

PHYSICIAN COMPENSATION & RECRUITMENT

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Private practices catch up to hospital-owned starting salaries

Competition for new recruits, changing physician attitudes lead groups to increase initial offers

Compensation trends that have for a long time distinguished between hospital- and physician-owned practices may now be changing as physician recruitment becomes more competitive across settings. For years, physician compensation distribution across ownership settings has followed a similar pattern: Hospital-owned physician practices—as well as those owned by an integrated delivery system (IDS)—generally offered higher starting compensation levels than private physician-owned facilities, but taken over time, compensation levels in private practices were significantly higher.

Private practices were able to offer lower starting salaries because the prospect of partnership and long-term financial security enticed many physicians to forgo a higher starting salary.

However, the results of the 2007 MGMA *Physician Placement Starting Salary Survey* suggest that may no longer be the case. Compensation offered to first-year physicians in physician-owned practices is beginning to catch up to, and sometimes surpassing, levels offered in hospital- and IDS-owned practices.

For example, general internists earned more in physician-owned practices than in hospital- or IDS-owned settings—\$150,000 versus \$145,000 annually—according to the report. Yet the 2006 report showed the opposite: Internists made \$148,000 in hospital-owned settings and \$130,000 in physician-owned practices.

A similar reversal occurred in orthopedic surgery. Orthopedic surgeons in hospital-owned

practices made a median 5.8% more than surgeons in physician-owned practices in the 2006 report, but they earned 8.1% less in the 2007 report.

Although not all specialties have seen such dramatic reversals, the gap has begun to close, even for specialties that still show higher starting salary levels in hospital-owned settings.

“Hospitals recently are going out and recruiting those physicians that can enhance their offerings. As a private practice, you’ve got to keep up with that.”

—Michael Kasher

The reason? Physician recruitment, like health-care management in general, is much more competitive, and many practices have no choice but to ramp up starting salary levels to remain competitive, says **Michael Kasher**, director of survey operations for MGMA.

“Private practices are trying to keep up with the hospital offerings, particularly in some of the competitive specialties,” he says. “Those are some of the hot areas, and hospitals recently are going out and recruiting those physicians that can enhance their offerings. As a private practice, you’ve got to keep up with that.”

Starting salaries

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Physician values have changed

Although increased competition is the impetus for the rising starting salaries in physician-owned practices, the shift might not have happened were it not for a cultural change in the physician community and a rejection of the entrepreneurial model of practicing medicine by some, says Kasher.

Work-life balance and steady employment have climbed up many physicians' list of priorities and can be as important as compensation levels when it comes to selecting a practice opportunity. Many would rather sign a contract

with a hospital to work a fixed number of hours and be freed from the business hassles of managing a practice, particularly given the pressures of annual Medicare cuts and rising healthcare costs.

The lure of a future partnership in a practice and a higher income down the road simply isn't enough to recruit some physicians into a private practice setting anymore. So to keep up, private practices have to offer more up front.

"You're starting to see more of a bend toward some lifestyle decisions. The whole issue of not having to worry about the business of medicine and maybe not having to work quite so hard in getting your salary up front becomes attractive to those physicians," Kasher says.

First-year and total compensation by practice type

Specialty	First-year physicians*		All physicians	
	Physician-owned	Hospital-owned	Physician-owned	Hospital-owned
Anesthesiology	\$300,000	\$300,000	\$364,758	\$365,737
Cardiology (Noninvasive)	\$350,000	\$340,000	\$367,704	\$367,500
Dermatology	NA	NA	\$337,507	\$329,272
Emergency medicine	\$180,000	\$215,518	\$252,779	\$229,960
Family practice (w/OB)	\$150,000	\$130,000	\$167,745	\$185,782
Gastroenterology	\$300,000	\$335,000	\$405,787	\$411,166
General surgery	\$203,364	\$275,000	\$308,182	\$290,028
Hospitalists	\$159,789	\$152,500	\$196,146	\$188,488
Internal medicine	\$150,000	\$145,000	\$185,955	\$168,801
OB/GYN	\$190,000	\$220,000	\$272,815	\$266,379
Orthopedic surgery	\$400,000	\$367,500	\$429,540	\$404,612
Otolaryngology	\$282,500	\$250,000	\$323,021	\$353,746
Pediatrics	\$140,000	\$132,000	\$174,577	\$173,863
Radiology (Noninterventional)	\$350,000	\$345,000	\$429,525	\$422,560

* Includes all physicians in a new practice.

