For the most part, CMS simply clarified or corrected aspects of rules or proposals issued in previous regulations. But in some cases, as with a new safe harbor that pertains to gainsharing arrangements, the agency ventured into new territory.

Now, CMS is clarifying the requirement so that it applies only to physicians with an ownership interest in the physician organization. If a physician has a compensation arrangement with an organization but not an ownership or investment interest, he or she will not be required to stand in the shoes of the group, says Robert Wade, a partner at Baker & Daniels, LLP, in South Bend, IN.

» Gainsharing/pay for performance. CMS has offered its first generally applicable proposal for gainsharing arrangements, presented as the new “Incentive Payment and Shared Savings Programs” in this year’s physician fee schedule. Until now, CMS has provided little guidance on how gainsharing arrangements might implicate Stark self-referral restrictions, says David Harlow, a principal at The Harlow Group, LLC, a healthcare law and consulting firm in Newton, MA.
Stark changes
continued from p. 1

The OIG has issued a series of 11 advisory opinions giving approval to specific gainsharing models, but those opinions applied to very specific scenarios and didn’t offer far-reaching guidance on how other facilities might implement their own gainsharing arrangements.

“In any event, the OIG advisory opinions give comfort only with respect to the anti-kickback statute, and not the Stark law or others,” Harlow says.

Now, gainsharing programs will meet Stark requirements if the following proposals are finalized later this year:

- It must be documented that the program seeks to improve the quality of care through changes in physician clinical or administrative practices or actual cost savings resulting from the reduction of waste, without an adverse affect on care
- Programs must be reviewed prior to implementation and at least annually thereafter
- Participation must be limited to those physicians who are members of the hospital’s medical staff when the program launches
- Physicians must have access to items or supplies that they deem medically necessary for a patient’s care
- Programs can be no shorter than one year and no longer than three years
- Sharing of cost savings is limited to 50%
- Savings calculations must be incremental (i.e., changes made in year one cannot factor into payments in year two)
- All performance and savings measures must use an objective methodology, be verifiable, be supported by credible medical evidence, and be individually tracked

Although the proposal clarifies CMS’ position regarding Stark, noticeably absent from the proposal was any mention of the anti-kickback statute, says Harlow.

Some hospitals will likely move ahead with gainsharing programs and use the previous OIG advisory opinions and the new Stark proposal (assuming it is finalized) for guidance. However, given the lingering ambiguity regarding the legality of gainsharing on the anti-kickback side, some more conservative hospitals might still opt to go through the OIG advisory opinion process for approval, Harlow says.

“Both are legitimate perspectives,” he adds. “You get the feeling that, sooner or later, there will be a safe-harbor promulgated regulation [for the anti-kickback statute].”

- Alternative method of compliance: signature. If a financial arrangement meets all requirements of an exception, but the facilities don’t have a signature on a written agreement, the arrangement can now still qualify for an exception as long as the signature is obtained within:
  - 90 days after the financial relationship begins if the failure to obtain the signature was inadvertent
  - 30 days after the financial relationship begins if the failure to obtain the signature was not inadvertent

The second example might occur if a physician suddenly dies and a hospital immediately finds another physician to take his or her place, but the contract isn’t set up at the beginning of the relationship.

“This is a recognition by CMS of the complexities that are involved in contracting with physicians,” Wade says.

- Percentage-based compensation. CMS is modifying the percentage-based compensation exception, making it clear that the compensation can apply only to revenue generated from a physician’s personally performed services.

  “For example, you could not compensate a physician on a percentage basis for collections of a department of a hospital, because those would be services that are not directly related to a doctor’s personally performed services,” Wade says.

  Office space and equipment rentals, as well as fair market value compensation and indirect compensation, were also singled out as prohibited uses of percentage-based compensation.

  The rule doesn’t take effect until October 2009 to give some existing arrangements time to be modified.

