

2020 REVIEW

OF PHYSICIAN AND ADVANCED PRACTITIONER RECRUITING INCENTIVES AND THE IMPACT OF **COVID-19**



27TH
EDITION
1994-2020

An Overview of the Salaries, Bonuses, and Other Incentives Customarily Used to Recruit Physicians, Physician Assistants and Nurse Practitioners and How These May Be Affected by the Coronavirus Pandemic

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Overview

Merritt Hawkins is a national healthcare search and consulting firm specializing in the recruitment of physicians in all medical specialties, physician leaders, and advanced practice professionals. Now celebrating our 33rd year of service to the healthcare industry, Merritt Hawkins is a company of AMN Healthcare (NYSE: AMN), the nation's largest healthcare staffing organization and the industry innovator of healthcare workforce solutions.

This report marks Merritt Hawkins' 27th annual *Review* of the search and consulting engagements the firm conducts on behalf of its clients. Merritt Hawkins' *Review* is the longest consecutively published and most comprehensive report on physician recruiting incentives in the industry.

Over the past 27 years the *Review* has become a standard benchmarking resource throughout the healthcare industry used by hospitals, medical groups and other healthcare facilities to determine which incentives are customary and competitive in physician recruitment. The *Review* also has become a resource widely utilized by healthcare journalists, analysts, policy makers and others who track trends in physician supply, demand and compensation.

ONGOING THOUGHT LEADERSHIP

The *Review* is part of Merritt Hawkins' ongoing thought leadership efforts, which include surveys and white papers conducted for Merritt Hawkins' proprietary use, and surveys, white papers and analyses Merritt Hawkins has completed on behalf

of prominent third parties, including **The Physicians Foundation**, the **Indian Health Service**, the **American Academy of Physician Assistants**, **Trinity University**, **Texas Hospital Trustees**, the **North Texas Regional Extension Center/Office of the National Coordinator of Health Information Technology**, the **Society for Vascular Surgery**, the **Maryland State Medical Society**, the **American Academy of Surgical Administrators**, the **Association of Managers of Gynecology and Obstetrics** and **Subcommittees of the Congress of the United States**.



The 2020 *Review* is based on a sample of the 3,251 permanent physician and advanced practitioner search engagements that Merritt Hawkins/AMN Healthcare's physician staffing companies had ongoing or were engaged to conduct during the 12-month period from April 1, 2019, to March 31, 2020.

The intent of the *Review* is to quantify financial and other incentives offered by our clients to physician and advanced practitioner candidates during the course of recruitment. Incentives cited in the *Review* are based on contracts or incentive

packages used by hospitals, medical groups and other facilities in real-world recruiting engagements.

A KEY DIFFERENTIATOR

Unlike other physician compensation surveys, Merritt Hawkins' *Review* tracks **physician starting salaries** and other recruiting incentives, rather than total annual physician compensation. It therefore reflects the incentives physicians are *offered* to attract them to new practice settings rather than what physicians in general may actually earn and report on their tax returns.

The range of incentives detailed in the *Review* may be used as benchmarks for evaluating which recruitment incentives are customary and competitive in today's physician recruiting market. In addition, the *Review* is based on a national sample of search engagements and provides an indication of which medical specialties are currently in the greatest demand as well as the types of medical settings into which physicians are being recruited.

THE IMPACT OF COVID-19

The coronavirus pandemic has had a profound impact on the economy and on all aspects of healthcare, including physician compensation and recruiting. The starting salaries and other data tracked in this *Review* are almost entirely derived from physician search engagements that Merritt Hawkins conducted before the repercussions of the pandemic were fully felt.

The 2020 *Review* therefore provides data for physician salaries and other recruiting incentives that were prevalent in the pre-Covid-19 world, in which the dynamics of physician supply, demand, recruiting and compensation were different than they are today. In acknowledgement of this fact, the 2020 *Review* will focus on how these dynamics have changed and project potential physician recruiting and compensation trends in the emerging "new normal." As in the past, it will review physician recruiting incentive benchmarks, such as starting salaries, but will do so in the context of the coronavirus pandemic and its far reaching effects.

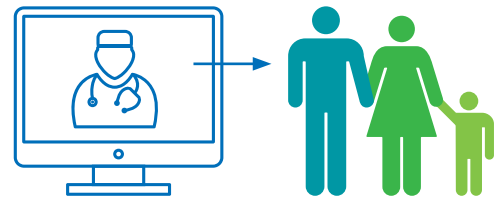
Following are several key findings of the 2020 *Review*.

Key Findings

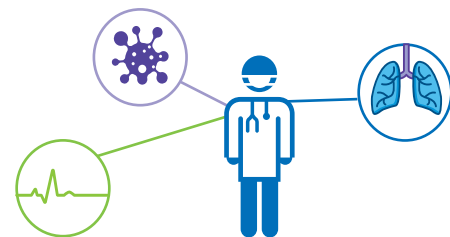
Merritt Hawkins' 2020 Review of Physician and Advanced Practitioner Recruiting Incentives reveals a number of trends within the physician and advanced practitioner recruiting market, including:



- **As a result of the 2020 coronavirus pandemic, the market for physicians has flipped – from a buyer's market in which physicians had multiple practice opportunities from which to choose, to a seller's market in which physicians may have to compete for job openings. This sea change took place in a matter of some 60 days.**
- While the number of physician search engagements Merritt Hawkins conducted increased during the one year period ending on March 31, 2020, search engagements taken on by Merritt Hawkins have decreased by more than 30% since, underscoring how the market for physicians has changed.