Source: 2007 MGMA Physician Placement Starting Salary Survey. Reprinted with permission.

Many physicians also come out of training looking to get out of debt and establish a financial portfolio, and because of the increasingly competitive recruitment environment, they are able to interview at several facilities and weigh their options.

“They are anxious to get on top of the school loans and are often looking to buy a house,” says **Patrick S. Fahey, MBA, FACMPE**. As administrator of Heart Consultants, PC, a 17-physician cardiology practice in Omaha, NE,

Fahey says he has heard such concerns in recent interviews with recruits.

“I think there’s a balancing act that has to play out where typically physicians who would prefer to be in an independent practice see some immediate financial security that comes with those base guarantees. They may be overwhelmed with debt, and their thinking is influenced by that,” he adds.

Upcoming audioconference

Retention strategies to keep top physicians

Want to learn more about some of the physician retention topics you’ve read about in **PCR**? Join HealthLeaders Media at 1 p.m. (EST) on February 12 for a one-hour audioconference, “Retention strategies to keep top physicians.”

Why you should listen

It can cost 2.7 times a physician’s annual salary to find a replacement when he or she leaves, and as the market evolves, retaining physicians has become more complicated than simply offering more money. Cultural fit and other nonmonetary factors also play a role. Developing a strong retention plan will enable your organization to maintain a cohesive culture and avoid the high costs of recruiting.

What you’ll learn

During this 60-minute audioconference, you’ll discover retention strategies that you can implement immediately without breaking the bank. Brian McCartie of Cejka Search and Kevin Donovan, FACHE, FACMPE, of Elliot Health System will explain why many physicians leave practices and how you can keep them happy.

How to sign up

To learn more about the speakers and the topics they’ll cover, or to sign up for the program, visit www.hcmarketplace.com/prod-6118.html.



Offering more is worthwhile for most

For many practices, the consequence of this shift in salaries is a further pinch on already tight budgets. The funds to increase initial compensation levels often come from physician owners and partners. They have to sacrifice some of their own income to bring in a new physician and keep the practice viable.

However, the financial sacrifice is often worthwhile if it brings a new physician on board, Fahey says. In order to remain competitive with other major cardiology practices in the area, both hospital- and physician-owned, Heart Consultants, PC, has had to increase base salary levels and now pays new physicians the same base salary as partners. Although shareholding physicians still earn more overall—they are eligible for bonuses and dividends to boost compensation—the parity in base salary levels impresses physician recruits when they are comparing opportunities at several facilities, he says.

“We used that to send a message to new recruits. One of our recruiting pitches is that ‘you’ll be paid the same base salary as everybody else in the practice.’ ”

Before upping base salary levels, the practice lost a few potential recruits to a nearby hospital-owned practice with “deep pockets,” he says. In areas where practices engage in similar bidding wars, offering higher starting salaries is relatively inconsequential, particularly in larger groups that can diffuse the cost among its physicians, he adds. “When you’re at 17 physicians, the impact is spread out. Physicians generally come up to speed and start producing fairly quickly.”

PCR sources

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General surgery comp lags behind that of subspecialists

Compensation data for general surgery paint two pictures, depending on which general surgeons you're considering. For traditional general surgeons, compensation is increasing modestly, but at \$306,115 per year, according to the 2007 MGMA *Physician Compensation and Production Survey*, it is one of the lowest levels of any surgical specialty.

