Executive Summary Report

MGMA 2016
Provider Compensation and Production Report
Based on 2015 Survey Data
MGMA 2016 Provider Compensation and Production Report

Medical Group Management Association (MGMA) continues to be the national leader in medical practice benchmarking data. This year’s provider compensation and production data remains the gold standard, representing 2015 compensation and productivity information provided by more than 3,000 groups, which collectively represent more than 80,000 providers.

The following analyses were created to help industry professionals understand what drives compensation and give insight into current trends. Unless otherwise stated, all reported values represent medians.

Five-year compensation data

Among primary care physicians, the average yearly compensation increase from 2011 to 2015 was 4.27%. Among specialty care physicians, the average yearly compensation increase during the same time frame was 2.57%. While compensation levels for specialists are much greater than for primary care physicians, the change in compensation for primary care was greater. The increased compensation levels for primary care physicians reflect the increased demand for primary care services and the relative shortage of primary care physicians. Multispecialty groups and hospital-owned practices have the ability to cross subsidize primary care compensation and often do so in order to recruit and retain primary care physicians. The relative change in overall compensation may reflect this cross subsidy and the importance of primary care to larger practices.

For more information on using compensation data, download the MGMA Research & Analysis report, How to Use MGMA Data, at online.mgma.com/how-to-use-data.
Compensation plans

The graphs below show the difference in the compensation plans that physician-owned practices and hospital/IDS-owned practices utilize. The majority of physician-owned practices — 35.26% — utilize compensation plans based on 100% on productivity, while the majority of hospital/IDS owned practices — 41.59% — utilize compensation plans based on 50% or more production plus incentive.

This demonstrates the entrepreneurial focus of physician-owned practices compared to groups that are part of larger health systems. Physician-owned practices have twice the percentage of compensation plans that are 100% productivity and are essentially the only type of practices that uses a compensation plan that is based on an equal distribution of net profits. Hospital systems are much more apt to have a compensation plan that has either a salary or production core element and to include additional incentives such as quality metrics, seniority, administrative duties and patient satisfaction scores.

Compensation Plans for Physician-Owned Practices

Compensation Plans for Hospital/IDS-Owned Practices

Have you adjusted your physician compensation plan within the past two years?

Text MGMAStat to 33550 to participate and make your voice heard.
According to the results of a May 31, 2016, MGMA Stat poll—a real-time text-based polling initiative, 50.94% of 371 respondents’ physician and nonphysician provider (NPP) compensation plans are not aligned.

Compensation plan impacts on compensation

Different types of compensation plans provide different incentives for a practice’s providers. The chart below, which depicts primary care specialties, shows that the greatest compensation levels were associated with productivity-based compensation plans, plans that are 100% productivity or majority productivity plus incentive. These plans reward increased productivity with greater compensation and suggest a link between increased physician production and increased practice revenue. This increases the pool of net income that is paid to the practice shareholder/partners in physician-owned practices or the net profits for hospital-owned practices.

Visit mgma.org/polls for more MGMA Stat results
Production ratios

The following graph and chart show that as work RVUs and total compensation increase, the compensation-to-work-RVU ratio decreases. The graph shows how physicians whose work RVU production was in the first quartile had the lowest median compensation while the physicians with production in the fourth quartile had the greatest compensation. While the direct relation of productivity and compensation is apparent, when we examine another variable, the compensation-to-work-RVU ratio, we see something different. As clearly depicted, the physicians who produced in the first quartile had the highest ratio, and the ratios showed a general decline as productivity increased. Why does this occur? Simply, the physicians who produce the least are subsidized by those who produce more — for example because they are newly hired and have a salary guarantee while they build their patient base.

Quartiles* Grouped by Work RVUs for Cardiology: Invasive-Interventional

<table>
<thead>
<tr>
<th>Work RVUs</th>
<th>1st Quartile</th>
<th>2nd Quartile</th>
<th>3rd Quartile</th>
<th>4th Quartile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median Total Compensation</td>
<td>$468,434</td>
<td>$544,182</td>
<td>$629,950</td>
<td>$726,034</td>
</tr>
<tr>
<td>Median Compensation-to-Work-RVUs Ratio</td>
<td>$79.73</td>
<td>$65.78</td>
<td>$60.50</td>
<td>$54.23</td>
</tr>
<tr>
<td>Median Work RVUs</td>
<td>5,565</td>
<td>8,356</td>
<td>10,582</td>
<td>13,973</td>
</tr>
</tbody>
</table>

For more detail on the relationship between compensation and work RVUs, see the article, “There is no substitute for hard work” by David Gans, MSHA, FACMPE, in the September 2016 MGMA Connection Data Mine at mgma.org/datamine16. *Quartile data can be found in the quartile tool report, available in the Provider Compensation and Production Enterprise DataDive. For more information about Enterprise DataDive access, visit mgma.com/enterprise.
**Compensation for physicians with on-call duties**

Primary and specialty care physicians who have on-call duties report higher compensation than those who do not. In some cases, a practice requires all physicians to have call responsibility, with the only providers who are excused from call being senior physicians who are reducing their total work hours prior to retirement. MGMA data shows the economic cost to providers of reducing call responsibilities, which affects specialists much more than primary care physicians.

**Compensation for Established and Newly Hired Physicians**

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Total Compensation</th>
<th>Guaranteed Compensation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anesthesiology</td>
<td>$411,715</td>
<td>$287,750</td>
</tr>
<tr>
<td>Family Medicine</td>
<td>$238,737</td>
<td>$199,996</td>
</tr>
<tr>
<td>Hospitalist: Internal Medicine</td>
<td>$255,940</td>
<td>$209,997</td>
</tr>
<tr>
<td>Pediatrics: General</td>
<td>$195,456</td>
<td>$130,000</td>
</tr>
</tbody>
</table>

**Starting-salary compensation for newly hired physicians**

When hiring a provider, MGMA recommends using the guaranteed first-year compensation benchmark for newly hired physicians found in the Provider Placement Starting Salary dataset.* The table to the left compares starting-salary data to total compensation for physicians reported in the Provider Compensation and Production dataset, which includes on-call pay, pay for administrative work, production bonuses and other incentives. These physicians have one to two years’ experience in their specialty, making them the most junior of established providers within a practice.

*Guaranteed compensation data found in the Provider Placement Starting Salary dataset within MGMA DataDive Provider Compensation 2016.

Numerous components influence provider compensation and production. Understanding how to effectively benchmark data against various demographic and trend characteristics can give a practice the competitive edge it needs to recruit and retain providers. MGMA DataDive Provider Compensation 2016 allows for a wide range of additional analyses beyond those included within this executive summary.

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For more information on MGMA research initiatives, visit mgma.org/research-analysis.