- Per-click arrangements. In 2007’s fee schedule, CMS looked to tighten restrictions on per-click, or unit-of-service, payments for space and equipment leases when a physician leases equipment he or she owns to a hospital. CMS declared that the per-click fees physicians would receive each time a
patient is referred to the hospital are “inherently susceptible to abuse.”

CMS expanded the definition slightly in the most recent rule to also include the reverse situation: A hospital leases equipment to an independent physician, and one of the hospital’s employed physicians refers a patient to the independent physician.

However, the restriction applies only to per-click leases. Hospitals and physicians can still lease equipment using a block lease, hourly arrangement, or using a full-time annual lease agreement, Wade says.

Definition of a designated health service (DHS) entity. CMS is amending the definition of “DHS entity” to include, in addition to the entity that billed for the DHS, the person or entity that performed the DHS as well.

CMS received a lot of feedback from commenters asking for elaboration on what “performing” a DHS means, but CMS stated that it shall have its common meaning without providing further definition.

However, because DHS is composed of multiple components in addition to performing services (e.g., lease or sell space or equipment, furnish supplies that are not separately billable, or provide management or billing services or personnel), as long as one component is not provided by a group, it may not technically be considered a DHS entity, Wade says.

This change, which will be effective October 1, 2009, may require many “under arrangements” to be either eliminated or restructured.

CMS revises DFRR process

In fall 2007, CMS began an investigation into hospital-physician financial relationships that stalled once organizations began complaining about the financial and administrative burden of the reporting process.

The Disclosure of Financial Relationships Report (DFRR) was initially planned to go to 500 hospitals, and CMS indicated that it may be the first step toward implementing a regular financial disclosure process that would apply to all Medicare-participating hospitals.

CMS took time to assess the feedback, and the process is again moving forward as planned.

The agency released revised estimates of the burden on hospitals in this year’s inpatient prospective payment system final rule.

CMS initially estimated that it would take each hospital 31 hours and approximately $1,550 to complete the DFRR.

Many hospitals argued that that wasn’t enough time or money to complete the eight-page worksheet that asked for financial documents for physicians and the hospital, including leases, medical director agreements, on-call stipends, charitable donations and nonmonetary compensation arrangements (including birthday presents and sporting event tickets), leases, ownership arrangements, and more.

The new estimates are slightly more accurate—100 hours to complete and $4,080 in costs—but they still don’t likely reflect reality, says Robert Wade, a partner at Baker & Daniels, LLP, in South Bend, IN.

“They’ve recognized that accountants and lawyers are going to be involved in this process, and I know very few that are being billed for $40.80 an hour,” Wade says.

Hospitals will have 60 days to complete the report and may be subject to civil monetary penalties of up to $10,000 for each day after the deadline is missed.

For now, CMS has decided to limit this to a one-time reporting process. “Depending on the information we receive on the DFRR and other factors, we may propose future rulemaking to use the DFRR or some other instrument as a periodic or regular collection instrument,” CMS notes.

PCR sources

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Robert Wade, partner, Baker & Daniels, LLP, 202 South Michigan Street, Suite 1400, South Bend, IN 46601, 574/239-1906; bob.wade@bakerd.com.
Primary care reports bigger compensation increases than normal as specialists struggle to keep pace with inflation

Although the results of the 2008 MGMA Physician Compensation and Production Survey—one of the most widely used industry surveys and the first released this year—revealed bigger compensation increases than the 2007 survey, the overall physician compensation picture is still one of relative stagnation.

However, there was a nugget of good news in the data for primary care physicians. Compensation increases were larger than normal for primary care from 2006 to 2007 (the survey is based on data from 2007) after years of flat or declining compensation, and overall primary care compensation increased at roughly twice the rate as overall specialty compensation.

Median compensation for primary care physicians jumped 6.3% from 2006 to 2007—a bigger increase than primary care has seen in the past five MGMA surveys. For comparison, from 2005 to 2006, primary care compensation increased only 2.03%. It is still too early to tell whether that is indicative of a long-term trend.

