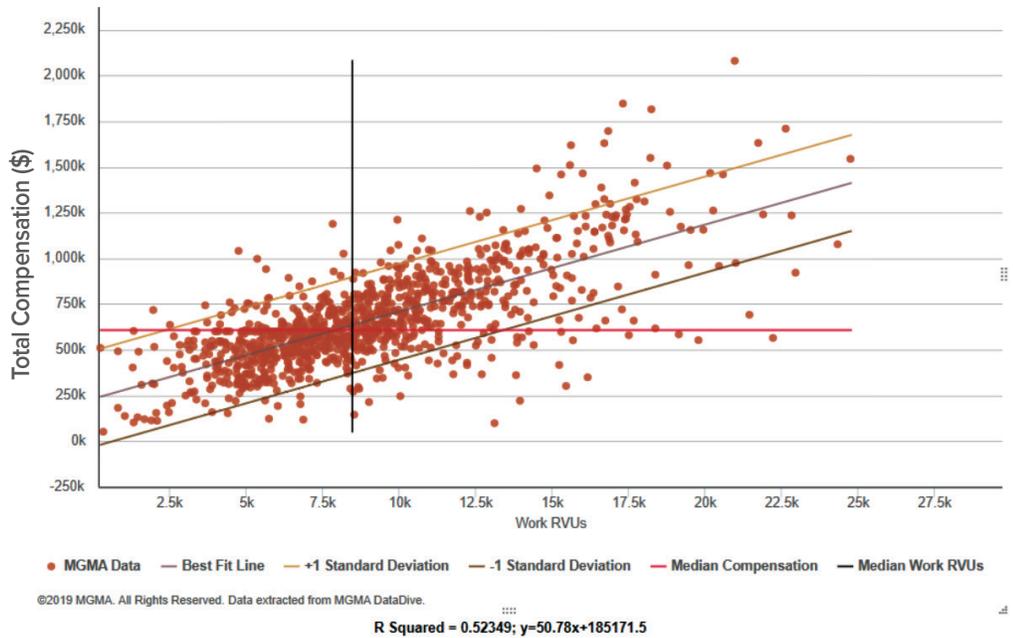
**“In evaluating the Pay to Production Plotter, it was clear that hospital-based specialties (e.g., hospitalists) had a very low correlation between compensation and wRVU production.** The tool allowed the parties to see that the compensation structure would put the physicians at unusual places on the plot of compensation to production.”



## 2018 Hospitalist: Family Medicine Compensation and wRVUs Plotter



## 2018 Orthopedic Surgery: General Compensation and wRVUs Plotter



## RESULTS

Argueso found that simply analyzing the compensation and productivity data for these two specialties does not clearly illustrate their correlation or lack of one. **However, using the Pay to Production Plotter was a game-changer since it visually depicted the relationship between the benchmarks.**

### Hospitalist: Family Medicine

BENCHMARK	GROUPS	PROVIDERS	10TH %ILE	25TH %ILE	MEDIAN	75TH %ILE	90TH %ILE
Hours per week	17	53	36	40	40	40	41
Total encounters	5	36	1,196	1,791	2,610	3,212	3,563
wRVUs	49	318	879	2,632	4,517	5,641	7,336

Source: 2019 MGMA DataDive Provider Compensation

**“As a result, the parties agreed to evaluate shift-based compensation for shifts taken at the hospital.** When mapping the compensation using this payment structure to the Pay to Production Plotter, it was clear that the physicians would earn fair compensation that made all parties happy and was compliant with the law,” Argueso concluded.

**“In addition to the Pay to Production Plotter, we also looked at MGMA data related to other production benchmarks (e.g., encounters and hours worked) to help validate our findings and further convince the parties of the logic of the new compensation plan.”**

**— Luis Argueso, partner, Healthcare Appraisers Inc., Denver**

## UNDERSTAND THE TERMINOLOGY USED BY THE TOOL:

- **R<sup>2</sup> value:** Known as the coefficient of determination, this value is the degree that variation in compensation is explained by the linear regression line in the Pay to Production Plotter. R<sup>2</sup> values closer to 1 indicate a stronger correlation, or relationship, in the dataset, whereas R<sup>2</sup> values closer to 0 indicate a weaker correlation.
- **Best fit line:** A line through a scatter plot of data points that best expresses the relationship between those points.
- **Percentile:** A measure used in statistics indicating the value below which a given percentage of observation in a group of observations falls. For example, the 20th percentile is the value below which 20% of the observations may be found.
- **Standard deviation:** In lay terms, standard deviation refers to how spread out or scattered the responses are from the mean. The higher the standard deviation, the wider the data.

