Comp rises as physician executive market matures

When Ed Millermaier, MD, MBA, began practicing as an internist, he never imagined he’d one day be working in a full-time administrative role. But he started by participating in leadership activities and taking on administrative duties, which led to more administrative duties and leadership responsibilities. And after a long transition, he was working as the chief operating and medical officer for Borgess Ambulatory Care in Kalamazoo, MI.

Like many physician executives, Millermaier’s experience practicing medicine makes him a unique asset to a leadership team. Physician executives have firsthand experience with on-the-ground aspects of healthcare delivery, and most importantly, they are able to bridge the gap between physicians and administrators.

“It has been extremely helpful to have come from that background because I do understand what it’s like to practice medicine,” he says. As the business of healthcare becomes more complex, and the margin for error becomes smaller, strong leadership becomes more important for organizational success. Increasingly, this means facilities of all types—from hospitals to large group practices—are turning to physicians to fill key executive positions.

And as demand increases, so does compensation. According to the 2007 Physician Executive Compensation Survey, which was conducted by Cejka Search and the American College of Physician Executives (ACPE), compensation for physician executives grew 7.5%, from $240,000 to $258,000, between 2005 and 2007 and has climbed 36.6% since the survey was first published in 1997.

“The physician executive market has significantly matured in the last few years, and physicians now have a demonstrated track record of adding value to an organization,” says Lois Dister, vice president and practice leader with the Cejka Search executive search division.

Rural comp catches up

Nowhere is the need for quality physician leaders greater than in rural hospitals and clinics. Compensation is growing twice as fast for rural physician executives as for their urban and suburban counterparts, according to the biennial survey, which found a 12.5% compensation increase between 2005 and 2007 for physician executives in rural areas compared with 6.1% in urban settings.

The difference in gains reflects rural compensation’s “catching up” to urban levels—median salaries are roughly 5% lower in rural facilities—and skyrocketing demand for solid leadership.

“As the complexity of healthcare management increases in these rural settings, hospitals are committed to physicians having a firm and
permanent seat at the leadership table and contribute to the strategy of the organization,” Dister explains.

Rural hospitals often look for executives with a broad healthcare background who can provide a fresh set of eyes to hospital operations, so they may look to recruit a physician executive rather than develop talent from within the organization, she says.

“They want to show the community that they are bringing improvements in public health and bringing different clinical programs to the organization. So a lot of times they feel like they need to go outside the specific community to bring in that talent,” says Dister.

But rural facilities are no longer able to argue that lower costs of living justify lower compensation levels when looking to bring in an executive and must pay market levels to successfully recruit talented physician leaders, she says. “They are looking more to import talent, and that’s always going to cost a little extra.”

To attain these business administration physicians, some physician executives are obtaining postgraduate business management degrees, the most common being an MBA—one in five physician executives has this degree, according to the survey.

But experience plays an equal, if not greater, role in making a successful physician leader, Millermaier says. He went back and picked up his MBA after several years of administrative work. And although he says it helped hone his talents, it was no substitute for eight years of on-the-job training making operational decisions.

What distinguishes practicing physicians from physician executives, he says, is the ability and desire to tackle the business side of medicine, which he acknowledges isn’t for every physician.

“[It takes] a willingness to understand the business and corporate side of healthcare. That’s a challenge for practicing physicians because we aren’t trained in that area. So it makes it difficult for practicing clinicians to be fully engaged in all the corporate work necessary to make things work.”

Performance incentives determine pay

As the physician executive market matures, so do compensation methodologies.

In many cases, this means a greater focus on bonuses tied to performance incentives. More than half of physician executives reported receiving a bonus as part of their compensation package in the 2007 survey, up slightly from the previous report.

This typically translates into higher overall compensation for the executive. Median administrative compensation for executives with a bonus of 10% or less was $250,000, but administrative compensation levels increased as the bonus percentages rose:

- Bonus: 11%–20%, compensation: $282,500
- Bonus: 21%–30%, compensation: $307,000
- Bonus: 31%–40%, compensation: $377,500
- Bonus: 41% or more, compensation: $400,000

The most common measurement of success is organizational goals—62% of respondents reported this bonus component. However, personal objectives, organizational profit, quality measurements, and patient satisfaction are also common measurements of executive performance.

Physicians enter the C-suite

Physician executives aren’t just getting paid more; they’re filling new roles and taking on true administrative responsibilities. Traditionally, physicians have held “medical director” and “chief medical officer” (CMO) titles, which account for 46% of the respondents to the Cejka Search/ACPE physician executive survey. But some are beginning to move beyond those positions, entering the C-suite and focusing solely on administration, Millermaier says.