- **For the 14th consecutive year, family physicians topped the list of Merritt Hawkins' 20 most requested recruiting engagements, underscoring continued demand for primary care. However, the Covid-19 pandemic, with its corresponding shift to telehealth, is likely to change compensation and practice patterns in primary care.**
- While primary care physicians remain in demand, a growing volume of physician recruiting activity is shifting toward medical specialties. 78% of Merritt Hawkins' physician search engagements tracked in the 2020 Review were for medical specialists, up from 67% five years ago, while 22% were for primary care. Demand and compensation for specialists also will change as a result of Covid-19 in response to declines in the volume of medical procedures.



- **Demand for physicians on the front lines of virus care, including emergency medicine physicians, pulmonologists/critical care physicians, and infectious disease specialists is projected to increase as a result of Covid-19.**



- **Psychiatrists were third on the list of Merritt Hawkins' most requested recruiting engagements, reflecting a continued severe shortage of mental health professionals likely to be exacerbated by the coronavirus pandemic.**



- **Demand for nurse practitioners (NPs) and physician assistants (PAs) is increasing. For the first time, NPs placed second on Merritt Hawkins' list of most requested search engagements. The number of searches Merritt Hawkins conducted for NPs and PAs increased by 54% year-over-year, with their role likely to increase post-Covid-19.**
- Invasive cardiologists are offered the highest average starting salaries of physicians tracked in the 2020 *Review* at \$640,000, followed by orthopedic surgeons at \$626,000.

- The use of quality/value-based physician compensation is rising. 64% of physician production bonus formulas tracked in the 2020 *Review* featured quality-based metrics, up from 56% the previous year. Going forward, production bonuses are likely to include metrics based on Covid-19 testing, tracking and treatment.
- Employment rather than independent practice remains the dominant physician recruiting model. Approximately 95% of Merritt Hawkins' search engagements feature practice settings where physicians are employed by hospitals, hospital-owned medical groups, physician-owned medical groups or other employers. Only about 5% feature independent practices where physicians are owners or partners. Covid-19 is likely to expand the prevalence of the employed physician model and reduce even further the prevalence of the independent practice model.
- The average starting salary for family medicine physicians is \$240,000, flat over the last three years, underscoring a relative reduction in demand for primary care physicians.
- The average starting salary for nurse practitioners (NPs) is \$126,000, while the average for physician assistants (PAs) is \$112,000.
- The average signing bonus for physicians is \$27,893, while the average signing bonus for NPs and PAs is \$8,500.

Following is a breakout of the characteristics and metrics of Merritt Hawkins' 2019/20 recruiting engagements.

Merritt Hawkins' 2020 Review of Physician and Advanced Practitioner Recruiting Incentives: Recruiting Engagement Characteristics and Metrics

All of the following numbers are rounded to the nearest full digit.

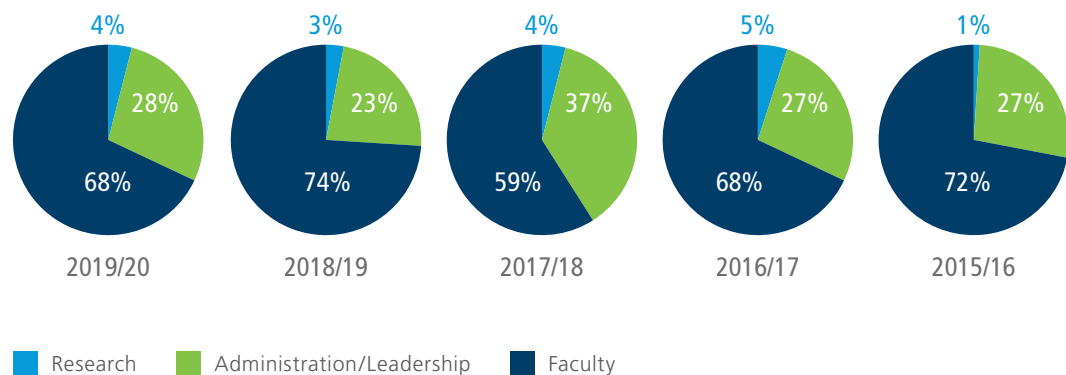
1 Total Number of Physician/Advanced Practitioner Search Engagements Represented

The 2020 Review is based on a representative sample of the 3,251 permanent physician and advanced practitioner search engagements Merritt Hawkins/AMN Healthcare's physician staffing companies had ongoing or were engaged to conduct during the 12 month period from April 1, 2019 to March 31, 2020, up from the 3,131 the previous year.

2 Settings of Physician Search Engagements

	2019/20	2018/19	2017/18	2016/17	2015/16	2014/15
Hospital	1,168 (36%)	1,065 (34%)	1,230 (40%)	1,415 (43%)	1,639 (49%)	1,596 (51%)
Group	1,042 (32%)	877 (28%)	798 (26%)	886 (27%)	628 (19%)	625 (20%)
Solo/Direct Pay/Concierge	92 (3%)	31 (1%)	45 (2%)	34 (1%)	181 (5%)	125 (4%)
CHC/FQHC/IHS	199 (6%)	282 (9%)	363 (12%)	497 (15%)	434 (13%)	406 (13%)
Academics	591 (18%)	626 (20%)	464 (15%)	374 (11%)	367 (11%)	252 (8%)
Other (Urgent Care, HMO, Association, etc.)	159 (5%)	250 (8%)	145 (5%)	81 (3%)	93 (3%)	92 (3%)

If Academics, what type of position? (of 591 Academic setting positions)



3 States Where Search Engagements Were Conducted

Searches also conducted in the District of Columbia.