However, the bad news is that for the industry as a whole, physician compensation levels struggled to keep pace with inflation. Although specialty physicians also reported a bigger compensation increase than in 2007—3.16% in this year’s survey compared to 1.78% in the 2007 results—specialists’ compensation increased only 0.31% when adjusted for inflation.

“The percentage increases, for the most part, are barely keeping pace or are being outpaced by inflation,” says Crystal Taylor, MHA, MGMA’s assistant director of survey operations. “They are not huge increases.”

Market shifts toward primary care

The larger-than-normal jump in primary care compensation is due in part to a growing recognition that primary care physicians have been undervalued by the healthcare system, Taylor says.

“In primary care, we’re seeing a market adjustment where the market is starting to move back toward placing importance on primary care,” she says. “We continued to see primary care increase in the past two years at a faster pace than specialty care.”

Although supply and demand influence compensation levels, CMS is also making more efforts to boost primary care reimbursement.

“We’re seeing a refocus in reimbursement drivers such as Medicare and RVU values being more emphasized on primary care procedures like the evaluation and management codes,” Taylor says.

Although high-volume specialty care procedures are still the bigger revenue generators, primary care is very important to the overall healthcare system, and the increases are beginning to reflect that.

Shift in regions

Another unexpected finding in this year’s survey was a shift in primary care compensation levels by region.

Typically, the southern region of the United States has the highest compensation, due in part to high demand in areas such as Florida.

This year, however, compensation for primary care was higher in the West.

It’s difficult to tell whether the shift reflects the beginning of a trend or a one-year anomaly in the data, says Taylor.

Usually, regional differences are driven by increased competition for physicians due to shortages, medical malpractice crises, or the managed care market.

Winners and losers

Although specialty compensation was flat overall, some did considerably better than others. Noninvasive cardiologists’ compensation increased more than any other specialty’s at 11.72%.

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The continued growth of noninvasive cardiology is reflective of a trend toward managing cardiovascular disease medically rather than surgically, Taylor says.

Other significant increases included:
- Anesthesiology: 9.47%
- Urology: 8.53%
- Pulmonary medicine: 7.25%
- Ophthalmology: 6.22%

On paper, hematology/oncology saw the biggest decrease, with a 16.83% drop in compensation from 2006 to 2007. However, MGMA analysts believe the drastic drop was due to new data that skewed this year’s results, Taylor says.

This year’s data point may not reflect the true market rate, and facilities should use multiple sources to ensure accuracy. Other than hematology/oncology, invasive cardiology was the only specialty that saw a decline in compensation, although the 0.18% drop meant levels essentially stayed the same.

Some of the other specialties that saw the least amount of growth were:
- Emergency medicine: 2.71%
- Gastroenterology: 2.9%
- Orthopedic surgery: 3.02%

“Overall practice costs continue to rise at staggering rates,” William F. Jessee, MD, FACMPE, president and CEO of MGMA, said in a press release. “The continued uncertainty of the reimbursement environment creates an untenable situation for physician groups.”

Crystal Taylor, MHA, assistant director of survey operations, MGMA, 104 Inverness Terrace East, Englewood, CO 80112, 877/275-6462, Ext. 1350; ctaylor@mgma.com.

### 2008 MGMA Physician Compensation and Production Survey

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*Renamed in the 2008 report from Internal medicine: Hospitalist.

Low comp creates geriatrician shortage as population ages

With the number of older adults in the United States expected to nearly double by 2030, the need for geriatricians has never been higher. But training new geriatric specialists has rarely been more difficult, due in large part to the specialty’s low compensation levels compared to other specialties.

In fact, the Institute of Medicine (IOM) predicts an impending healthcare crisis caused by a widening gap between the number of geriatricians needed and the number currently being trained. The IOM report, Retooling for an Aging America: Building the Health Care Workforce, released earlier this year, advocated improving recruitment and retention of geriatric specialists and paying higher salaries.

The Institute of Medicine (IOM) predicts an impending healthcare crisis caused by a widening gap between the number of geriatricians needed and the number currently being trained.

