Physician recruiting incentives: Salaries, signing bonuses, value-based pay and benefits

Received (in revised form): 15th April, 2019

Kurt Mosley

serves as Vice President of Strategic Alliances for Merritt Hawkins and Staff Care, companies of AMN Healthcare (NYSE: AMN), the largest health staffing organisation in the United States as ranked by Staffing Industry Analysts. With over 28 years of healthcare staffing experience, Mosley is a leading authority on medical staffing trends and has been cited for his expertise in numerous publications, including *USA Today, U.S. News & World Report, Modern Healthcare, Hospitals & Health Networks, HealthLeaders and Medical Economics*. Mosley served on the Council on Physician and Nurse Supply, a group of healthcare experts based at the University of Pennsylvania dedicated to finding solutions to the shortage of nurses and physicians. A nationally noted speaker, Mosley has addressed over 70 healthcare professional organisations over the last two years, reaching over 5,000 industry leaders. A graduate of California State University, Fullerton, Mosley resides in Dallas, Texas.

Merritt Hawkins, 8840 Cypress Waters Blvd. Ste. 300, Dallas, TX 75019, USA
Tel: +1 469-524-1446
E-mail: Kurt.mosley@amnhealthcare.com

Phillip Miller

serves as Vice President of Communications for Merritt Hawkins and Staff Care, companies of AMN Healthcare, the largest healthcare staffing organisation in the United States as ranked by Staffing Industry Analysts. Miller has over 33 years of experience in corporate communications, including over 30 years with Merritt Hawkins. Miller has authored or co-authored dozens of articles on healthcare staffing issues for numerous journals, including *Health Affairs*. He is the author or co-author of four books, including *Will the Last Physician in America Please Turn Off the Lights? A Look at America's Looming Doctor Shortage; Merritt Hawkins' Guide to Physician Recruiting; and Have Stethoscope, Will Travel, Staff Care's Guide to Locum Tenens*. Miller is the lead author of a number of national surveys and white papers, including Health Reform and the Decline of Physician Private Practice, a major white paper completed by Merritt Hawkins on behalf of the Physicians Foundation, a non-profit, grant-making organisation comprising 20 state and regional medical societies. Miller is the lead analyst and author of *A Survey of America's Physicians: Practice Patterns and Perspectives*, of one of the largest physician surveys conducted in the United States, which is commissioned biennially by the Physicians Foundation. Miller is also the lead analyst and author of survey reports completed by Merritt Hawkins on behalf of the Indian Health Service, Trinity University's Department of Healthcare Administration, the American Academy of Physician Assistants and other organisations. A graduate of the University of Texas, Austin, Miller resides in Dallas, Texas.

Merritt Hawkins, 8840 Cypress Waters Blvd. Ste. 300, Dallas, TX 75019, USA
Tel: +1 469-524-1420
E-mail: Phil.miller@amnhealthcare.com

Abstract In order to recruit physicians, healthcare facilities must offer salaries and other incentives customarily included in physician employment contracts. This paper outlines the cost/benefits of offering such incentives and also examines the specific incentives typically used to recruit doctors today, including salaries, production bonuses, signing bonuses, continuing medical education bonuses and others. The paper further reviews how other features of the employment contract, including schedules and work hours, shape the overall character and dynamics of a practice. The paper concludes with a discussion of non-competes, admitting privileges, termination and tail coverage.

KEYWORDS: physician compensation; physician economic impact; physician employment contracts; signing bonuses; value-based payments.

Hospitals, medical groups and other healthcare organisations recruit physicians for a variety of reasons, the primary one being to provide patients with access to the services they need to maintain and enhance health.

While promoting access to quality care is the main driver of physician recruitment, economic factors also come into play. According to Merritt Hawkins' 2019 *Physician Inpatient/Outpatient Revenue Survey*, physicians generate an average of US$2.4m in net annual revenue on behalf of their affiliated hospitals.[1] This income is derived from patient admissions to the hospital, tests and treatments ordered by physicians or procedures performed. The following chart indicates the top ten medical specialities based on the amount of net annual revenue they generate on behalf of their affiliated hospitals (Table 1).

Table 1: Average Annual Net Revenue Generated for Hospitals by Speciality

1.	Cardiovascular surgery	US$3,697,916
2.	Cardiology (invasive)	US$3,484,375
3.	Neurosurgery	US$3,437,500
4.	Orthopaedic surgery	US$3,286,764
5.	Gastroenterology	US$2,965,277
6.	Haematology/oncology	US$2,855,000
7.	General surgery	US$2,707,317
8.	Internal medicine	US$2,673,387
9.	Pulmonology	US$2,361,111
10.	Cardiology (non-invasive)	US$2,310,000

Source: Merritt Hawkins' 2019 Physician Inpatient/ Outpatient Revenue Survey.