AK, AL, AR, AZ, CA, CO, CT, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MA, MD, MI, MN, MO, MS, MT, NC, ND, NE, NJ, NM, NV, NY, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VA, WA, WI, WV, WY

4 Number of Searches by Community Size

	2019/20	2018/19	2017/18	2016/17	2015/16	2014/15
0-25,000	549 (17%)	534 (17%)	612 (20%)	755 (23%)	870 (26%)	1,184 (38%)
25,001-100,000	588 (18%)	530 (17%)	545 (18%)	742 (22%)	766 (23%)	689 (22%)
100,001+	2,114 (65%)	2,067 (66%)	1,888 (62%)	1,790 (55%)	1,706 (51%)	1,247(40%)

5 Top 20 Most Requested Searches by Specialty

Specialty	2019/20	2018/19	2017/18	2016/17	2015/16	2014/15
Family Medicine (includes FP/OB)	448	457	497	607	627	734
Nurse Practitioner	270	169	205	137	150	143
Psychiatry	182	199	243	256	250	230
Radiology	163	148	132	80	40	24
Internal Medicine	146	148	150	193	233	237
OB/GYN	122	161	118	109	112	112
Cardiology	115	84	61	62	33	36
Hematology & Oncology	91	53	31	22	16	24
Physician Assistant	84	41	40	87	60	63
Anesthesiology	72	70	40	43	28	16
Hospitalist	71	143	118	94	228	176
Certified Registered Nurse Anesthetists	71	47	23	N/A	N/A	N/A
Gastroenterology	65	85	102	66	58	43
Neurology	56	97	57	61	101	60
Orthopedic Surgery	55	73	85	61	81	106
Pediatrics	54	85	63	76	76	71
Urology	47	54	41	37	51	40
Dermatology	43	60	66	83	71	44
Pulmonology	37	56	40	62	46	38

6 Other Specialty Recruitment Engagements

Addiction Medicine	Neurology, Headache & Neuropathic Pain	Pathology, Anatomic Pathology
Adolescent Medicine	Neurology, Hospitalist	Pathology, Anatomic Pathology & Clinical Pathology
Adult Medicine	Neurology, Multiple Sclerosis	Pathology, Cytopathology
Allergy & Immunology	Neurology, Neuro-Critical Care	Pathology, Dermatopathology
Anesthesiology, Cardiac	Neurology, Oncology	Pathology, Forensic Pathology
Anesthesiology, Pediatric	Neurology, Parkinson's/Movement Disorders	Pathology, Gastroenterology
Cardiology - Advanced Cardiac Imaging	Neurology, Sleep Medicine	Pediatrics, Genetics
Cardiology - Electrophysiology	Neurology, Stroke	Pediatrics, Hospice and Palliative Medicine
Cardiology - Heart Failure	Neurology, Vascular Neurology / Stroke	Pediatrics, Hospitalist
Cardiothoracic Surgery	Neuromusculoskeletal Medicine & OMM	Pediatrics, Neonatal-Perinatal Medicine / Neonatology
Clinical & Laboratory Immunology	Obstetrics & Gynecology, Gynecologic Oncology	Pediatrics, Pediatric Cardiology
Critical Care-Intensivist Medicine	Obstetrics & Gynecology, Gynecology	Pediatrics, Pediatric Critical Care Medicine
Dermatology, MOHS-Micrographic Surgery	Obstetrics & Gynecology, Laborist	Pediatric Endocrinology
Dermatology, Pediatric Dermatology	Obstetrics & Gynecology, Maternal & Fetal Medicine	Pediatric Gastroenterology
Emergency Medicine, Pediatric	Ophthalmology	Pediatric Hematology-Oncology
Emergency Medicine	Ophthalmology, Glaucoma	Pediatric Nephrology
Emergency Medicine, Undersea and Hyperbaric Medicine	Ophthalmology, Oculoplastic	Pediatric Pulmonology
Family Medicine, Geriatric Medicine	Ophthalmology, Pediatric	Pediatrics, Sleep Medicine
Family Medicine, Hospice and Palliative Medicine	Ophthalmology, Retina Surgery	Physical Medicine & Rehabilitation
Family Medicine, Obstetrics	Oral & Maxillofacial Surgery	Physical Medicine & Rehabilitation, Pain Medicine
Family Medicine, Sports Medicine	Orthopedic Surgery, Adult	Plastic Surgery
Functional Medicine	Reconstructive Orthopedic Surgery / Total Joint	Preventive Medicine, Occupational Medicine
General Practice	Orthopedic Surgery, Foot and Ankle Surgery	Psychiatry, Addiction Psychiatry
Geriatric Medicine	Orthopedic Surgery, Hand Surgery	Psychiatry, Child & Adolescent Psychiatry
Hematology	Orthopedic Surgery, Oncology	Psychiatry, Forensic Psychiatry
Hematology & Oncology - Bone Marrow Transplantation	Orthopedic Surgery, Pediatric Orthopedic Surgery	Psychiatry, Geriatric Psychiatry
Hospice and Palliative Medicine	Orthopedic Surgery, Spine	Psychiatry, Psychosomatic Medicine
Hospitalist, Nocturnist	Orthopedic Surgery, Sports Medicine	Pulmonary and Sleep Medicine
Infectious Disease	Orthopedic Surgery, Trauma	Radiology, Body Imaging
Medical Oncology	Otolaryngology	Radiology, Diagnostic Neuroimaging
Medical Genetics	Otolaryngology, Head and Neck	Radiology, Mammographer
Medical Genetics, Clinical Biochemical Genetics	Otolaryngology, Otology & Neurotology	Radiology, Musculoskeletal
Nephrology	Otolaryngology, Pediatric Otolaryngology	Radiology, Neuro-Interventional
Neurological Surgery	Pain Medicine	Radiology, Neuroradiology
Neurology, Behavioral Neurology & Neuropsychiatry	Pain Medicine, Interventional Pain Medicine	Radiology, Nuclear Radiology
Neurology, Child Neurology / Pediatric Neurology	Pathology	Radiology, Pediatric Radiology
Neurology, Clinical Neurophysiology / EMG		Radiology, Radiation Oncology
Neurology, Epilepsy		Radiology, Teleradiology
		Reproductive Endocrinology