But that is easier said than done. Physicians are increasingly reluctant to enter the field. For example, in 2007, only 54% of geriatric medicine first-year fellowship training slots were filled, according to the American Geriatrics Society. The current shortage of geriatricians is expected to grow more severe if training rates don’t increase substantially.

Without a marked increase in compensation, it’s difficult to see that trend turning around. Geriatrics is one of the lowest-paid specialties in medicine.

“This is one of the great paradoxes of medicine. You have an area that’s very much a shortage area, an area where the public perceives an important need, yet it’s among the lowest in compensation,” says David Reuben, MD, past-president of the American Geriatrics Society and chief of the division of geriatrics at UCLA’s David Geffen School of Medicine in Los Angeles.

Median annual compensation rates are hovering around $162,000, with only marginal increases in the past few years. (See “Geriatrics median compensation trends” on p. 7 for more information.)

That’s not enough to entice medical students who are leaving training with more than $100,000 of debt, says Victor Hirth, MD, medical director of geriatric services at Palmetto Health in Columbia, SC. “With the low average salary in geriatrics, it makes it a challenge to service your debt,” Hirth says.

Lagging behind primary care

It’s not just low geriatric physician compensation that is problematic; it’s that they actually receive less money for additional years of training. Geriatricians complete a three-year internal medicine or family practice residency before entering into an additional geriatric medicine fellowship. And although most subspecialists in other fields earn more money after completing a fellowship, average geriatrician salaries are less than they would be if they had stayed in primary care as generalists.

Internists earned $177,059, and family practitioners (with OB) made $176,796—roughly $15,000 more than geriatricians—according to the 2007 MGMA Physician Compensation and Production Survey.

“Another one of these negative incentives for geriatrics is the fact that, on average, for each additional year of fellowship training for geriatrics, average salary is [considerably] less than if they had gone into primary internal medicine without additional training,” Hirth says.

However, several factors keep reimbursement low and make it difficult for practices to justify higher compensation. The primary obstacle is the makeup of the patient population. Geriatricians work primarily with Medicare patients, and annual payment cuts have kept reimbursement stagnant, relative to inflation, for several years.

On top of that, because geriatricians care for patients who are often 85–95 years old, patient visits take longer and the cases are more complex, making the specialty a relatively inefficient revenue generator.

Investing in service lines

Despite the financial constraints, some hospitals still invest in geriatric service lines and establish centers for senior care, although the decision is usually driven by demographics rather than finances. Particularly in areas with significant elderly
populations, geriatric services can bring indirect benefits through prevention, care management, and a reduction in ED visits. Many quality measures (e.g., pressure ulcers and catheter infections) are tied to geriatric care, as are a growing number of nonreimbursed errors known as “never events.”

However, there are numerous financial challenges, Hirth says. Because geriatric services aren’t a revenue generator, many hospitals with programs primarily seek to keep the programs cost-neutral. “If you’re looking to build a group or a healthcare system, there are a lot of downstream revenues from having geriatricians,” Reuben says. “The patients we see are high utilizers of healthcare.”

Looking for a solution

Given the challenges facing the specialty, what is the next step for providing care for the elderly?

Many geriatricians look to the medical home model of care delivery to revive their practices. Geriatricians often serve as primary care coordinators for the elderly, and the team-based medical home approach would help maximize their skills, Reuben says.

“If you take a look at elements of the patient-centered medical home and take a look at a geriatrician’s practice, they are very similar,” he adds.

However, even a new model will unlikely counteract the effects of a severe shortage of physicians, and compensation levels have yet to increase at the rates needed to draw more students into the field. Medical training is likely to remain organ- or disease-based, rather than focused on a specific patient population such as geriatrics. Realizing this, some in the field advocate training other specialists (e.g., cardiologists and orthopedic surgeons) to better deal with the unique needs of elderly patients.

PCR sources

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Geriatrics median compensation trends

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+ Survey results are based on the previous year’s data.
* Represents combined specialties.