“When you identify yourself as a chief medical officer, people understand you’re a physician leader. The CMO role is quite well understood,” he says. “When you also add the COO title, that completely changes people’s understanding of what my role is. True physician executive leadership is only newly emerging, where physicians are CEOs and COOs.”

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The most common measurement of success is organizational goals—62% of respondents reported this bonus component. However, personal objectives, organizational profit, quality measurements, and patient satisfaction are also common measurements of executive performance.
The shift toward more incentive-based compensation is driven in part by the physicians themselves, Dister says. Physicians are more savvy when it comes to compensation packages than they were 10 years ago, and many are eager to tie a greater portion of overall compensation to their performance.

“[Physicians] realize how they can contribute to the clinical outcomes, the financial performance, and the overall goals of the organization. They get very excited by the opportunity . . . and they’ll even suggest putting more money at risk,” Dister says. “In the last couple of years, I’ve noticed a marked difference in how they view compensation and how excited they get about the bonus potential.”

A glass ceiling?

Another sign of progress in the physician executive market: Women are better represented among physician executives today. However, they are still underrepresented overall, and the increases have come at a very slow pace.

The proportion of female survey respondents was 13% in 2007, up from 10% a decade earlier. Also, female executives earned 15% less than males, according to the results.

In certain positions, such as medical director roles, that representation is better and improving at a faster pace. Nearly one in five medical directors is female according to the 2007 survey, compared with 16% in 2005 and 12% in 1997.

But women are still underrepresented in the general physician population—they still make up less than 30% of practicing physicians—even more so in the older generations that typically have the experience to fill executive positions.

Given the current gender parity in medical schools, female representation in executive positions will likely continue to rise as the younger generation of physicians gains more experience and takes on new leadership roles.

**Physician executive compensation trends**

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</tr>
</thead>
<tbody>
<tr>
<td>All physician executives</td>
<td>$258,000</td>
<td>$240,000</td>
<td>$188,850</td>
<td>75.0%</td>
<td>36.60%</td>
</tr>
<tr>
<td>CEO/president</td>
<td>$339,324</td>
<td>$301,500</td>
<td>$245,000</td>
<td>12.50%</td>
<td>38.50%</td>
</tr>
<tr>
<td>Department/division chair/manager</td>
<td>$300,000</td>
<td>$271,000</td>
<td>$201,000</td>
<td>10.70%</td>
<td>49.30%</td>
</tr>
<tr>
<td>Chief medical officer</td>
<td>$292,000</td>
<td>$265,750</td>
<td>$200,000</td>
<td>9.90%</td>
<td>46.00%</td>
</tr>
<tr>
<td>Vice president of medical affairs</td>
<td>$275,000</td>
<td>$243,000</td>
<td>$200,000</td>
<td>13.20%</td>
<td>37.50%</td>
</tr>
<tr>
<td>Medical director</td>
<td>$240,000</td>
<td>$223,250</td>
<td>$175,000</td>
<td>7.50%</td>
<td>37.10%</td>
</tr>
<tr>
<td>Associate/assistant medical director</td>
<td>$210,000</td>
<td>$205,000</td>
<td>$160,000</td>
<td>2.40%</td>
<td>31.30%</td>
</tr>
</tbody>
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**Source:** Data excerpted from the Cejka Search/American College of Physician Executives 2007 Physician Executive Compensation Survey. Reprinted with permission.

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Dermatology compensation increases more than skin deep

From a physician’s perspective, dermatology is the specialty that has it all—reasonable practice hours, little call, and rapidly rising compensation levels. In fact, compensation grew more for dermatologists in the past five years than for any other specialty, climbing 30% between 2002 and 2006, according to the MGMA 2007 Physician Compensation and Production Survey. Dermatology isn’t the top-paying specialty, but it’s getting there. In 2002, median compensation levels were roughly $270,000, but by 2006, dermatologists were averaging nearly $100,000 more.

Botox injections, chemical peels, spa treatments, and other cosmetic enhancements are extremely profitable because they are often paid for out of pocket. And they’re growing in popularity.

—Brian McCartie

The impetus for the rising compensation comes primarily from elective procedures, says Brian McCartie, regional vice president with Cejka Search. “Where I see the increases in incomes are the dermatologists that are being added to a group that’s heavily investing in fee-for-service [FFS] business,” he says.