The Medical Group Management Association's (MGMA) annual *Physician Compensation and Production Survey* offers similar benchmarks indicating revenues generated by physicians in various specialities on behalf of their medical groups.[2]

Physicians also have a considerable economic impact on the communities in which they practise. In its January 2019 paper The National Economic Impact of Physicians,[3] the American Medical Association (AMA) specifies additional economic benefits derived from physicians, including:

Total physician economic impact. The combined economic output of office-based physicians in the USA is US$2.3tn.

Per capita economic impact. Each office-based physician supports a per capita economic output of US$3.1m.

Jobs. On average, each office-based physician supports 17 jobs.

Wages and benefits. On average, each office-based physician pays US$1.4m in wages and benefits.

Tax revenues. On average, each office-based physician supports US$126,129 in local and state tax revenues.

Against these economic benefits must be set the cost of salaries, signing bonuses and benefits necessary to recruit physicians today. Following this paragraph is a review of incentives typically found in physician employment contracts today.

INCOME GUARANTEES TO SALARIES

As with many other aspects of healthcare, physician recruiting incentives have evolved in recent years. When Merritt Hawkins began recruiting physicians in 1987, the majority of physicians in the United States owned and operated a solo practice or were partners/owners of small medical groups. They typically did not fund or conduct physician recruiting efforts themselves. In most cases, physician recruiting was both paid for and conducted by the hospitals with which independent physicians were affiliated.

In a typical scenario, the hospital would help newly recruited physicians establish a practice by fronting them an 'income guarantee'. In effect, the 'guarantee' was a

loan that had to be repaid over time but that could be 'forgiven' in exchange for the physician's commitment to remain in the community for a stipulated number of years.

Much time and effort were often expended in negotiating the terms of the guarantee, including the dollar amount and the time period over which it would be forgiven. Because the guarantee could be construed as an inducement to refer patients to the hospital, compliance with Stark and federal fraud and abuse laws was imperative.

The situation today is considerably different. The majority of physicians are no longer practice owners or partners. They are employees of a hospital, a hospital-owned medical group, a physician-owned medical group or some other entity. The following chart indicates current physician practice status based on a national survey of 8,777 physicians conducted by Merritt Hawkins on behalf of the Physicians Foundation (www.physiciansfoundation.org) (Table 2).[4]

Table 2: What Is Your Practice Status?

Practice owner/partner	31.4%
Employed by a hospital	19.1%
Employed by a hospital-owned group	17.4%
Employed by a physician-owned group	12.6%
Other	19.5%

Source: A Survey of America's Physicians. The Physicians Foundation/Merritt Hawkins. September 2018.

As these numbers demonstrate, less than one-third of physicians today indicate they are practice owners or partners, compared with almost 50 per cent who identified as owners/partners in the 2012 version of the survey. Physicians who are recruited today are rarely set up in private practice. Instead, they are recruited as employees of hospitals, hospital-owned medical groups, increasingly large physician-owned medical groups, urgent care centres and a proliferating number of other entities now employing doctors. As such, they are almost always offered a starting salary rather than an income guarantee.

In its annual *Review of Physician and Advanced Practitioner Recruiting Incentives*,[5] Merritt Hawkins tracks the methods by which newly recruited physicians are paid and the salaries and other perks used to recruit them. The 2019 *Review* is based on 3,131 search assignments that Merritt Hawkins conducted across the country from April 1, 2018 to March 31, 2019 (Table 3). The following chart shows how physician compensation was structured in these searches:

Table 3: Types of Physician Compensation Structures

Salary	22%
Salary with production bonus	70%
Income guarantee	2%
Other	6%

Source: Merritt Hawkins' 2019 Review of Physician and Advanced Practitioner Recruiting Incentives.

As these numbers indicate, physician contracts today almost exclusively feature either a straight salary, or, more commonly, a salary with a production bonus. Outpatient settings such as urgent care centres and government-subsidised settings such as federally qualified health centres (FQHCs) typically offer physicians a straight salary. In settings where the physician is working for a hospital, a hospital-owned group or a physician-owned group, a salary with production bonus is the typical compensation structure. Income guarantees, by contrast, are virtually a thing of the past.