## USE CASE: ZEROING IN ON THE RIGHT FIGURE

Jonathan Sheridan, CVA, medical consultant, Medical Management Associates, Inc., Atlanta.

### HOW DO YOU UTILIZE THE PAY TO PRODUCTION PLOTTER?

I have been using this tool since MGMA came out with it on the CD version. I think **it's a great illustration of where a physician's compensation and productivity lines up with MGMA's actual respondents within the same specialty, which we use often in conjunction with fair market valuations of physician compensation for medical groups, hospitals and health systems.** The tool also allows the user to further refine the MGMA data points to only include respondents with similar practice characteristics (e.g., size, location, employment arrangement) to that of the subject physician; something that is lacking in other commonly referenced benchmark surveys. By clicking on a data point on the plotter, you can see the respondents' compensation and productivity, not just data normalized into quartiles. I use it when conducting compensation valuations as a kind of gut check to see whether I need to dive into greater detail on the relationship between the physician's compensation and productivity.

The first thing I do is research the general benchmarks from MGMA for productivity and compensation for a given specialty and see how those figures line up to the subject physician. I will then plot the physician's compensation and productivity to see how it matches up to his or her peers. From the plot we can ask: Is the physician's compensation and productivity commensurate with his or her peers based on data parameters selected? Is he or she within one standard deviation of MGMA's best fit line? If not, then let's analyze why not. If so, okay, the compensation appears to be reasonable based on the productivity.

### FOR WHAT TYPE OF SCENARIOS DO YOU USE THE PAY TO PRODUCTION PLOTTER?

We typically use the Pay to Production Plotter tool when conducting compensation valuations, assessing productivity-based compensation arrangements and reviewing second-generation compensation arrangements. We also frequently use this tool to provide a powerful visual of the compensation arrangement to our clients or the physician in question. **From an illustrative standpoint, you are able to show where their current compensation is, where it'll be on this new proposed plan and how it aligns with everyone else.**

We have found **the tool is particularly useful when you have part-time physicians who are paid solely on a compensation per-wRVU basis.** This tool allows you to ask: "Does your productivity justify your compensation?" We know in a specialty such as primary care you might have a lot of part-time physicians, so comparing these part-time physicians to full-time physician benchmarks may not be appropriate. What we can say is, "let's just benchmark your productivity compared to your compensation and see how that lines up on the Pay to Production Plotter tool." That'll give us a good gut check on whether your productivity can justify a certain level of compensation.

### LESSONS LEARNED

The advice I would give to anybody working on any new system is to take some time and play around in it. Input some data, change the parameters and see how the results differ. This will help you understand what the reports are really telling you. From there, you can make educated recommendations and conclusions based on the data.



## TYPICAL USE CASES FOR THE MGMA PAY TO PRODUCTION PLOTTER

### PHYSICIAN CONTRACTING

In physician contracting and negotiation situations, use the Pay to Production Plotter to plot the provider's compensation and productivity and compare against others in their specialty.

Jay Moore, CMPE, executive director, Hays Medical Center, Hays, Kan., often takes the following approach with physician contract negotiations.

- Moore presents to the physician what he and his team believe is a fair contract in terms of compensation and other factors. In his experience, a physician will oftentimes want to negotiate for higher compensation, citing productivity as a factor.
- Moore and his team use the Pay to Production Plotter to plot the physician's requested compensation based on his or her specialty. With this, they are able to show physicians a visual representation of their request and answer the questions: "Is the negotiation request something that makes sense? Or is it way outside of reason based on the data?"

"I think anybody who employs physicians should really look at the tool, just to see how close they are to the rest of the country ... **I think a lot of people already look at the compensation data, but the question is: 'How does that relate to production? It is really important to understand this,'** Moore says.

## COMPENSATION VS. PRODUCTIVITY ANALYSIS

When building appropriate and fair compensation plans, the Pay to Production Plotter succinctly illustrates the correlation between provider compensation and productivity by specialty.