Rheumatology	Surgery, Pediatric Cardiovascular	Surgery, Vascular Surgery
Vascular & Interventional Radiology	Surgery, Plastic and Reconstructive Surgery	Thoracic Surgery
Surgery, General	Surgery, Surgical Critical Care (Trauma Surgery)	Urgent Care
Surgery, Bariatric	Surgery, Surgical Oncology	Urology, Endourology
Surgery, Breast	Surgical Trauma Surgery (Critical Care)	Urology, Neurology
Surgery, Burn		Urology, Pediatric Urology
Surgery, Colon & Rectal Surgery		

7 Academic Titles Include:

Assistant Professor	Chief of Rheumatology	Director of Psychiatry Emergency Services
Associate Professor	Chief Medical Officer	Director of Student Health
Associate Chief of Perioperative Anesthesiology	Chief Pediatrics	Director of Burn Surgery
Associate Dean for Clinical Integration	Chief Pediatrics: Allergy, Immunology and Rheumatology	Endowed Chair for Women's Health
Associate Chair for Clinical Affairs	Chief Pediatrics: Anesthesiology	Endowed Professor
Associate Dean for Clerkship and Core Site Development	Chief Pediatrics: Cardiology	Executive Medical Oncology Director
Chair of Biomedical Informatics	Chief Pediatrics: Cardiac Anesthesiology	Fellowship Director
Chair of Internal Medicine	Chief Pediatrics: Critical Care	Medical Director Heart Failure
Chair of Machine Learning	Chief Pediatrics: Endocrinology	Medical Director Hospitalist
Chair of Osteopathic Practices and Principles	Chief Pediatrics: Hematology/Oncology	Medical Director Pulmonary Critical Care
Chair of Osteopathic Manipulative Medicine	Chief Pediatrics: Neonatal Perinatal Medicine	Professor
Chair of Physical Medicine and Rehabilitation	Chief Pediatrics: Neurology	Program Director for General Surgery
Chair of Population Health	Chief Pediatrics: Otolaryngology	Program Director for Psychiatry
Chair of Psychiatry	Dean and President	Residency Program Director Family Medicine
Chair of Women's Health	Dean School of Medicine	Residency Program Director Internal Medicine
Chief Breast Medicine	Designated Institutional Official	Residency Program Director Emergency Medicine
Chief Dermatology	Director of Age Friendly Health Systems	Residency Program Director Psychiatry
Chief Endocrinology	Director of Clinical Genetics	Residency Program Director General Surgery
Chief Geriatrics	Director of Cytopathology	Site Director for Dentistry
Chief Gastroenterology	Director of Graduate Medical Education	Vice Chair for Research
Chief Hematology and Oncology	Director of General Internal Medicine	Vice President of Health Affairs
Chief Nuclear Medicine Radiology	Director of Molecular Pathology and Cytogenetics	
Chief Non-Invasive Cardiology		

8 Executive Titles Include:

Chief Executive Officer	Director of Nursing	Director Accreditation and Regulatory Affairs
Chief Medical Officer	Chief Diversity Officer	Chief Quality Officer
Chief of Service Line	Chief Experience Officer	Vice President, Chief Quality Officer
Vice President of Medical Affairs	Chief Financial Officer	
Chief Nursing Officer	Chief Quality & Patient Safety Officer	

9 Income Offered to Top 20 Recruited Specialties

(Base salary or guaranteed income only, does not include production bonus or benefits)

Family Practice	Low	Average	High
2019/20	\$140,000	\$240,000	\$325,000
2018/19	\$130,000	\$239,000	\$400,000
2017/18	\$165,000	\$241,000	\$400,000
2016/17	\$110,000	\$231,000	\$400,000
2015/16	\$135,000	\$225,000	\$340,000
2014/15	\$112,000	\$198,000	\$330,000

YOY CHANGE -0.4%

Nurse Practitioner	Low	Average	High
2019/20	\$90,000	\$126,000	\$234,000
2018/19	\$90,000	\$124,000	\$200,000
2017/18	\$85,000	\$129,000	\$205,000
2016/17	\$85,000	\$123,000	\$181,000
2015/16	\$92,000	\$117,000	\$197,000
2014/15	\$78,000	\$107,000	\$129,000

YOY CHANGE +1.6%

Psychiatry	Low	Average	High
2019/20	\$185,000	\$276,000	\$400,000
2018/19	\$184,000	\$273,000	\$400,000
2017/18	\$200,000	\$261,220	\$465,000
2016/17	\$120,000	\$263,000	\$450,000
2015/16	\$195,000	\$250,000	\$370,000
2014/15	\$172,000	\$226,000	\$325,000