Few physicians today are seeking to be set up in private practice through an income guarantee that carries with it financial risk. Most prefer the security of a salary with the opportunity to earn more through a production bonus. By employing physicians directly, hospitals and large medical groups seek to achieve the integration deemed necessary to transition to emerging value-based payment models while capturing

market share. Employing physicians also obviates some Stark/fraud and abuse concerns.

PRODUCTION BONUSES

The production bonuses featured in many physician contracts allow physicians to earn more on the basis of their level of effort as measured by a variety of volume-based metrics as well as quality-based metrics. From the employer's perspective, they are levers by which hospitals, medical groups and other facilities can direct physician practice patterns, rewarding doctors for seeing a high volume of patients, for generating revenue through net collections or gross billings, for generating relative value units (RVUs) or for adhering to value/quality guidelines and requirements.

The following chart (Table 4) indicates typical production bonus components in today's physician employment contracts (multiple components possible):

Table 4: Physician Contract Production Bonus Metrics

RVUs	70%
Net collections	18%
Patient encounters	9%
Gross billings	3%
Quality	56%
Other	0%

Source: Merritt Hawkins' 2019 Review of Physician and Advanced Practitioner Recruiting Incentives.[6]

As these numbers indicate, volume-based metrics such as RVUs and net collections continue to be significant mechanisms by which physicians can achieve bonuses. The numbers also show that quality-based metrics have not been universally embraced by entities employing physicians. Despite an industry-wide move towards quality/value-based payments, last year only 56 per cent of Merritt Hawkins' search assignments in which a production bonus was offered featured a quality component. This, however, is up from 7 per cent in 2011, underscoring the fact that quality is likely to play an increasingly important role in physician compensation.

In the 2018 *Survey of America's Physicians* that Merritt Hawkins conducted on behalf of the Physicians Foundation,[7] only 47 per cent of 8,774 physicians indicated their compensation was tied to quality/value-based metrics. Nevertheless, this was up from 43 per cent in 2016, further indicating the direction in which physician compensation is headed.

The following chart (Table 5) indicates how quality or value is usually measured:

Table 5: How Quality or Value Is Measured

Physician Contract Quality-Based Components
Exceeding average patient satisfaction scores
Correctly documenting charts
Appropriate coding and billing
Citizenship (peer review, community relations)
Accuracy of charting/EMR input
Participation in annual quality improvement projects
Patient safety
Clinical process effectiveness
Efficient use of resources
Population/public health participation

Of the physician employment contracts, Merritt Hawkins tracked in its 2019 Review that featured a production bonus, quality metrics accounted for an average of 11 per cent of total physician compensation. In the *Survey of America's Physicians* cited previously, physicians who said their compensation was tied to quality payments indicated that such payments accounted for 14 per cent of their total compensation.

STARTING SALARIES

Merritt Hawkins' annual *Review* tracks average starting salaries for physicians in a variety of specialities that are offered by our clients when recruiting physicians. The following data (Table 6) are average starting salaries in several of these specialities as tracked in the 2019 *Review* compared with starting salaries in the same specialities as tracked in the 2013 *Review*:

Table 6: Average Starting Salaries/Select Specialities

	2013	2019	Increase (%)
Family medicine	US$199,000	US$239,000	20
Psychiatry	US$217,000	US$273,000	26
Internal medicine	US$198,000	US$264,000	33
Orthopaedic surgery	US$488,000	US$536,000	9

The salary increases noted reflect current market conditions in which there are generally more openings for physicians than there are candidates to fill them. In its April 2018 report, *The Complexities of Physician Supply and Demand: Projections from 2016 to 2030*,[8] the Association of American Medical Colleges (AAMC) projects a deficit of up to 121,300 physicians by 2030, including approximately 49,000 too few primary care physicians and 72,000 too few specialists. In Merritt Hawkins' 2017 *Survey of Final-Year Medical Residents*,[9] 50 per cent of final-year residents indicated they had received 100 or more job solicitations during the course of their training, underscoring the intense competition for physician candidates in today's market.

Financial incentives should therefore reflect current market conditions both locally and nationally. It should be noted that the starting salaries tracked by Merritt Hawkins do not include additional income that may be earned when production bonuses are featured in the contract and usually do not include signing bonuses. Average total physician compensation (not just starting salary) is tracked by a number of organisations, including the MGMA and the American Medical Group Association (AMGA). These sources also may be referenced when determining physician financial recruiting incentives.