General surgery subspecialists (e.g., general surgeons who have fellowshiped in hand, pediatric, vascular, trauma surgery, etc.), on the other hand, earn significantly more and are seeing bigger year-to-year increases.

"You still have the bread-and-butter general surgeons out there, but I'm seeing more moving into a specialized field."

—Rob Rector

For example, trauma surgeons earned a median compensation of \$344,629, according to MGMA data from 2006, a 14% increase from the previous year.

Vascular surgery also saw a double-digit increase and grew to \$362,832. Standard general surgery increased only 1.8% during the same period.

Attracted by the higher earning potential, more general surgeons are taking the extra time to fellowship in one of these subspecialty areas.

"You still have the bread-and-butter general surgeons out there, but I'm seeing more moving into a specialized field," says **Rob Rector**, senior vice president of recruiting with Atlanta-based Pinnacle Health Group. "If you've got an

added specialization other than basic general surgery . . . that gives you a little bit more of a marketable skill."

There is still enough demand for surgical services to keep general surgeons busy. However, surgical subspecialization has in part caused the relatively slow climb because subspecialists draw from patients who, at one time, may have been treated by general surgeons. The competition often isn't as fierce in rural areas, where the demand for all surgical services is high, but "as you get closer to metropolitan areas, [physicians] have got to bring a little more to the table and maybe subspecialize a little," Rector says.

Technology cuts caseload

But it isn't just subspecialized surgeons that are cutting into general surgeons' procedural volume and creating professional turf battles. General surgery is being sliced and diced into segments due to competition from some nonsurgical specialists as well.

OB/GYNs performing C-sections or gastroenterologists operating an ambulatory surgery center are siphoning off procedures that were previously covered by general surgeons.

Advances in technology (e.g., the growth of the use of minimally invasive procedures) are also partly to blame. During the past 10 years, technological strides have made it possible for physicians to perform a host of procedures through small incisions.

For example, interventional radiologists are able to address complications of the disease process (e.g., the percutaneous draining of an inflamed gallbladder). Also, more highly trained, minimally invasive surgeons perform surgical procedures such as colectomy and appendectomy, which may require the use of a laparoscope in lieu of the conventional general surgeon.

"A lot of things that we used to remove surgically, like a small polyp, many of these things are performed endoscopically now. So there are a lot of turf wars. The whole trend is toward minimally invasive approaches," says **Edward Mun, MD**, director of bariatric surgery at Faulkner Hospital and assistant professor at Harvard Medical School in Boston.

Although using these minimally invasive procedures benefits the patient through faster recovery, reduced pain, and lower levels of procedural complications, they also result

Specialty compensation calendar

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

- » Pulmonary medicine
- » Radiology
- » OB/GYN

in financial losses for general surgeons. “If you take what a general surgeon does and start chipping away at the potential patient base, that can be a big factor in compensation. You have a pie that keeps getting sliced away,” Rector says.

However, as physicians continue to subspecialize, the turf distinctions between the fields will likely become more clear-cut, says Mun.

Surgicalists address lifestyle, call issues


General surgery is also being affected by problems common to other specialties, such as physicians’ preferences for schedules that allow for a balanced lifestyle and struggles over being paid for call coverage.

Enter the surgicalist, a general surgeon who works on-site at a hospital to handle emergency cases. Hospitals are increasingly adopting this nascent model—which is essentially an adaptation of the hospitalist employment structure—to address call coverage issues and physician work-life balance concerns.

Most surgicalists are employed directly by the hospital, which pays for malpractice insurance and takes care of other financial considerations. Hospitals and surgical groups are also finding that employing a few general surgeons within a multispecialty group to handle call cases can increase throughput at the hospital and increase the quality of life

for the rest of the physician group practice—at little detriment to the income of the remaining physicians.

For example, a hospital can assign employed surgicalists to emergency, unscheduled surgeries, ensuring that there is always a surgeon available for emergencies. This frees general surgeons so they can focus on scheduled and elective cases.