Luis Argueso, CVA, partner, Healthcare Appraisers Inc., Denver, utilizes the Pay to Production Plotter when trying to understand how a physician compares to others in regard to his or her current productivity and compensation.

By viewing specific data points in the plotter, Argueso can better understand where each provider lies on the spectrum and the relationship between their compensation and their productivity, beyond just looking at the data for each percentile.

“This tool is especially useful for some of the exceptionally productive providers that might be in the higher percentiles for productivity,” Argueso noted. “It helps us answer the questions: ‘Are you really an exception to the rule? Or are there other providers out there with similar data?’ Physicians want to see something in their hands demonstrating how they stack up against their peers.”



The power of the tool is in its data visualization, which can be compelling in contract negotiations and help both parties understand whether the negotiation request makes sense. For visual learners, this tool can be very powerful in helping practices understand what their data means. It illustrates that more productive physicians do not necessarily receive higher pay rates.

Additionally, the  $R^2$  value and best fit line can be very helpful when viewing the Pay to Production Plotter. For example, when using the tool to plot a provider's proposed compensation and current productivity, if the plot falls far outside of best fit line, you can advise that the compensation be adjusted fairly.



## PROFESSIONAL SERVICES AGREEMENTS (PSAs)

For healthcare appraisers working with practices on PSAs or with those considering a sale to a hospital system, the Pay to Production Plotter can be an educational tool for practices, in that it visually depicts each provider's performance as it relates to their pay.

Darcy Devine, ASA, CVA, healthcare appraiser, Buckhead FMV, Atlanta, works with privately owned physician practices either considering a sale to a hospital system or professional services agreement (PSA) with a hospital, which could change their compensation from a typical private practice methodology to a wRVU-based compensation plan.

In Devine's experience, using the Pay to Production Plotter allows her to assist practices with understanding wRVU compensation plans and the relationship between each physician's production and compensation.

"There seems to be a thinking, especially among the highly productive physicians, that the rate of pay per wRVU (the conversion factor) should mirror their production levels. The Pay to Production Plotter is helpful to illustrate that the higher producing physicians do not necessarily get the higher rates of pay per unit of production. These physicians may benchmark at higher percentiles for compensation and wRVUs, but their compensation per wRVU tends to be more around the median or 60th percentile. The physicians actually getting the higher compensation per-wRVU rates are usually starting up/slowing down or have other non-clinical type work. Something else is going on there that's driving that conversion factor higher into the benchmarks," Devine explains.



# 5 tips for using the MGMA Pay to Production Plotter

## 1. Familiarize yourself with the tool.

- Understand the layout of the tool, how to overlay data and how to clearly describe the results.

## 2. Use the tool in conjunction with other resources.

- Utilize compensation/productivity benchmarking data from **MGMA DataDive Provider Compensation**.
- Explore the Quartile Tool to dive deeper into each quartile of the compensation and productivity data.

## 3. Consult with experts and peers.

- Engage with **The Financial Management Network (MGMA member community)**.
- Attend **MGMA conferences and webinars**.
- Contact our data analysts at **survey@mgma.com**.

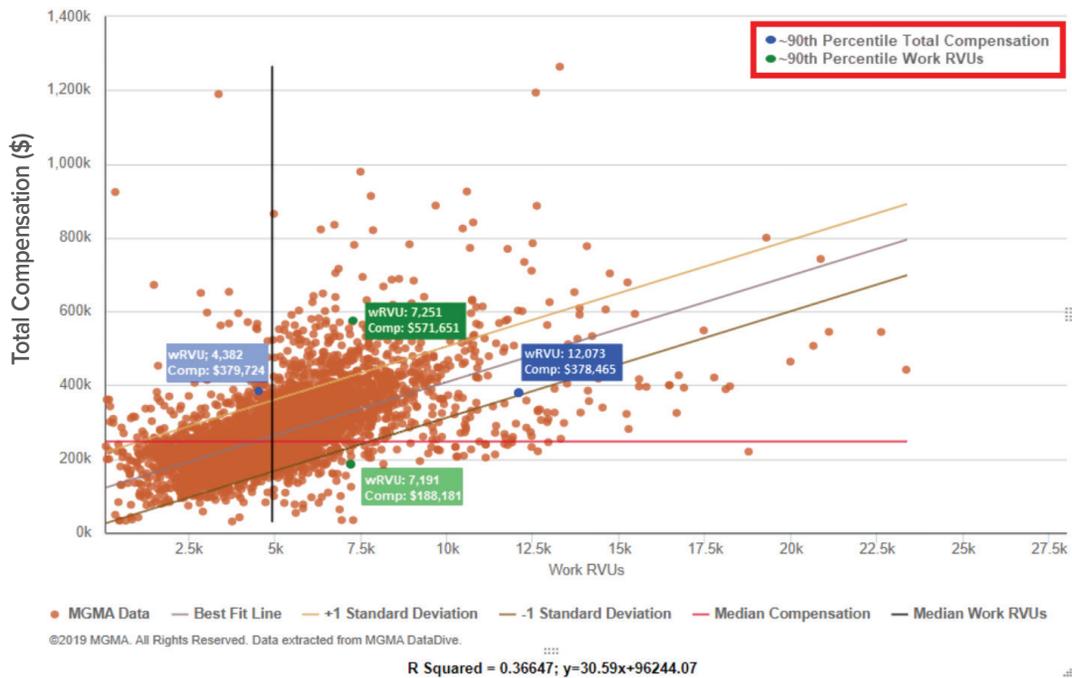
## 4. Apply filters to customize the data to best represent your practice and compare to similar practices.