The amount physicians may achieve through a production bonus will vary by speciality and by the dynamics of each practice. In situations where the payer mix is positive and patients are abundant or where quality goals are achievable and significantly impact total compensation, production bonuses can increase total physician compensation by as much as 30 per cent to 40 per cent for primary care physicians and 10 per cent to 20 per cent for specialists.

SIGNING BONUSES, CME, RELOCATION ALLOWANCES AND BENEFITS

It is common for physician contracts today to feature signing bonuses, Continuing medical education (CME) allowances, relocation allowances and additional benefits. As tracked in the 2019 *Review* (Table 7), signing bonuses were a feature of 71 per cent of physician employment contracts over the last year, with low, average and high signing bonus amounts as follows:

Table 7: Signing Bonus Amounts (2019)

Low	Average	High
US$3,000	US$32,692	US$225,000

Source: Merritt Hawkins' 2019 Review of Physician and Advanced Practitioner Recruiting Incentives.[10]

Signing bonuses, which are usually offered in addition to base salaries, were once relatively rare in physician contracts but have become common as the competition for physicians has increased. They act as an additional motivation for physicians to commit to an opportunity and may make it more practical for physicians to disengage from their current practice and home in order to relocate.

CME allowances were offered in 98 per cent of Merritt Hawkins' search assignments tracked in the 2019 *Review* (Table 8), in the following amounts:

Table 8: Medical Education Allowances

Low	Average	High
US$1,000	US$3,620	US$35,000

Source: Merritt Hawkins' 2019 Review of Physician and Advanced Practitioner Recruiting Incentives.[11]

Relocation allowances, another standard perk in physician contracts, were offered in 98 per cent of Merritt Hawkins' search assignments in 2019 (Table 9), in the following amounts:

Table 9: Relocation Allowances (2019)

Low	Average	High
US$2,000	US$10,393	US$30,000

Source: Merritt Hawkins' 2019 Review of Physician and Advanced Practitioner Recruiting Incentives.

Physician employment contracts also typically feature a range of other benefits. The following chart (Table 10) shows the frequency with which these benefits were offered in the physician recruiting contracts as tracked in the 2019 Review:

Table 10: Employment Benefits

Health insurance	99%
Malpractice	98%
Retirement/401K	96%
Disability	97%
Educational loan forgiveness	31%

Source: Merritt Hawkins' 2019 Review of Physician and Advanced Practitioner Recruiting Incentives.[12]

In addition, some employment agreements feature on-call compensation, with an average for primary care of between US$400 and US$500 a day and rates that can be two to three times that for surgical and other types of specialists. In an era when the employment of physicians has become more pervasive, standard employment benefits such as those listed above also have become more pervasive, though in the past they were less likely to be featured as part of private practice income guarantees.

RECRUITING COSTS

The cost of physician recruiting, including the incentives referenced above, will depend on which type of physician is being sought. The following chart (Table 11) outlines potential recruiting costs for a family medicine physician.

Table 11: Cost to Recruit a Family Medicine Physician

Salary	US$239,000
Benefits	US$50,000
Signing bonus	US$20,000
Recruiter costs (in-house or agency)	US$30,000
Candidate sourcing	US$10,000
Relocation	US$10,000
CME	US$3,000
Marketing/misc.	US$3,000
Total	US$365,000

Some of these costs are one-time, such as the signing bonus and other recruiting costs, while the salary and benefits amounts remain constant, with some variations up or down possible as physician contracts and compensation formulas change. The benefits physicians bring in terms of quality and access to care are difficult to quantify. But a financial cost/benefit comparison is possible by comparing the amount of revenue physicians generate relative to the cost of employing them, using data from Merritt Hawkins' *Physician Inpatient/Outpatient Revenue Survey*, such as the following one for family medicine (Table 12).

Table 12: Family Medicine Recruitment Cost/Benefit Comparison

Cost to Recruit	Annual Net Revenue to the Hospital
US$365,000	US$2,111,931

ADDITIONAL ELEMENTS OF PHYSICIAN RECRUITING CONTRACTS

While physician contracts will feature hard numbers such as salaries and signing bonuses, they will also feature other elements that will help shape the overall character of the practice. Some contracts are structured to be

more entrepreneurial and incentive-laden, while others may reflect a more flexible approach characterised by controllable, lifestyle-friendly schedules. This is a reflection of each medical group's culture. Some groups emphasise a high-volume, high-income ethic and therefore seek 'Type A' personalities willing to work comparatively long hours and see many patients or generate a comparatively high volume of RVUs. Other groups promote an environment that favours flexibility and may include part-time schedules and practice sharing.