In fact, some large medical groups are beginning to recruit surgeons to work as surgicalists, handling call duties for the rest of the group, much like some primary care groups assign a physician to serve as a hospitalist. This improves the group’s overall recruitment efforts, as it can promise nonsurgicalist recruits a better payer mix and freedom from call duty. “A lot of surgeons, when we’re operating at two in the morning, wish we had a surgicalist who can cover these shifts,” says Mun. However, some surgeons are concerned about how follow-up care is delivered and whether surgicalists will interrupt the continuity of care. How surgicalists will ultimately affect the specialty remains to be seen, he adds. “I don’t know how this is going to pan out in the future,” he says. “It’s an interesting concept.” 

PCR sources

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General surgery compensation trends

Compensation survey	2007 median+	2006 median+	2005 median+	% chg 2006-2007	% chg 2005-2006
<i>AMGA Medical Group Compensation and Financial Survey</i>	\$327,902	\$310,736	\$294,000	5.52%	5.69%
<i>HCS Physician Salary Survey Report (salary data only)</i>	\$209,267	\$188,729	\$161,601	10.88%	16.79%
<i>MGMA Physician Compensation and Production Survey</i>	\$306,115	\$300,800	\$282,504	1.77%	6.48%
<i>Sullivan, Cotter and Associates Physician Compensation and Productivity Survey</i>	NA	\$264,497	\$270,005	NA	-2.04%

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

Source: Data excerpted from AMGA, Hospital & Healthcare Compensation Service, MGMA, and Sullivan, Cotter and Associates compensation surveys. Reprinted with permission.

Pay physicians for call with nonqualified deferred compensation

When medical staff physicians at Winchester (VA) Medical Center grew unhappy with call volume and began asking to be paid for call coverage roughly three years ago, administrators researched how other hospitals were handling the issue and came away unsatisfied with the typical solution.

As hospitals and physicians increasingly butt heads over pay for call, many hospitals attempt to solve the problem by paying some sort of stipend or per diem rate to the specialists with the highest call burden.

"Once the plan was announced to the broader medical staff, the problem went away overnight. Not only were there no physicians expressing concern about taking call anymore, but we had several physicians . . . come back to taking call because of the financial compensation and recognition associated with it."

—James Woodward, FACHE

Although this method might have satisfied physicians, it wouldn't have engaged the medical staff or built a sense of partnership between the physicians and the hospital, says **James Woodward, FACHE**, who was president and CEO of Winchester at the time. And as many hospitals have discovered, paying specialists for call can be extremely expensive and can quickly spiral out of control.

With physician alignment in mind, Woodward teamed up with Horty, Springer & Mattern, a healthcare law firm based in Pittsburgh, and MaxWorth Consulting Group, LLC, in Charlotte, NC, to develop a unique approach. Rather than just writing a check to physicians, they structured payments in a nonqualified deferred compensation plan, a method corporations often use to align interests with highly paid executives.

Physicians were happy because they began receiving pay for previously uncompensated call coverage, and the structure of the pay system benefited the hospital because physicians had

to meet preset conditions before receiving the compensation. "Once the plan was announced to the broader medical staff, the problem went away overnight," says Woodward. "Not only were there no physicians expressing concern about taking call anymore, but we had several physicians who had either planned to stop taking call or already had done so come back to taking call because of the financial compensation and recognition associated with it."

The nuts and bolts

The deferred compensation plan, which MaxWorth Consulting has since trademarked as the Call-Pay Solution, is built as a 457(f) supplemental retirement plan under IRS terminology and "looks and feels" like a 401(k) plan, says **Steve Worthy**, a senior partner at MaxWorth Consulting.

Money is deposited into a physician's account based on a tiered ranking of specialties (tier one represents the highest burden of call and receives the largest payment), and can be invested and shifted much like a standard retirement account.