Proposed EMTALA change may ease burden of ED call

Paying physicians for ED call coverage has become a significant financial drain for many hospitals, but a new CMS proposal may offer some relief by allowing hospitals to share the burden.

CMS has proposed adjusting its on-call policies under the Emergency Medical Treatment and Active Labor Act of 1986 (EMTALA) to allow hospitals in a particular region to designate one of the facilities as an on-call site for a designated period. That could allow hospitals to essentially share the cost of on-call compensation between multiple facilities, resulting in a cost savings for all, says Mike Williams, MPA/HSA, president of The Abaris Group in Walnut Creek, CA.

“The obligation for call coverage has historically been perceived to be a hospital obligation and to be fulfilled hospital by hospital,” Williams says. “What CMS is saying now is that when communities come together and wish to create regional call for some specialties where there’s limited coverage, that’s acceptable.”

To participate, facilities must develop a formal community call plan that includes, at a minimum, the following elements:

» Clear delineation of on-call responsibilities (i.e., when each hospital is responsible for coverage)
» Definitions of the specific geographic region covered by the plan
» Signatures from each participating hospital
» Integration into the local or regional emergency medical services plan

» Participation in a community needs assessment from all hospitals
» Language specifying that even if an individual arrives at a hospital that is not designated as the on-call hospital, it still has an EMTALA obligation to provide a medical screening examination and stabilizing treatment
» Annual reassessment of the community call plan

In the rule, the agency gave an example in which two hospitals make a formal community call arrangement: “Hospital A could be designated as the on-call facility for the first 15 days of each month, and Hospital B could be designated as the on-call facility for the rest of each month. Alternatively, Hospital A could be designated as on-call for cases requiring specialized interventional cardiac care, while Hospital B could be designated as on-call for neurosurgical cases.”

Individual hospitals with EDs would still be required to give each emergency patient a medical screening examination and to have a plan for how to proceed if an on-call physician was not available when necessary.

“We believe that community call would afford additional flexibility to hospitals providing on-call services and improve access to specialty physician services for individuals in an emergency department,” the rule states. [H]
The recruiting challenge for internal medicine

by Allen Dye and Troy Fowler

There has long been an institutional bias in medical education against primary care. Many doctors we have spoken with have recounted how they were steered away from primary care by preceptors in medical school. The general sentiment conveyed to medical students has been that surgical and diagnostic specialties are for the most accomplished students and that primary care is for the less accomplished.

This bias has been combined in recent years with a growing disparity in income between primary care physicians and specialists. The result is an acute shortage of primary care doctors and a particularly severe shortage of general internists.

Less than 30% of medical students selecting internal medicine residencies now plan to practice primary care, according to an Association of American Medical Colleges survey. The majority are opting to become hospitalists or internal medicine subspecialists.

The recruitment challenge

As a result, internal medicine is the most challenging specialty to recruit for today. Finding a traditional general internist—one who rounds on patients in the morning, maintains an office practice, then rounds again in the evening—is the recruiting equivalent of scaling Mount Everest.

Whereas an internist practicing as a hospitalist might work 40 hours per week and, with a rotation of seven days on and seven off, enjoy 20 weeks of vacation per year, a traditional internist typically works 60 hours per week and has four weeks of vacation. In addition, a hospitalist is likely to earn several thousand dollars more per year than a traditional internist.

The traditional internal medicine model is close to moribund. This obliges hospitals to establish hospitalist programs so that they can offer internists outpatient-only settings, which are usually more attractive than traditional internal medicine settings.

However, even the outpatient-only model may not be as attractive to internists as working as a hospitalist. Hospitalists typically see 15 or fewer patients per day, whereas internists often see 25 or more. In addition, hospitalists are employed by a hospital or a group, whereas many internal medicine settings feature independent practices in which physicians must contend with reimbursement and other practice management issues.

Many physicians today prefer the security of employment to the uncertainty of private practice.