Physician contracts will also include other stipulations such as emergency room (ER) call, indicating whether it is assigned or unassigned, and whether there is on-call compensation. If RVUs are included in the compensation package, the formula should be outlined in the contract. Other practice characteristics may be referenced, such as the inpatient census of the practice, or the payment policy on phone calls and prescription refills. Expectations regarding work hours should be specified in the contract. Some employment agreements will stipulate that the physician be present during 'normal hours of operation'. If so, the definition of 'normal' should be made explicit.

Paid time off (PTO) is generally a standard feature of physician employment contracts today. It typically runs between four and five weeks for most physicians, though this can be negotiated. There is a difference between vacation time and overall PTO, and this should be delineated in the agreement.

As referenced earlier, schedule flexibility is an increasingly important consideration, particularly for younger physicians in their child-rearing years. More practices today are open to part-time schedules or to practice sharing, at least verbally, but it is important to ensure schedules are verified in writing to prevent 'schedule creep'.

Practice flexibility may also include the physician's ability to build his or her own concierge/direct pay patient base, while continuing to accept third-party payments from the majority of patients. In some practices, concierge/direct pay reimbursement can be pooled together or paid separately to individual doctors.

NON-COMPETES, ADMITTING PRIVILEGES, TERMINATION AND TAIL

In today's market, most large physician employers are not particularly concerned about non-compete agreements as few physicians leave to set up practice on their own. If employers are concerned about this, the non-compete clauses featured in their employment agreements are usually iron clad. In those cases where non-competes are an issue, they may impact a physician's desire to moonlight. Physicians who do have such an interest should obtain permission in writing.

Similarly, some physicians may wish to pursue outside business interests, such as patents, clinical trials, devices or speaking engagements. Such income should be considered separate from the physician's salary and production bonus and be stipulated as such in the agreement. The employment agreement should also state the facilities at which the physician is required to have admitting privileges. Physicians should not be prevented from obtaining privileges where they wish. In addition, there should be no language in the agreement, specific or implied, tying physician compensation to volume of patient referrals. This is a violation of federal fraud and abuse and tax laws, as are salaries or income guarantees that are beyond what is customary and reasonable in a given speciality.

The standard period for termination is 30–90 days without cause. Physicians should not have to stay at the facility or practice for several months or more if they are not satisfied or are uncomfortable. Termination for cause is usually for clear offences.

Larger employers today usually pick up tail insurance as a matter of course. If physicians leave without cause during the contract period, however, the obligation to obtain such insurance may be on them.

A CHANGING MODEL

The healthcare system in the USA is in the midst of an evolution that includes fundamental changes in the way healthcare facilities and healthcare professionals are reimbursed and in the way physicians choose to practise. The independent model in which physicians own their practices and pay themselves after expenses are met is giving way to the employed model, in which physicians receive salaries from hospitals, hospital-owned groups and other entities, often in conjunction with a production bonus. The production bonus may be structured around volume-based metrics, value-based metrics or a combination of both. Physician recruiting incentives are also likely to include a signing bonus, relocation allowance, a CME allowance and a range of employee benefits. By stipulating hours, work expectations and other practice characteristics, the recruiting contract may shape the culture of the practice. All aspects of the incentive package should be carefully considered to ensure that it is competitive and reflects the needs of both the recruiting facility and potential physician candidates.

References and Notes

1. Physician Inpatient/Outpatient Revenue Survey. Merritt Hawkins. March, 2019.
2. The Medical Group Management Association's (MGMA) Annual Physician Compensation and Production Survey.
3. The National Economic Impact of Physicians. Prepared for the American Medical Association by IQVIA. January, 2018.
4. A Survey of America's Physicians: Practice Plans and Perspectives. Prepared for the Physicians Foundation by Merritt Hawkins. September, 2018.
5. Review of Physician and Advanced Practitioner Recruiting Incentives. Merritt Hawkins. July, 2019.
6. *Ibid.*
7. *Ibid.*, ref. 4 above.
8. Dall, T., West, T., Chakrabarti, R., Reynolds, R. (March 2018) 'The complexities of physician supply and demand: Projections from 2016-2030', Association of American Medical Colleges, available at: https://aamc-black.global.ssl.fastly.net/production/media/filer_public/31/13/3113ee5c-a038-4c16-89af-294a69826650/2019_update_-_the_complexities_of_physician_supply_and_demand_-_projections_from_2017-2032.pdf.
9. Merritt Hawkins' 2017 *Survey of Final-Year Medical Residents*.
10. *Ibid.*, ref. 5 above.
11. *Ibid.*
12. *Ibid.*