Botox injections, chemical peels, spa treatments, and other cosmetic enhancements are extremely profitable because they are often paid for out of pocket. And they’re growing in popularity, McCartie says.

The U.S. population is living longer and is generally healthier than at any other point in history, and with a significant amount of disposable wealth, many people of all ages are willing to spend money on procedures that aren’t medically necessary—a trend that will likely continue in the near future as the baby boomer generation purchases more cosmetic services.

“Seventy is the new 55,” McCartie says. “Thirty years ago when people aged they spent little time on appearance, but now the trend is toward keeping a youthful appearance. As this population ages there will be more interest in these kinds of procedures.”

Bidding wars

That’s not to say that demand for clinical dermatological procedures has dropped off—in fact, it’s increasing as well. The skin is the largest organ of the human body, and skin cancers and other conditions are becoming more common in an aging population.

Many physicians perform a combination of clinical and elective procedures. In an average day, a physician could deal with skin conditions including cancer, acne, and hair loss, as well as cosmetic procedures, varicose veins, tattoo removal, or surgery.

But clinically based procedures don’t generate the collections that many elective FFS procedures do, and many practicing dermatologists are enticed by the higher salaries in FFS settings, where McCartie says he has seen annual compensation levels top $1 million on rare occasions.

Multispecialty and plastic surgery groups have such high demand for dermatological services that they will often engage in bidding wars over a physician and drive up salaries in a region. “We have many multispecialty groups with so much pent-up demand that they’ll pay $400,000 or $450,000 because they know they can keep the dermatologist busy from day one,” McCartie says.

In some cases, particularly at a large integrated academic group, that leaves general internists or other primary care physicians to pick up the slack and incorporate basic dermatological procedures into their practice.

Other specialists, including gynecologists and surgeons, even attempt to get a piece of the cosmetic services pie and offer basic aesthetic procedures. However, the demand is high enough that this doesn’t cut into dermatologists’ profits, McCartie says.

Specialty compensation calendar

Check PCR in coming months for coverage of the following specialties:

- General surgery
- Pulmonary medicine
- Radiology
Mixing clinical, cosmetic

Cosmetic dermatology generates more revenue but has its drawbacks. Because the procedures aren’t medically necessary, it can take more time and money (i.e., marketing) to find patients.

“The question is, ‘How do you draw in the aesthetic patient?’ There are expenses associated with that,” says Mark S. Nestor, MD, PhD, clinical associate professor of dermatology at the University of Miami School of Medicine and cochair of Advanced Dermatology Management, Inc., a single-specialty dermatology practice with 37 physicians practicing in 26 facilities across Florida.

Advanced Dermatology Management’s physicians practice both clinical and cosmetic dermatology, and Nestor says the clinical practice often serves as a marketing vehicle for cosmetic physicians. “While the aesthetic parts are profitable in cash, the feed for that comes from the medical side of dermatology. Patients feed through their office and they can learn about what the dermatologist does aesthetically.”

The physician’s specialty

As if the rapidly rising compensation levels weren’t enough to attract physicians, dermatology also offers the work-life balance benefits to physicians interested in “9 to 5” medicine. “From the lifestyle standpoint, dermatology has it all over every other specialty,” Nestor says. “It’s incredibly reasonable in terms of hours, and there aren’t a lot of issues with call.”

Dermatologists also have a workflow advantage over other specialties, relying on a high volume of short patient visits, which tend to be more profitable than lengthier patient encounters. Dermatologists typically see upward of 150 patients per week, Nestor says. That number can be even higher if the dermatologist partners with a nonphysician provider to improve efficiency, McCartie says.

These factors combine to make dermatology residencies some of the most competitive in terms of admission, but caps on slots will make it hard to meet demand in the coming years. As a result, both Nestor and McCartie predict physician supply will lag behind demand, and compensation will likely continue trending upward for some time.

“It’s a great time to be a dermatologist,” McCartie says.  

Dermatology compensation trends

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</thead>
<tbody>
<tr>
<td>AMGA Medical Group Compensation and Financial Survey</td>
<td>$316,473</td>
<td>$306,935</td>
<td>$274,014</td>
<td>3.11%</td>
<td>12.01%</td>
</tr>
<tr>
<td>HCS Physician Salary Survey Report (salary data only)</td>
<td>$194,213</td>
<td>$191,299</td>
<td>$165,517</td>
<td>1.52%</td>
<td>15.58%</td>
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<tr>
<td>MGMA Physician Compensation and Production Survey</td>
<td>$348,706</td>
<td>$334,277</td>
<td>$308,855</td>
<td>4.32%</td>
<td>8.23%</td>
</tr>
<tr>
<td>Sullivan, Cotter and Associates Physician Compensation and Productivity Survey</td>
<td>N/A</td>
<td>$247,491</td>
<td>$247,491</td>
<td>N/A</td>
<td>0.00%</td>
</tr>
</tbody>
</table>

+ Survey results are based on the previous year’s data.