Focusing on patients

The attraction of internal medicine—whether traditional or outpatient only—is patient rapport. Hospitalists see acute patients who have interesting cases, but such cases can be draining when they are all the doctor sees. Hospitalists also tend to get barraged on weekends, when the hospital staff is reduced and they must manage heavy patient loads. In addition, hospitalists don’t experience patient continuity. Once discharged from the hospital, patients go back to their general internists.

An internist, by contrast, will see healthy patients and can follow patients over time. The emotional rewards of general internal medicine still trump the shift work of hospital practice for some physicians. Although the emotional appeal of internal medicine will attract some candidates, today’s market requires that incentives be competitive.

A competitive internal medicine opportunity will feature balance: a reasonably high salary ($160,000–$170,000 for outpatient only, $180,000–$200,000 for traditional), combined with four to five weeks of vacation/CME, a turnkey setting that does not require a long ramp-up time, minimal night and weekend call, employment, and, where appropriate, educational loan forgiveness.

As long as reimbursement is weighted toward procedures and away from consultative practice, and as long as medical school bias exists, the supply of primary care physicians, internists in particular, will be constrained. This challenge can be met by aggressively seeking candidates who are attracted to the emotional rewards of internal medicine, emphasizing those aspects during the recruitment process, and offering incentive packages that are balanced and competitive.

Editor’s note: Dye is vice president of marketing and Fowler is vice president of recruiting at Merritt, Hawkins & Associates, a national physician search and consulting firm. They can be reached at adye@mhagroup.com and tfowler@mhagroup.com.
Recruiters seek efficiency in ailing economy, tight market
One interview per candidate, housing assistance becoming increasingly common

Physicians are in high demand, as the much-discussed staffing shortage and an ailing economy affect all parts of the country. Like many others, the healthcare job market is feeling the financial strain, leading the way toward new, innovative recruiting strategies. And it’s pushing recruiters to step up their game.

Get creative: Develop a more efficient recruitment process to compete

In addition to competition, the economy is now playing a major role in the physician recruitment process, says Scott Hurst, director of consulting at Dallas-based Delta Physician Placement. Hurst estimates that less than 1,000 physicians are currently seeking new employment opportunities, whereas approximately 5,700 hospitals and health systems are trying to recruit them.

Rather than holding an initial interview, followed by subsequent interviews based on interest in the potential employee, recruiters are opting to conduct only one interview per candidate. This is a cost-saving measure, as recruiters only need to pay once for candidates’ travel expenses, Hurst says.

The one-interview approach serves to expedite the entire hiring process; the more conventional interviewing process simply does not work in today’s market. Hurst notes that traditionally, the initial and follow-up interviews are conducted over a period of one or two weeks. From there, a contract needs to be developed for the chosen candidate, negotiated, and reviewed by legal counsel; the latter can take up to two weeks.

And with competition so fierce, there isn’t that much time to spare. “Once [a physician] becomes a candidate, they’re going to get hit by almost every recruiter out there,” Hurst says. “So the greater speed at which you can move [in the recruitment process], the better.”

Many practices are getting more creative with their recruitment as well. Smallwood says they’re offering housing allowances, more relocation assistance, and hearty sign-on bonuses that will assist with relocation.

In today’s ailing real estate market, it’s becoming increasingly difficult to sell. This forces far too many high-quality physician candidates to turn down positions, Smallwood says, noting that he’s been seeing “more and more fear and anxiety about this.”

He urges candidates to put their property on the market and look at renting or leasing until they find a new home, which can ultimately assist recruiters in expediting the overall process.

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“If you’re starting the interview process, you should start the relocation process at the same time,” Smallwood says.

Making the right choice

So with such an expedited process, how do you know you’re choosing the best candidate? According to Smallwood, preparation is key.

To conduct the one-interview process effectively and efficiently, all of the key players in the recruitment process—recruiters, CEOs, practice leaders, managers—must be present and involved, Smallwood says, noting that some practices have tried cutting down on the number of interviews but lack a strong commitment by everyone to be involved until the final stages of the process.