YOY CHANGE +1.1%

Radiology	Low	Average	High
2019/20	\$275,000	\$423,000	\$577,000
2018/19	\$245,000	\$387,000	\$550,000
2018/19 (Telerad)	\$320,000	\$360,000	\$400,000
2017/18	\$309,000	\$371,000	\$650,000
2017/18 (Telerad)	\$350,000	\$375,000	\$500,000
2016/17	\$300,000	\$436,000	\$725,000
2016/17 (Telerad)	\$400,000	\$494,000	\$600,000
2015/16	\$275,000	\$475,000	\$750,000
2014/15	\$150,000	\$400,000	\$500,000

YOY CHANGE +9.3%

Internal Medicine	Low	Average	High
2019/20	\$175,000	\$255,000	\$400,000
2018/19	\$180,000	\$264,000	\$500,000
2017/18	\$190,000	\$261,000	\$475,000
2016/17	\$170,000	\$257,000	\$600,000
2015/16	\$195,000	\$237,000	\$320,000
2014/15	\$100,000	\$207,000	\$260,000

YOY CHANGE -3.4%

OB/GYN	Low	Average	High
2019/20	\$200,000	\$327,000	\$600,000
2018/19	\$200,000	\$318,000	\$475,000
2017/18	\$200,000	\$324,000	\$550,000
2016/17	\$175,000	\$335,000	\$700,000
2015/16	\$210,000	\$321,000	\$500,000
2014/15	\$140,000	\$276,000	\$450,000

YOY CHANGE +2.8%

Cardiology (non-invasive)	Low	Average	High
2019/20	\$300,000	\$409,000	\$575,000
2018/19	\$325,000	\$441,000	\$620,000
2017/18	\$300,000	\$427,000	\$580,000
2016/17	\$300,000	\$428,000	\$580,000
2015/16	\$250,000	\$493,000	\$700,000
2014/15	\$200,000	\$279,000	\$400,000

YOY CHANGE -7.3%

Cardiology (invasive)	Low	Average	High
2019/20	\$500,000	\$640,000	\$750,000
2018/19	\$575,000	\$648,000	\$725,000
2017/18	\$480,000	\$590,000	\$810,000
2016/17	\$480,000	\$563,000	\$810,000
2015/16	\$475,000	\$545,000	\$700,000
2014/15	\$450,000	\$525,000	\$650,000

YOY CHANGE -1.2%

Hematology/ Oncology	Low	Average	High
2019/20	\$220,000	\$403,000	\$612,000
2018/19	\$200,000	\$393,000	\$450,000
2017/18	N/A	\$391,000	NA
2016/17	N/A	\$388,000	NA
2015/16	N/A	\$405,000	NA
2014/15	N/A	\$397,000	N/A

YOY CHANGE +2.5%

Physician Assistant	Low	Average	High
2019/20	\$90,000	\$112,000	\$145,000
2018/19	\$90,000	\$110,000	\$140,000
2017/18	\$89,000	\$109,000	\$141,000
2016/17	\$99,000	\$115,000	\$145,000
2015/16	\$92,000	\$114,000	\$180,000
2014/15	\$80,000	\$107,000	\$145,000

YOY CHANGE +1.8%

Anesthesiology	Low	Average	High
2019/20	\$280,000	\$399,000	\$535,000
2018/19	\$281,000	\$404,000	\$450,000
2017/18	\$325,000	\$371,000	\$540,000
2016/17	\$249,000	\$376,000	\$520,000
2015/16	\$360,000	\$397,000	\$450,000
2014/15	\$270,000	\$361,000	\$400,000

YOY CHANGE -1.2%

Hospitalist	Low	Average	High
2019/20	\$170,000	\$254,000	\$349,000
2018/19	\$170,000	\$268,000	\$450,000
2017/18	\$215,000	\$269,000	\$365,000
2016/17	\$200,000	\$264,000	\$400,000
2015/16	\$180,000	\$249,000	\$390,000
2014/15	\$170,000	\$232,000	\$300,000

YOY CHANGE -5.2%

Certified Registered Nurse Anesthetists	Low	Average	High
2019/20	\$170,000	\$215,000	\$260,000
2018/19	\$154,000	\$197,000	\$250,000
2017/18	NA	\$194,000	NA
2016/17	NA	\$202,000	NA
2015/16	NA	\$190,000	NA

YOY CHANGE +9.1%

Gastroenterology	Low	Average	High
2019/20	\$300,000	\$457,000	\$600,000
2018/19	\$350,000	\$495,000	\$650,000
2017/18	\$355,000	\$487,000	\$725,000
2016/17	\$300,000	\$492,000	\$800,000
2015/16	\$300,000	\$458,000	\$600,000
2014/15	\$275,000	\$455,000	\$600,000

YOY CHANGE -7.7%

Neurology	Low	Average	High
2019/20	\$255,000	\$295,000	\$450,000
2018/19	\$250,000	\$317,000	\$400,000
2017/18	\$255,000	\$301,000	\$395,000
2016/17	\$220,000	\$305,000	\$400,000
2015/16	\$220,000	\$285,000	\$500,000
2014/15	\$180,000	\$277,000	\$350,000

YOY CHANGE -6.9%

Orthopedic Surgery	Low	Average	High
2019/20	\$425,000	\$626,000	\$850,000
2018/19	\$350,000	\$536,000	\$850,000
2017/18	\$340,000	\$533,000	\$985,000
2016/17	\$192,000	\$579,000	\$1,000,000
2015/16	\$350,000	\$521,000	\$800,000
2014/15	\$350,000	\$497,000	\$800,000