Source: Data excerpted from AMA, Hospital & Healthcare Compensation Service, and MGMA compensation surveys. Reprinted with permission.

PCR sources

Brian McCartie, regional vice president, Cejka Search, 4 CityPlace Drive, Suite 300, St. Louis, MO 63141, 314/236-4481; bmccartie@cejkasearch.com.

Mark S. Nestor, MD, PhD, cochair, Advanced Dermatology Management, Inc., 2925 Aventura Boulevard, Suite 205, Aventura, FL 33180, 305/933-6716; mnestormd@admcorp.com.
Calculate break-even point to choose in-house or external recruiter

Forget signing bonuses and other up-front salary incentives—recruiting a physician becomes costly before compensation even enters the picture. Factor in advertising to find a candidate and interview expenses, such as airfare and lodging, and the administrative costs of recruiting a physician can average between $20,000 and $50,000.

But a physician vacancy isn’t cheap either, often resulting in hundreds of thousands of dollars in lost revenue. Facilities must be willing to spend money to bring the right physician in, but finding the most economical strategy can lead to a substantial savings.

A small practice may have no choice but to turn to a hospital for help or pay a physician search firm to handle the job. But for larger practices and hospitals, which may recruit dozens of physicians in a year, hiring a permanent in-house physician recruiter may be a cheaper option.

Costs shouldn’t be the only concern—the cheaper option isn’t always beneficial if it doesn’t bring in the right physician—but it’s important to be aware of both the benefits and drawbacks of in-house and external search options.

Which option is better?

As a general rule, an in-house recruiter becomes cheaper as he or she recruits more physicians per year. So the question becomes, how many physicians must a recruiter bring in to make the in-house option more cost-effective than using a search firm?

The magic number is roughly seven, according to Chris Kashnig, manager of physician recruitment with Christie Clinic in Champaign, IL. The key is to look for the break-even point at which the amount of the recruiter’s salary dedicated to each search is roughly equal to the average search firm charge.

When a facility recruits seven physicians annually, the average cost per physician between the two options evens out, says Kashnig, who calculated the threshold based on average recruiter salaries and search-firm costs. Recruit more than that, and recruitment costs are generally lower when handled in-house, particularly when recruiting within a single specialty.

“If you’re looking for a number of physicians in a given specialty, there are some economies of scale on the sourcing,” Kashnig says. For example, if a facility needs to hire a dozen primary care physicians, one ad may net 10 responses from potential candidates, of which two or three may eventually join the practice.

Because an in-house recruiter’s salary is fixed, the costs are diffused as he or she successfully recruits more searches. For example, if the average recruiter makes a $60,000 annual salary with $12,000 in fringe benefits, a facility is effectively allocating $14,400 in recruiter salary per physician if only five physicians are recruited per year (see “Sample recruitment cost calculations” on p. 7 for a detailed breakdown).

Most other recruitment expenses don’t have similar economies of scale (interview costs, for example, will be the same per physician regardless of the number being recruited), so the recruiter’s salary has a significant effect on overall costs.

Increase the number of recruits to 10 physicians per year using the same example, and $7,200 of the recruiter’s salary goes to each physician.

Consider region, specialty

Although his calculations can provide a useful benchmark, they may not apply equally to all situations, Kashnig says. Recruiting a physician can be much more difficult and costly in certain specialties or regions of the country.

In general, an in-house recruiter can handle between 15 and 20 searches annually, Kashnig says. But there are significant exceptions to that assumption. “In a rural area, you may work the entire year and only bring in four physicians. That may be your capacity because they’re so hard to find,” he says.

On the other hand, a recruiter in an urban area with residency programs nearby or in-house could handle a workload as high as 30 physicians per year simply because of the larger pool of potential recruits close by. The recruiter in this scenario would likely need fewer resources per recruit than his or her rural counterpart.

Similarly, some specialties are in greater demand and generate a great deal of revenue and often warrant a more aggressive and expensive search. “In the big picture, most employers are not that price sensitive for certain specialties,” Kashnig says. “An orthopedic surgeon, for example, is worth
so much to an organization that if you end up spending three times as much money to find someone and they’re productive, it’s worth it.”