But deferred compensation plans, per IRS rules, must have a significant risk of forfeiture, so physicians participate in a vesting period—often between five and 10 years—before receiving the funds. During the deferral period, the contributions remain as an asset of the hospital, creating a "balance sheet-friendly approach to compensation," says Worthy.

If a physician leaves the hospital before the end of the vesting period, he or she essentially forfeits the entire amount, creating an obvious benefit from the hospital's perspective. Many hospitals, including Winchester, also purchase corporate-owned life insurance, a unique institutional type of investment that includes a life insurance benefit. The proceeds of the investment are paid exclusively to the hospital, but in the event of the death or disability of a physician, the account value is paid to the physician or a beneficiary.

These two cost-recovery features combine to protect the hospital, and over time money recovered from forfeitures and life insurance policies can help fund the program. "If the hospital doesn't do well in a particular year and has difficulty funding the plan, there's money to pull from," Woodward says.

This also prevents costs from spiraling out of control, says **Max Hockenberry**, a founding member of MaxWorth

Consulting. “The important thing there is the budget is not doubling or tripling in the next few years. The budget is staying flat.”

The catch

Winchester Medical Center had success implementing the plan, in part, because it had recently moved to a Level 2 trauma center status, making it a regional referral center. Its physicians, while taking call, were being inundated with a large volume of patients—including many uninsured—with whom they had no association, meaning their time and fees were going uncompensated.

But would the system work for every hospital? Although physicians who haven’t received pay for call in the past frequently welcome any new form of compensation, if a hospital already pays its physicians for call coverage, it may be a tougher sell to the medical staff physicians.

The sticking point with physicians is the vesting period before the compensation is received and the restrictions that accompany it, says **Eddie Phillips**, a shareholder with Pershing Yoakley & Associates, PC, in Atlanta. Physicians may not like being constrained by the vesting period, knowing that they would lose the money they’ve earned if they take another position in the near future or leave for other reasons.

“You could not put this in a situation where you’re already paying for call coverage. You couldn’t offer [deferred compensation] instead. Physicians would revolt,” he says.

Involve medical staff

Given physicians’ concerns about the vesting requirements, careful implementation is crucial to making a deferred compensation plan successful.

The Call-Pay Solution is centered on decisions made by the medical staff, which plays an important role in its success, according to Hockenberry.

The first step in the program involves setting up a “governance group call committee,” made up primarily of physicians, to assign the tiers that determine pay rates.

Medical staff physicians meet and divide specialists into tiers based on four factors:

1. Frequency of call
2. Intensity of call

3. Liability and risks
4. Community need for services

Allowing physicians to rank each other based on these criteria prevents finger-pointing or perceptions of unfairness that might come from a unilateral assignment from hospital administrators, Woodward says.

“You could not put this in a situation where you’re already paying for call coverage. You couldn’t offer [deferred compensation] instead. Physicians would revolt.”

—Eddie Phillips

Physician involvement and leadership helped the plan succeed at Winchester, he adds. “In my career it was one of the defining projects I’ve worked on, where administration and the medical staff come together and solve something for the benefit of the community. It was a win-win all the way around,” he says. 🏠

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Offer compensation to encourage medical staff leadership

In recent years, finding medical staff members to assume leadership positions has become an increasingly daunting task. The mounting pressure on physicians' time and the increasing burden of leadership work has dissuaded many excellent doctors from stepping forward into these roles.

In addition, many physicians dislike organizational politics, detest meetings, and are averse to any activity that takes them away from the office, off the hospital floors, or out of the OR.

Indeed, these locations are where physicians find the reward of providing good patient care as well as performing the activities that generate their income.

For independent physicians—who comprise the bulk of the membership on most medical staffs—there is insufficient financial incentive, too little personal satisfaction, and not enough spare time to readily induce them into administrative roles.

To overcome these barriers, the medical staff organization must have an aggressive and proactive approach to the recruitment of physician leaders.

Offering compensation helps stir interest in medical staff leadership, potentially getting more qualified individuals to volunteer. It also helps encourage and motivate physician leaders, who might otherwise resent their medical staff responsibilities.