YOY CHANGE +16.7%

Pediatrics	Low	Average	High
2019/20	\$170,000	\$221,000	\$300,000
2018/19	\$140,000	\$242,000	\$400,000
2017/18	\$189,000	\$230,000	\$355,000
2016/17	\$170,000	\$240,000	\$400,000
2015/16	\$165,000	\$224,000	\$308,000
2014/15	\$100,000	\$195,000	\$275,000

YOY CHANGE -8.7%

Urology	Low	Average	High
2019/20	\$300,000	\$477,000	\$625,000
2018/19	\$300,000	\$464,000	\$575,000
2017/18	\$290,000	\$386,000	\$700,000
2016/17	NA	\$460,000	NA
2015/16	\$325,000	\$471,000	\$625,000
2014/15	\$260,000	\$412,000	\$550,000

YOY CHANGE +2.8%

Dermatology	Low	Average	High
2019/20	\$300,000	\$419,000	\$700,000
2018/19	\$250,000	\$420,000	\$700,000
2017/18	\$280,000	\$425,000	\$650,000
2016/17	\$250,000	\$421,000	\$1,000,000
2015/16	\$250,000	\$444,000	\$650,000
2014/15	\$265,000	\$398,000	\$550,000

YOY CHANGE -0.2%

Pulmonology/ Critical Care	Low	Average	High
2019/20	\$350,000	\$430,000	\$500,000
2018/19	\$325,000	\$399,000	\$460,000
2017/18	\$355,000	\$418,000	\$725,000
2016/17	\$225,000	\$390,000	\$530,000
2015/16	\$275,000	\$380,000	\$500,000
2014/15	\$260,000	\$331,000	\$386,000

YOY CHANGE +7.7%

10 Type of Incentive Offered

	Salary	Salary with Bonus	Income Guarantee	Other
2019/20	809 (25%)	2,349 (72%)	21 (<1%)	72 (2%)
2018/19	686 (22%)	2,198 (70%)	61 (2%)	184 (6%)
2017/18	515 (17%)	2,285 (75%)	89 (3%)	156 (5%)
2016/17	723 (22%)	2,359 (72%)	121 (4%)	84 (2%)
2015/16	767 (23%)	2,512 (75%)	32 (1%)	31 (1%)
2014/15	715 (23%)	2,219 (71%)	124 (4%)	62 (2%)

11 If Salary Plus Production Bonus, on Which Types of Metrics Was the Bonus Based? (of 2,349 searches offering salary plus bonus, multiple responses possible).

	RVU Based	Net Collections	Gross Billings	Patient Encounters	Quality	Other
2019/20	73%	13%	2%	12%	64%	0%
2018/19	70%	18%	3%	9%	56%	0%
2017/18	50%	10%	1%	4%	43%	4%
2016/17	52%	28%	6%	14%	39%	9%
2015/16	58%	22%	2%	8%	32%	8%
2014/15	57%	23%	2%	9%	23%	4%

12 If quality factors were included in the production bonus, about what percent of physician's total compensation determined by quality? (Question asked for the first time in 2017/18)

2019/20	2018/19	2017/18
11%	11%	8%

13 Searches Offering Relocation Allowance

	2019/20	2018/19	2017/18	2016/17	2015/16	2014/15
Yes	3,147 (97%)	3,064 (98%)	2,999 (98%)	3,132 (95%)	3,173 (95%)	2,623 (84%)
No	104 (3%)	67 (2%)	46 (2%)	155 (5%)	169 (5%)	497 (16%)

14 Amount of Relocation Allowance (Physicians only)

	Low	Average	High
2019/20	\$1,000	\$10,553	\$40,000
2018/19	\$2,000	\$10,393	\$30,000
2017/18	\$2,500	\$9,441	\$25,000
2016/17	\$2,500	\$10,072	\$44,000
2015/16	\$2,500	\$10,226	\$30,000
2014/15	\$2,000	\$10,292	\$50,000

15 Amount of Relocation Allowance (NPs and PAs only)

	Low	Average	High
2019/20	\$2,000	\$7,114	\$15,000
2018/19	\$2,500	\$7,067	\$15,000
2017/18	\$1,500	\$6,250	\$25,000
2016/17	\$2,500	\$8,063	\$25,000
2015/16	\$2,500	\$8,649	\$25,000
2014/15	\$2,500	\$9,436	\$35,000

16 Searches Offering Signing Bonus

	2019/20	2018/19	2017/18	2016/17	2015/16	2014/15
Yes	2,344 (72%)	2,220 (71%)	2,135 (70%)	2,501 (76%)	2,576 (77%)	2,280 (73%)
No	907 (28%)	911 (29%)	910 (30%)	786 (24%)	766 (23%)	840 (27%)

17 Amount of Signing Bonus Offered (Physicians only)

	Low	Average	High
2019/20	\$2,500	\$27,893	\$100,000
2018/19	\$3,000	\$32,692	\$225,000
2017/18	\$2,500	\$33,707	\$180,000
2016/17	\$2,500	\$32,636	\$275,000
2015/16	\$1,000	\$26,889	\$350,000
2014/15	\$2,500	\$26,365	\$275,000

18 Amount of Signing Bonus Offered (NPs and PAs only)

	Low	Average	High
2019/20	\$2,500	\$8,500	\$35,000
2018/19	2,500	\$9,000	\$25,000
2017/18	\$5,000	\$11,944	\$30,000
2016/17	\$2,500	\$8,576	\$25,000
2015/16	\$2,500	\$10,340	\$40,000
2014/15	\$2,500	\$8,791	\$20,000