**Mix both methods**

Even when hiring an in-house recruiter is the more cost-effective option, many facilities rely on both methods to maximize efficiency.

For example, the in-house recruiter may handle the majority of searches but then hire a search firm for one or two of the most hard-to-fill specialties.

**Kevin Donovan**, vice president of physician and ambulatory services for Elliot Health System in Manchester, NH, uses a combination of the methods for hard-to-find specialties and to increase search capacity. Through partnership with a national search firm, searches for some specialties, such as primary care, are typically handled in-house because the staff is better equipped to find these candidates. But hard-to-place specialties (e.g., general surgery, cardiology, pulmonology, etc.) are handled by the search firm, which has more experience and resources to find and sign niche physicians, he says.

Utilizing both also allows his organization to conduct more searches without increasing the fixed costs of his recruitment department, he adds.

“Both options have benefits and both have negatives. The mix of the two, if you can figure out how to marry them together, is really the way to go,” Donovan says.

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**Sample recruitment cost calculations**

Below are two sample recruitment cost calculations for a facility conducting 14 searches in a year, 10 of which are successfully filled. In the first scenario, recruitment firms are used for at least two of the searches. A half-time assistant helps with administrative duties in both scenarios.

<table>
<thead>
<tr>
<th>Cost</th>
<th>In-house</th>
<th>Recruitment firm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recruiter’s salary &amp; fringe benefits</td>
<td>$72,000</td>
<td>N/A</td>
</tr>
<tr>
<td>Assistant’s salary &amp; fringe benefits (half-time)</td>
<td>$18,000</td>
<td>$18,000</td>
</tr>
<tr>
<td>Interview expenses ($1,750 x 14 searches x 4 candidates per search)</td>
<td>$98,000</td>
<td>$98,000</td>
</tr>
<tr>
<td>Out-of-pocket expenses ($4,000 x 14)</td>
<td>$56,000</td>
<td>N/A</td>
</tr>
<tr>
<td>Relocation expenses ($7,000 x 10)</td>
<td>$70,000</td>
<td>$70,000</td>
</tr>
<tr>
<td>Database support &amp; trade shows</td>
<td>$10,000</td>
<td>N/A</td>
</tr>
<tr>
<td>Background checks ($700 x 10)</td>
<td>$7,000</td>
<td>$7,000</td>
</tr>
<tr>
<td>Use of recruitment firms ($22,000 each)</td>
<td>$44,000</td>
<td>$220,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$375,000</td>
<td>$413,000</td>
</tr>
</tbody>
</table>

*Source: Chris Kashnig, manager of physician recruitment with Christie Clinic in Champaign, IL. Reprinted with permission.*
Physician supply: Surplus or shortage?
Experts continue to debate whether the United States has too many physicians or too few

by Mark Smith

Only a few years ago, the majority of healthcare experts and analysts who follow physician supply trends supported the premise that the United States had too many physicians. Today, the majority now sees things the other way—a change reflected in the positions of such organizations as the Association of American Medical Colleges, the AMA, and the Council on Graduate Medical Education, all of which now project a physician shortage.

Nevertheless, pro-surplus theorists continue to make their case. Just last month, an article in the December *The Atlantic Monthly* reignited the debate between those who believe the United States has too many physicians and those who believe it has too few.

The two primary arguments recycled by those who contend there is a surplus of physicians are economic ones.

The first is that demand for medical services is driven by doctors themselves. The more physicians in a given population, the more medical services (and, therefore, the more medical spending) a population is likely to generate. The solution to high medical spending and to reducing unnecessary medical procedures, the argument goes, is to reduce the number of doctors.

The second argument is based on the outcomes achieved at medical centers with a relatively high number of physicians per patient population versus outcomes achieved at medical centers with a relatively low number of physicians per patient population.

According to a study conducted by Dartmouth researchers, patients do better at facilities such as the Mayo Clinic in Rochester, MN, which has a relatively low physician-per-patient ratio, than they do at facilities such as New York University Hospital, which has a relatively high physician-per-patient ratio. The way to improve outcomes, they conclude, is to reduce the number of doctors.

These arguments have been most conspicuously contested by Richard “Buz” Cooper, MD, an academic at the University of Pennsylvania and cochair of the Council on Physician and Nurse Supply. Note: The Council on Physician and Nurse Supply is funded by Merritt, Hawkins & Associates’ parent company, AMN Healthcare.