## 5. Add your data for side-by-side comparison.

- Input your practice's data in DataDive to see how your practice and providers compare to MGMA benchmarks.

# THE MGMA PAY TO PRODUCTION PLOTTER IN ACTION

## 2018 Family Medicine (without OB) Compensation and Work RVUs Plotter



Compensation and productivity rates vary among providers, as demonstrated in the above image. Some providers are compensated at the 90th percentile (demonstrated by the blue dots), but produce lower/higher wRVUs than their peers. Similarly, some providers perform at the 90th percentile (demonstrated by the green dots), but are compensated at varying rates.

Some of the factors that account for this variation, as they relate to compensation packages include:

- **Compensation plans not tied to productivity.** If a provider's compensation isn't tied to productivity measures, he or she could produce at a higher rate and compensation may not reflect the higher workload.
- **Providers who are new to a practice.** These providers may be compensated at a higher rate than their workload justifies as they work to build up their patient panel. Or they may receive guaranteed compensation and see many patients, therefore producing at a higher rate than reflected by their compensation.
- **Providers who are close to retiring.** Similarly, these providers may be compensated at a higher rate than their workload justifies as they are paid for their tenure, but they may be decreasing their panel size.

**“ This tool is especially useful for providers who might be in the higher percentiles for productivity. It helps answer the questions: Are you really an exception to the rule? Or are there other providers with similar data?”**

**“The Pay to Production Plotter is helpful to illustrate ... that the higher-producing physicians do not necessarily get the higher rates of pay per unit of production. These physicians may benchmark at higher percentiles for compensation and wRVUs, but their compensation per-wRVU tends to be more around the median or 60th percentile. The physicians actually getting the higher compensation per wRVU rates are usually starting up/ slowing down, have other non-clinical type work.”**

**— Luis Argueso, CVA, partner, Healthcare Appraisers Inc., Denver**

# RESOURCES



## Benchmark – [mgma.com/data](https://mgma.com/data)

- **MGMA DataDive**
- **MGMA Data Tools**
- **MGMA Stat**



## Read – [mgma.com/resources](https://mgma.com/resources)

- **Data Sanity: A Quantum Leap to Unprecedented Results, 2nd edition**
- **MGMA Research & Analysis reports**
- **MGMA Data Best Practices**



## Engage – [community.mgma.com](https://community.mgma.com)

- **MGMA Member Community**
- **Pay to Production Plotter Overview video**



## Consulting Services

- **MGMA Consulting:** Our consultants tap a robust suite of recruitment strategies to match the right candidates to your organization — providers and staff who will stay. Beyond that, they offer compensation benchmarking to ensure that your organization extends pay rates that benefit both the employer (keeping overheads low) and the employee (making for an attractive offer).



## MGMA DataDive assistance

- **MGMA DataDive Onboarding:** Contact the Data Solutions team for personalized assistance at [survey@mgma.com](mailto:survey@mgma.com) or 877.275.6462, ext. 1895.



Access the electronic version of the report by visiting the 'Resources' section in **MGMA DataDive** or **[mgma.com/ptppreport](https://mgma.com/ptppreport)**.

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