However, even those who agree that leaders should be compensated have disagreements about where the funds should come from, which leaders should be compensated, and how much they should be paid.

Where should the funds come from?

Which entity—the medical staff or the hospital—contributes the funds to compensate physician leaders? Some

argue that because medical staff leadership is a medical staff function, the money should come out of medical staff funds. Others claim that even though leaders perform mainly medical staff functions, they also perform a valuable service for the hospital, so the hospital should pay.

Medical staffs that take responsibility for paying leaders must still decide how to raise the funds. Some staffs increase medical staff membership dues, arguing that doing so:

- » Is consistent with the value of medical staff activities
- » Preserves medical staff control over committees and other functions, instead of giving hospital administrators influence
- » Discourages physicians who have little interest in the hospital and leadership issues from applying for medical staff membership

Some organizations compromise and have both the hospital and the medical staff contribute compensation funds. This arrangement eliminates the “us versus them” philosophy that can develop if one entity foots the bill for leadership compensation. It also gives each body a vested interest in making physician leaders successful.

Which leaders should be compensated?

There is no agreement about which medical staff leaders should be compensated. Some medical staffs and/or hospitals compensate only the president (or chief) of the medical staff and the medical executive committee (MEC) chair. Others compensate the president and all members of the MEC, as well as department chairs and chairs of the quality and credentials committees.

Several factors influence this decision, including the financial resources available and the difficulty organizations have recruiting uncompensated leaders.

How much should they be paid?

The amount of money that medical staff leaders should receive is also a contentious subject. One medical staff leader suggests giving stipends to leaders who have a lot of responsibilities and paying other leaders on a fee-for-service basis—for example, \$200 per meeting for committee chairs and

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\$100 for each attendee. This plan would not only encourage attendance; it would give physicians an added incentive for maintaining ongoing interest in a committee.

Attendance at the general staff meeting would not be compensated, however, as that is a condition of medical staff membership. Any amount that the hospital can afford will show its appreciation for leadership activities.

Providing other benefits for physician leaders

Sometimes compensation is not enough to convince physicians to become medical staff leaders. Some feel they simply don't have the time to devote to leadership duties, or that they aren't prepared to take on the challenge. Other times, hospitals might not be able to pay a lot of money to physician leaders. In these cases, hospitals might consider other perks in addition to, or instead of, a stipend.

For example, consider the following strategies:

- » Waive medical staff fees for leaders
- » Provide leaders with leadership and management training to help them perform their jobs well
- » Demonstrate appreciation for physician leaders' hectic lives by developing a flexible meeting schedule
- » Supply leaders with subscriptions to management and medical periodicals, such as *The Wall Street Journal*, *Medical Economics*, **Medical Staff Briefing**, and physician leadership guidebooks
- » Provide leaders with an office, support staff, a laptop computer, a cell phone, a home fax machine, and other things to help them fulfill leadership responsibilities
- » Send leaders and their spouses or partners on an annual trip

There is a trend around the country to lengthen the terms of office for important medical staff positions. This is to promote continuity and to give leaders a chance to grow into their roles.

In many organizations, this is compounded by linking positions serially into a continuum of responsibility. For example, a president-elect becomes president and subsequently immediate past-president.

The upside of this trend is apparent, but the downside is a disinclination for new leaders to embark on the prolonged path.

New leaders should be encouraged to experiment with short-term roles, such as committee membership or task force membership.

If they find the work gratifying, a longer commitment in a different role may not seem as formidable. There should also be clear recognition within the organization that leaders may, from time to time, need to step down from positions because of unforeseen competition for their time and/or attention.

New leaders need to understand that commitments should not be abandoned without compelling reasons, but that if such reasons arise, leadership is not a trap. Indeed, an important reason for an effective leadership succession planning strategy is to be able to navigate these kinds of occurrences. ■

Editor's note: This article was adapted from How to Recruit and Develop Physician Leaders: A Strategy for Medical Staff Leadership Development, an HCPro, Inc., publication. For more information, visit <http://hcmarketplace.com/prod-2056.html>.