19 Amount of Signing Bonus offered for Top 5 most requested specialties

	Low	Average	High
Family Practice	\$2,500	\$25,100	\$75,000
Psychiatry	\$10,000	\$24,704	\$50,000
OBGYN	\$10,000	\$24,660	\$100,000
Internal Medicine	\$10,000	\$26,000	\$75,000
Radiology	\$8,000	\$23,428	\$100,000

20 Searches Offering to Pay Continuing Medical Education (CME)

	2019/20	2018/19	2017/18	2016/17	2015/16	2014/15
Yes	3,124 (96%)	2,966 (95%)	3,243 (97%)	3,116 (95%)	2,984 (98%)	3,061 (98%)
No	127 (4%)	154 (5%)	99 (3%)	171 (5%)	61 (2%)	70 (2%)

23 Amount of CME Allowance Pay Offered (Physicians only)

	Low	Average	High
2019/20	\$800	\$4,166	\$20,000
2018/19	\$1,000	\$3,620	\$35,000
2017/18	\$250	\$3,888	\$50,000
2016/17	\$500	\$3,613	\$30,000
2015/16	\$100	\$3,633	\$35,000
2014/15	\$500	\$3,649	\$35,000

24 Amount of CME Allowance Pay Offered (NPs and PAs only)

	Low	Average	High
2019/20	\$1,000	\$2,313	\$5,000
2018/19	\$1,000	\$2,862	\$5,000
2017/18	\$650	\$2,280	\$5,000
2016/17	\$400	\$2,126	\$5,000
2015/16	\$400	\$2,140	\$3,950
2014/15	\$1,000	\$2,241	\$5,000

25 Searches Offering to Pay Additional Benefits

	2019/20	2018/19	2017/18	2016/17	2015/16	2014/15
Health Insurance	98%	99%	99%	98%	98%	99%
Malpractice	98%	98%	99%	98%	99%	99%
Retirement /401K	95%	96%	94%	95%	96%	96%
Disability	94%	97%	98%	91%	97%	92%
Educational Forgiveness	24%	31%	18%	25%	26%	25%

26 If Educational Loan Forgiveness was Offered, What Was the Term? (of 784 searches offering loan forgiveness)

	2019/20	2018/19	2017/18	2016/17	2015/16	2014/15
One Year	72 (9%)	NA	18 (3%)	40 (5%)	45 (5%)	61 (8%)
Two Years	184 (24%)	NA	104 (19%)	191 (23%)	155 (18%)	104 (13%)
Three Years Plus	528 (67%)	NA	425 (78%)	592 (72%)	671 (77%)	619 (79%)

27 If Education Loan Forgiveness Was Offered, What Was the Amount? (Physicians only)

	Low	Average	High
2019/20	\$10,000	\$101,590	\$300,000
2018/19	\$10,000	\$101,571	\$300,000
2018/18	\$10,000	\$82,833	\$300,000
2016/17	\$10,000	\$80,923	\$260,000
2015/16	\$10,000	\$88,068	\$300,000
2014/15	\$2,500	\$89,479	\$250,000

28 If Education Loan Forgiveness Was Offered, What Was the Amount? (NPs and PAs only)

	Low	Average	High
2019/20	\$40,000	\$68,333	\$90,000
2018/19	\$20,000	\$61,250	\$100,000
2017/18	\$25,000	\$33,333	\$37,500
2016/17	\$35,000	\$56,442	\$100,000
2015/16	\$30,000	\$61,667	\$100,000
2014/15	\$30,000	\$54,286	\$100,000

Trends and Observations

Merritt Hawkins' annual Review of Physician and Advanced Practitioner Recruiting Incentives, now in its 27th year, tracks three key physician recruiting trends, as well as various advanced practitioner recruiting trends.

1. Based on the physician recruiting engagements Merritt Hawkins is contracted to conduct, the 2020 Review indicates which types of physicians are in the greatest demand and which are the most challenging to recruit.
2. The Review also indicates the types of practice settings into which physicians are being recruited (hospitals, medical groups, solo practice, etc.) and the types of communities that are recruiting physicians based on population size.
3. The Review further indicates the types of financial and other incentives that are being used to recruit physicians.

Each of these trends is discussed below, following an overview of the current healthcare market in which physician recruiting takes place.

MARKET CONTEXT: COVID-19 FLIPS THE SCRIPT

Last year, in Merritt Hawkins' 2019 Review of Physician and Advanced Practitioner Recruiting Incentives, we noted that the

healthcare sector of the economy was the key driver of employment in America. According to the 2019 Review

"More than 16 million people worked in healthcare jobs by the end of 2018, accounting for 11% of all jobs nationally, the Bureau of Labor Statistics reports. Healthcare continues to be a jobs generating behemoth, having created one in seven new jobs in 2018. Healthcare now is the number one employment sector in the U.S., after superseding retail two years ago."

"This torrid pace of job creation is not expected to slacken any time soon."

Unfortunately, the 2020 coronavirus pandemic greatly reduced the predictive ability of the crystal ball we consulted when completing the 2019 Review, and the pace of job growth in healthcare has indeed slackened.

Due to the pandemic, healthcare spending in the U.S. declined by 18% in the first quarter of 2020, the largest decline since 1959, according to the U.S. Department of Commerce. The American Hospital Association reports that hospitals and health systems lost \$200 billion in the first quarter of this year, while the Medical Group Management Association (MGMA) indicates that 97% of physician practices experienced a negative financial impact as a result of the virus. On average, physician practice revenue has declined by 55%, the MGMA reports (*Revenue Cycle Intelligence, May 26, 2020*), partly as a result of a 60% drop in the number of visits to ambulatory practices in April, 2020 (*The Commonwealth Fund, May 19, 2020*).