Cooper argues that demand for medical services is largely driven by economic growth, technology, population growth, and other factors, not by physicians. He also argues that it is spurious to compare medical outcomes in relatively affluent, demographically homogenous cities like Rochester to economically and ethnically heterogeneous cities like New York.

Which side is right?

Trends in physician recruiting incentives show that financial offers to physicians in most specialties have consistently increased in recent years, suggesting demand for physician services is growing and the supply of physicians is limited.

A key point to consider in the physician supply debate is that the supply of physicians cannot be increased if the number of residency slots available does not increase. However, no such increase will occur unless Congress removes the cap on what Medicare currently spends on residency training.

Although the physician supply debate largely takes place in academic circles, it has practical effects on physician compensation, recruitment, and retention. As long as the argument remains unresolved, physician supply is unlikely to increase and, based on physician demographics and other factors, can be expected to decrease.

That will put additional upward pressure on recruiting incentives and continued strain on hospitals, medical groups, and other organizations committed to maintaining or enhancing their medical staffs.

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Editor’s note: Smith is president of Merritt, Hawkins & Associates, a national physician search and consulting firm and a division of AMN Healthcare. He can be reached at msmith@mhagroup.com.
CMS delays ‘stand in shoes’ portion of Stark III

CMS has announced it will delay implementing the “stand in shoes” changes included in Stark III, which went into effect last month, until December 4. However, the rule is only being delayed as it applies to academic medical centers and 501(c)(3) integrated health systems.

The “stand in shoes” rule effectively redefined some indirect relationships as direct, making them susceptible to Stark self-referral regulations.

CMS says the delay does not indicate a change in position but is intended to give the agency time to “evaluate any unintended impact of the Phase III ‘stand in shoes’ provisions.”

In particular, industry representatives expressed concerns about support payments and similar monetary transfers that are common in such arrangements and previously did not trigger application of the Stark Law.

P4P programs don’t always improve outcomes

A recent study of pay for performance (P4P) in diabetes care has led to mixed results regarding the effectiveness of performance incentives in improving outcomes. Although providers performing under the system increased their use of guidance-compliant testing, that did not correlate with actual outcome improvement.

Researchers examined a performance-based compensation system for providers at a network of federally qualified health centers located in underserved communities throughout Chicago and surrounding suburbs.

The study involved 46 primary care physicians and 1,166 patients with diabetes. Most patients lived below 200% of the federal poverty level and were uninsured or covered by Medicaid.

Researchers concluded that, although P4P holds promise, it is not the cure-all for the healthcare system.

CMS releases final 2008 PQRI quality measures

CMS has posted details about the 2008 Physician Quality Reporting Initiative (PQRI) measures, including a document that finalizes 119 quality measures for the program. The 2008 PQRI measures now include:

» 59 measures endorsed by the National Quality Forum (NQF)
» 38 new measures developed through the AMA Physician Consortium for Performance Improvement
» Seven new measures for nonphysician eligible professionals developed through the Pennsylvania Quality Improvement Organization (PA-QIO)
» Two new structural measures also developed through the PA-QIO
» Five measures from the Ambulatory care Quality Alliance Starter Set of quality measures that are largely preventive in nature
» Six NQF-endorsed measures addressing pharmacologic therapy
» Two measures developed by the American Podiatric Medical Association

Groups report recruitment challenges

Medical groups had a harder time recruiting in 2007 than 2006, according to an informal survey of 170 healthcare executives conducted by Dallas-based recruiter The Delta Companies.

Survey results included the following:

» 73% say physician recruitment was more challenging in 2007 than in 2006, up from 68% who said recruiting was getting more difficult in a 2006 survey
» 70% of groups have needed to improve their offers from 2006 in order to attract physicians
» 28% note that voluntary physician resignations have increased
» 35% have a formalized medical staff retention program in place
» 67% note that the use of temporary clinical medical staff has not increased from 2006

Minnesota physicians rank insurers

Frustrated with insurers’ physician-ranking systems based on performance measures—arguing they create an administrative burden and don’t reward investments in IT—Minnesota physicians have turned the tables by rating nine pay-for-performance programs, the Minneapolis Star Tribune reports.

CMS topped the list, whereas the Bridges to Excellence program was ranked last.

Programs by Blue Cross Blue Shield of Minnesota, UCare, PreferredOne, HealthPartners, and Medica fell somewhere in between.
Western groups continue to outperform the rest of United States
Capitated reimbursement may be behind growing revenues and costs, lower compensation

With physician groups under tremendous pressure to deliver high-quality patient care in an increasingly competitive and regulated environment, practice leaders are eager for any insight into what makes a practice financially successful.