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Top 10 signs of a successful compensation plan

by Max Reiboldt, CPA

As private groups and hospitals consider alternatives for their compensation incentive plans for physicians, there are many traits that point to a successful plan's structuring and implementation.

As we work through the process of designing income distribution plans (IDP), at times it appears to be an almost futile effort; seemingly, no one is happy or even somewhat positive about the entire change process. Although this may be the case, the need for groups and hospital networks to complete this analysis is usually apparent and necessary.

Over the years, as we have worked with physician groups and hospital networks of all sizes and specialty makeups, it

has become apparent that although there is truly no perfect compensation plan, there are many traits that point to a successful change process.

The following summarizes the top 10 signs of success for compensation plans. Although not all of these will apply for various organizational structures, overall they point to a much more positive process. In the final analysis after the new IDP develops, productivity increases and incentives are much better aligned. ■

Editor's note: For more information, contact Max Reiboldt, CPA, The Coker Group's managing partner and CEO, at 678/832-2007 or via e-mail at mreiboldt@cokergroup.com.

Compensation plan success traits	Comments
1. Maintains physician's quality of life	Allowing the physicians to have a "life" outside of medicine is essential in this day and age.
2. Grows income via ancillary services	This is often a "reason for being" for many groups.
3. Solidifies relationships with: <ul style="list-style-type: none"> » Hospitals » Independent ventures » Other groups » Others 	Partnering is extremely important as a part of the alignment strategy.
4. Maintains mostly individually based production incentive/pay plan	At the end of the day, most physicians still prefer to be paid primarily based upon their individual production.
5. Revenue/cost sharing allocations done fairly, objectively; reflective of group structure and objectives	Appropriate revenue and cost allocations form the crux of the income distribution plans (IDP); this promotes group thinking and a cohesive mind-set—a very important ingredient to a successful IDP.
6. Considers appropriate allowances for part-time practitioners' compensation	This is a major issue with many physicians today; it cannot be overlooked within the IDP and must be fair to both the full-time and part-time associates.
7. Molds group/network mind-set	Virtually every incentive should be established with this as an overarching objective.
8. Responds to time-off policies	A heavy individual productivity-based plan must consider an allowance for the time not being worked by the physicians.
9. Considers non-productivity-based incentives: <ul style="list-style-type: none"> » Quality » Citizenship » Collegiality » Administrative adherence 	These are major ingredients to a successful practice and should be appropriately incentivized; quality and clinical performance will become even more prominent in the next few years.
10. Responds to overhead control requirements	In a heavy productivity-based model, this is often overlooked, but it should be an ingredient of the IDP; it is just as important to control costs as it is to increase revenue.

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CMS delays anti-markup rule changes until 2009

CMS has announced that it will delay implementing the final anti-markup regulations included in the final 2008 Medicare Physician Fee Schedule until January 1, 2009.

CMS cited the need to clarify what constitutes the “office of the billing physician” after receiving feedback from physician groups questioning the applicability of the rule to arrangements that otherwise comply with the federal Stark statute, claiming that patient access may be significantly disrupted due to the alleged inability of physician groups to render services in a cost-effective manner.

Tax credit to boost rural healthcare providers

New Mexico officials have announced a new tax credit for healthcare providers who provide care in rural, underserved areas of the state.

Physicians and other healthcare providers may be eligible for an income tax credit of \$3,000 or \$5,000. The New Mexico Department of Health began accepting applications for the Rural Health Care Practitioner Tax Credit Program at the beginning of the year.

Medicare participation deadline extended to February 15

Because of last-minute action by Congress to eliminate a proposed 10% reduction to physician payments, physicians will have until February 15 to

make changes to their 2008 participation status in the Medicare program. The law postpones a 10.1% cut in physician payments for six months and instead provides for a 0.5% increase until June 30.