“Now there’s a more dedicated effort,” Smallwood says.

And a more efficient process shows the practice’s desire to attract strong, quality candidates and bring them on board as soon as possible.

Check references, conduct background checks, and know exactly what you’re looking for in the ideal candidate prior to the interview.

Smallwood says this preparation should be the equivalent to the traditional first interview. You should also be studying candidates’ resumes beforehand to learn about the experience, qualifications, expertise, and skills they would potentially bring to the job.

“Being prepared gives [recruiters] greater peace of mind in finding the right candidate,” he says.

Hurst recommends that immediately following each interview, leaders and recruiters debrief in an effort to choose the best candidate as quickly as possible. And as soon as that choice is made, be prepared to immediately offer the candidate a contract.

“Know what you want and be prepared to move on the first candidate if you determine that person is the right fit,” Hurst says. “If you find the right person, hang on to them, offer them a contract right then, maybe even before they leave.”

PCR sources

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Upcoming audio conferences

October 7 at 1 p.m. (EST)—Physician Compensation Planning: Key Techniques for End-of-Year Evaluations

A misaligned physician compensation plan can cause a lot of problems for your practice: low productivity, physician discontent, or difficulty recruiting new doctors.

If you’re not performing an annual assessment of your income distribution formula, you may miss the early warning signs of trouble.

But with a variety of national and local benchmarking sources to choose from, how do you take this one-size-fits-all data and build a compensation model that works for your unique practice?

Join HealthLeaders Media and two physician compensation experts for this 60-minute audio conference as we explore the evaluation process.

Our discussion will focus on:

» Ways to boost performance by adjusting compensation formulas
» Recognizing red flags for high/low compensation levels
» Elements of external measurements and internal reports
» Incorporating local, national, and regional data into your review process

Learn what you can do now to make sure your compensation plan is working effectively for your practice. Don’t wait until next year to evaluate your income distribution formula.

To learn more about the speakers and the topics they’ll cover, or to sign up for the program, visit www.healthleadersmedia.com.
Ask the experts

What is the best method to calculate fair market value?

Editor’s note: PCR asked compensation experts to discuss options for determining the range of fair market value (FMV) of physician compensation. Their responses are below.

If you would like to ask a question to be featured in a future “Ask the experts” article, please e-mail ebakhtiari@healthleadersmedia.com.

Kim Mobley, principal, Sullivan, Cotter and Associates

FMV as it relates to total cash compensation typically ranges from the 25th to the 75th percentiles of the market. In instances when the total cash compensation exceeds the 75th percentile of the market, organizations can take into consideration other variables, such as productivity (e.g., the ratio of compensation to collections or the rate paid per wRVU), the physician’s unique qualifications or skills, other business judgment factors (e.g., limited supply of physicians within the local market that can provide the required services), and the physician’s historical compensation (for a new recruit).

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

FMV for physician compensation is best determined by using several national, regional, and local sources. At the national level, compensation surveys such as MGMA, AMGA, and others are used to determine the national FMV for each specialty. At the local and regional level, physician compensation FMV can be determined by networking and speaking with hospitals and medical practices within the same region.

Medical associations and societies can be a terrific source of physician compensation comparison. One of the best sources of information on physician compensation is professional physician recruitment firms.

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

The methodologies for determining FMV are based upon several things, including:

- Industry benchmarks and surveys
- Market comparables within the region and local market
- Defining the specific services to be performed
- Analysis of revenue minus applicable cost to derive potential income

When completing FMV reviews, it is important for the independent party to review all these areas and compile a well-analyzed and documented summary to ensure that FMV is concluded upon. Normally, FMV is stated with the specific services defined and will vary a great deal based upon those services.

For example, if the services include a more comprehensive array of work within the hospital as opposed to just pay for call, the analysis must consider this and ultimately quantify the value of those expanded services versus the more limited services for call only.

Also, the conclusion of FMV is normally assigned within a range of dollars, allowing flexibility and fluidness in ultimately deciding upon the actual payment.