Industry compensation and cost surveys show that, nationally, most groups are facing a situation in which costs are outpacing revenues and compensation levels are beginning to flatten out. The latest evidence: The AMGA 2007 Medical Group Compensation and Financial Survey reveals that most medical groups operated at an average loss of $119 per physician during 2006.

Although this was a clear improvement over the previous year’s findings, which showed an average loss of $1,264 per physician, medical groups are still struggling to turn a profit. This was most pronounced in the Southern region, where groups lost $6,049 per physician.

But there may be a glimmer of hope, or at least a bit of insight, in the regional data. For the second consecutive year, only organizations in the Western region operated at a profit, and the profit margin even increased. In 2006, groups in the Western region saw profits of $17,317 per physician, up from $7,970 in the previous year’s survey.

Capitation plays a role

So the question becomes, what is different about the medical groups in the West? For one, they are more likely to work under capitation. Although it’s impossible to credit the performance of medical groups in the Western United States entirely to a heavily capitated reimbursement environment, there does seem to be a correlation.

Eight of 32 survey respondents in the Western region reported that they received more than 35% of revenues from capitation compared to just two of 18 in the East, five of 47 in the North, and one of 49 in the South.

Fewer than half of respondents from the Western region reported no capitation, compared to 61% in the East, 75% in the North, and 78% in the South. And the large, predominantly physician-owned multispecialty medical groups that represent the core of AMGA’s survey universe are more likely than smaller groups to seek capitated arrangements.

Nevertheless, capitated groups are feeling the same squeeze as other AMGA survey respondents. In 2006, groups that received more than 35% of their revenues from capitation—regardless of region—sustained losses averaging $12,057 per physician, despite an increase in revenues, according to the survey data. In previous years, heavily capitated groups have outperformed the rest of the universe, says Brad Vaudrey, MBA, director of consulting in the Minneapolis office of RSM McGladrey, Inc., which produces the annual survey for AMGA.

One reason for that change could be the gradual erosion in the number of medical groups reporting high levels of...
capitation, which reduces the number of respondents in this category and can skew responses.

“We’re seeing a bit of a shift from the most heavily capitated category to those with less than 35% capitation, and we’ve been seeing that for several years,” Vaudrey says.

Investments affect bottom line

One-time capital expenses are another likely factor affecting 2006 results for capitated groups, according to Vaudrey. Although groups that participate heavily in prepaid health plan arrangements are more focused on cost control than revenue generation, “at some point, every medical group is going to have capital expenditures,” he says. “This could have been one of those years in the expense cycle.”

Groups with 35% or more of revenues from capitation incurred significant expenses—more than $50,000—related to capital costs for construction and other types of major investments, such as the purchase of information systems and electronic health records to improve overall practice efficiency. In the previous year’s survey, this category of expenses averaged only $14,000 for heavily capitated respondents, Vaudrey says. The difference of more than $42,000 per physician more than accounts for the year-to-year swing from profit to loss on a per-physician basis.

“Contract reimbursement doesn’t have this big of an effect in a single year,” Vaudrey says. “In fact, revenue per physician increased by 13% for groups that reported greater than 35% capitation, and compensation per physician also increased by approximately 10%. We’ll be watching to see if the higher expense was a one-time event. I imagine the bottom line will trend back to a more stable positive or at least break-even situation in the future.”

Overall, highly capitated groups tend to have lower professional and technical revenues than groups operating on a fee-for-service (FFS) basis, as their focus is more on efficient care delivery rather than maximizing tests and procedures.

On a per-physician basis, average physician compensation in heavily capitated groups also is lower than in groups without capitation. Salaries for medical assistants and aides are slightly higher, as capitated organizations tend to use more support staff to maximize the efficiency of physicians, but bad debt incurred by heavily capitated groups is significantly lower than groups that rely primarily on FFS revenues.

That gap may widen in the future, because medical groups with FFS contracts are confronting growing amounts of bad debt related to difficulties in collecting high up-front deductibles from patients enrolled in consumer-driven health plans.

Will capitation make a comeback?

In fact, highly capitated groups that responded to the AMGA survey generated more gross and net revenue per RVU than groups with less capitation. For net purposes, groups with 35% or more of revenues from capitation collected $173.13 per work RVU, whereas those with no capitation collected only $126.84 per work RVU.

“Historically, productivity has been a strong point for capitated groups, which goes along with their focus on cost control,” Vaudrey says. “Based on what they collect and how their contracts are structured, they actually took in more revenue and paid out more to their physicians per work RVU than other types of groups.”