The decision to participate in Medicare is binding for the entire year, so with a potential 10% payment cut looming in the middle of the year, CMS extended the deadline for physicians deciding about participation.

Sever doctor shortage predicted in Maryland

Much of Maryland faces a doctor shortage that could become severe by 2015, according to a report by two state healthcare groups.

The effect will be felt most acutely in overextended ERs, where finding specialists for on-call duty is already difficult. There are currently 16% less doctors in clinical practice in the state than the national per capita average, and in some areas nearly one in three specialists is over age 60.

Study: Training more docs will drive up costs

As many groups are calling for more physician training to meet the medical needs of the baby boom generation, researchers at Dartmouth Medical School’s Institute for Health Policy and Clinical Practice in Hanover, NH, contend that an influx of doctors will increase costs on an already financially troubled Medicare system.

“Calling for more doctors, like prescribing more drugs, for an already over-

medicated patient, may only make things worse,” said David Goodman, MD, a professor of pediatrics and family medicine at Dartmouth Medical School.

Physician-owned hospitals faulted for emergency care

Already under heavy fire because of concerns about their financial arrangements, physician-owned specialty hospitals are now coming under scrutiny regarding their ability to provide emergency care, according to *The Washington Post*.

A recent report by HHS found that many physician-owned specialty hospitals are ill-equipped to handle emergencies. Federal investigators found that only 55% of 109 physician-owned hospitals had emergency departments, and most of those had only one bed.

About one-third relied on dialing 911 to get emergency medical assistance, and less than one-third had physicians on-site at all times; 22% had no written policies for addressing emergency cases.

New York considers paying off student loans to attract docs

New York Governor Eliot Spitzer wants the state to pay off the student loans of physicians who agree to serve rural and urban areas without enough doctors, an administration official said.

A survey of hospitals by the Healthcare Association of New York found hospitals needed 845 more primary care physicians, surgeons, and specialists outside New York City. ■

Ask the experts

How to avoid pitfalls when implementing compensation plan

Editor's note: PCR asked compensation and recruitment experts to discuss the most common mistakes facilities make when implementing a new or revised compensation plan. 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.

James W. Lord, principal, ECG Management Consultants

Planning for implementation is often overlooked. A detailed operations manual that defines the specifics of the plan, including authority and accountabilities, is the difference between a smooth implementation and one with a few more bumps in the road. Done correctly, the plan manual ensures that all details are determined prior to transition to the new plan.

Marc Bowles, chief marketing officer, The Delta Companies

The most common mistake I see is not considering all the compensation models as options. By evaluating different models, such as RVU-based, production, salaried, or a combination of the three, the facility or practice may be able to provide its physicians with a more competitive income.

Max Reiboldt, CPA, CEO of The Coker Group

The following four things are extremely important:

1. Physician education. All physicians subject to the plan must be thoroughly educated and informed about how the compensation plan will work, including its incentives.
2. Thorough modeling process. Prior to the actual implemen-

tation of the new compensation plan, a concerted process of modeling the various options should take place.

3. Shadowing. The implementation stage of a plan should include a shadowing period. This entails actual performance results being tabulated and the compensation under the newly proposed plan actually calculated.
4. Feedback. Giving physicians feedback is extremely important to make sure that they are not only informed, but that they feel that there is a legitimate sounding board for their concerns and constructive complaints.

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

The most common mistake would probably be failing to consult the medical staff up front as to preferred structure.

Ron Siefert, senior consultant, Hay Group, Inc.

Regardless of how well designed a plan may be, if it is poorly implemented, you risk failure.

Ensuring success requires organizations to think carefully about the implementation process. Who will be affected, and how do we consciously manage the intended effect and messages of our new programs?

Communication should start early (and often). Consider a process that starts with a message and mode (e.g., e-mail, newsletter, presentations, etc.), then measure the effect (i.e., did people hear what we wanted them to hear?) and modify the message/mode of communication to ensure success. ■

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