Highly capitated groups paid their physicians $57.49 per work RVU—more than organizations with less or no capitation. But highly capitated groups were hurt by high expenses in other areas, including costs of $13.22 per work RVU for medical and surgical supplies and drugs and other expense of $14.80 per work RVU.

Regardless of whether these are one-year abnormalities, Vaudrey expects capitation to maintain or perhaps increase its penetration in the marketplace, especially if new reimbursement models such as the medical home concept incorporate elements of risk contracting.

“We’ve seen that a lot of groups want to stay capitated,” he says. “Beginning about five years ago, physicians saw that capitated contracts wouldn’t necessarily be as lucrative, so many groups got away from it. But the groups that have stayed with capitation are doing pretty well, and with all of the pressures to control expenses and the pay-for-performance initiatives, some groups are taking a second look.

He adds, “We’re in a transition period right now in terms of what healthcare will look like in five years. But I think capitation will come back in some form.”

PCR sources
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Generational differences present compensation challenges

Editor’s note: PCR asked compensation and recruitment experts to discuss perceived generational differences between today’s physicians and to assess how these differences might influence compensation and recruitment trends.

James W. Lord, principal, ECG Management Consultants

While generational differences are not new to the workplace, they appear to be more pronounced today than they have been during any other period.

Today, there are many more options (e.g., large group practice, employment, subspecialization, academia, etc.), and as a result, we see some physicians looking to limit call coverage requirements or investigate part-time opportunities.

However, administrators and independent physicians need not worry; the physician entrepreneur is not dead. In fact, high-producing, hard-charging physicians are still being minted in schools of medicine across the country. A well-designed compensation plan can provide a structure that allows variability across the group if desired.

Tiered compensation systems help to balance extremes and ensure that appropriate levels of compensation are available to high, low, and median producers. The tiered plan is also helpful in addressing the cost of part-time practice and can be very effective mechanisms to balance across generations.

David A. McKenzie, CAE, reimbursement director, American College of Emergency Physicians

Related to compensation and recruitment issues, we find that Gen X doctors are not willing to “pay their dues” and work undesirable shifts at lower pay until they make partner. Their feeling is that they should be paid more based on increased productivity. We also see that they want to work fewer shifts and want more balance between work and homelife than the boomers have historically. These factors combine to alter compensation packages and recruitment techniques structured by emergency medicine groups.

Marc Bowles, CPC-PRC, CMSR, FMSD, chief marketing officer, The Delta Companies

The differences are real, and good administrators will benefit from remembering who their audience is.

Max Reiboldt, CPA, managing partner and CEO of The Coker Group

In private groups, it is difficult to motivate younger physicians to produce at the level of productivity that justifies their expected compensation. That is why so many incentive-based plans are considered and indeed must be implemented in order to maintain sufficient motivation for individual productivity and also maintain a reasonable economic position for the practice and/or hospital network. Thus, there are many challenges confronting the practice as it considers recruiting and, even more importantly, retaining younger physicians. The ability to assimilate all of these “moving parts” is challenging. At the foundation of this is a sound operational and strategic plan including a well-thought-through income distribution plan that still ultimately compensates even the younger physicians on a fair and reasonable incentive basis, mostly tied to their individual productivity.
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Dear PCR subscriber,

As you open this month's issue, you will notice PCR's name has changed slightly—Physician Compensation Report is now Physician Compensation & Recruitment.

Don’t worry, we aren’t taking away any content—you will continue to receive the industry’s leading newsletter for in-depth compensation trend analysis and pay-plan explanations. But recruitment is inextricably tied to compensation, and we’ve been covering compensation-related recruitment topics all along: Stark restrictions, signing bonuses, specialty supply and demand trends, etc. The new name more accurately reflects this coverage.

You can get a taste of the new focus on p. 8 in this month’s issue, where guest columnist Mark Smith of Merritt, Hawkins & Associates discusses the looming physician shortage. In fact, the shortage is one of the reasons we’re making the change. Recruitment is becoming more difficult, and finding the right physician is incredibly important to physician retention and developing an effective compensation plan.

As recruitment gets more competitive, it is also getting more expensive. On p. 6, we break down some recruitment costs to help you decide whether an in-house recruiter or a search firm better suits your needs.

You can expect more coverage of these compensation-related recruitment topics, as well as the compensation data and plan analysis you’re accustomed to, in the coming months.

Now, we’d like to hear from you. We’re excited about the change and look forward to your feedback. Please feel free to drop me a line at any time.

Sincerely,

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