HEALTHCARE JOB LOSSES

As a result, the healthcare sector is losing jobs rather than gaining them. Over 1.4 million healthcare workers lost their jobs in April, 2020, according to the U.S. Department of Labor, including 135,000 hospital workers and 243,000 employees of physician offices (*Washington Post, June 2, 2020*). Even some physicians have lost their jobs, a trend Merritt Hawkins has never witnessed in our 33-year history.

An old adage in physician staffing circles states “there is no such thing as an unemployed physician.” This was clearly true pre-Covid-19, when it was a robust buyer’s market for physicians seeking medical practice opportunities. Merritt Hawkins’ 2019 *Survey of Final-Year Medical Residents* indicates that the majority of residents received 51 or more recruiting offers during their training pre-Covid-19, while almost half (45%) received 101 or more (see following chart:)



Source: Merritt Hawkins 2019 Survey of Final-Year Medical Resident

FROM A BUYER’S TO A SELLER’S MARKET

By contrast, an April, 2020 survey conducted by Merritt Hawkins in collaboration with The Physicians Foundation found that 21% of physicians have been furloughed or experienced a pay cut due to the pandemic.

Rather than have many practice opportunities to choose from, physicians now may have to compete to secure practice opportunities that meet their needs. Reflecting a decrease in demand for physicians, the number of search engagements Merritt Hawkins is requested to conduct dropped by more than 30% after April 1, 2020. The number of physicians contacting Merritt Hawkins to inquire about practice opportunities or to respond to job postings has significantly increased since the pandemic began.

In several short months, the pandemic has transformed physician recruiting from a strong buyer’s market to a strong seller’s market. ***As a result, for those hospitals, health systems, medical groups and other organizations that are seeking physicians or soon will be, this is a very favorable time to recruit.***

A TEMPORARY TREND

In an April, 2019 report, the Association of American Medical Colleges (AAMC) projected that there will be a shortage of up to 122,000 physicians by 2032 that may include:

- 55,000 too few primary care physicians

- 67,000 too few specialists

Source: *The Complexities of Physician Supply and Demand*. Association of American Medical Colleges. April, 2019

The coronavirus pandemic has recalibrated this equation – at least in the short-term. However, given the underlying dynamics of physician supply and demand, it is only a matter of time before physician shortages again become the status quo.

These dynamics are examined in detail in the Merritt Hawkins/AMN Leadership Solutions white paper *Will There Be a Doctor in the House? A White Paper Examining How the Coronavirus Pandemic is Affecting the Recruiting Market for Physicians as Well as Current and Long-term Physician Supply and Demand Trends*. Only a brief summation of them is required here (see following).



FACTORS DRIVING PHYSICIAN DEMAND

The following factors contributed to what was, pre-Covid-19, a pervasive and growing demand for physicians nationwide:

Population Aging

- *By 2032, there will be more seniors in the U.S. (78 million) than children 17 and under, the first time this has occurred in U.S. history.*
- *Though they account for only 14% of the population, seniors generate 37.4% of diagnostic tests and 34% of inpatient procedures, according to the CDC. They also and generate three times the annual physician visits of younger people. Population aging is consequently the single most important factor driving physician demand.*
- *Population aging is driving increased demand for specialist physicians, in particular, who care for the deteriorating organ systems, skeletal structures and mental health associated with aging.*

Population growth

- *The U.S. population will grow from 310 million people in 2010 to up to 458 million by 2050 (U.S. Census Bureau).*

Chronic disease

- *Six in 10 adults in the U.S. have a chronic illness such as heart disease or diabetes, while 4 in 10 have more than one (CDC).*

Social determinants of health

- *Forty million people in the U.S. have incomes below the poverty line (\$25,750 for a family of four), a low economic status that leads directly to poor health (Department of Health and Human Services).*

Deaths of despair

- *There were 70,237 drug overdose deaths in the U.S. in 2017 (HHS) while the suicide rate is up 33% since 1999 (CDC).*

Near full-employment and expanded access to healthcare insurance through the ACA

- *A robust job market and implementation of the Affordable Care Act (ACA) combined to reduce the number of Americans without healthcare coverage to about 10%, pre-Covid-19.*

FACTORS DRIVING PHYSICIAN SUPPLY

All of the factors cited above contributed to what was a sharply increasing demand for physicians, pre-Covid-19. The following factors contributed to what was an inadequate supply of physicians, pre-Covid-19.

The cap on physician GME spending

- *The 1997 cap Congress placed on how much the federal government spends to train physicians remains in place, limiting the number of physicians who join the workforce each year.*

Physician aging patterns

- *The U.S. faces a physician “retirement cliff” as close to 30% of active physicians are 60 or older.*

Physician paperwork burdens

- *23% of physician time is spent on non-clinical paperwork, according to the 2018*

Survey of America’s Physicians conducted by Merritt Hawkins on behalf of The Physicians Foundation, reducing overall physician FTEs.

Reduction in independent physicians

- *Employed physicians see 12% fewer patients on average than do independent physicians, according to the Survey of America’s Physicians, further reducing overall physician FTEs as the number of employed doctors grows.*

Low physician morale

According to the 2018 Survey of America’s Physicians:

- *62% of physicians are pessimistic about the future of the medical profession.*
- *78% sometimes, often or always experience burnout.*
- *80% have no time to see additional patients, take on new duties.*
- *Low morale can lead to high physician turnover and early physician retirement, disrupting the workforce and reducing FTEs.*



Telehealth a Supplement, Not a Solution

- *18% of physicians treated patients through telehealth in 2018, according to the Merritt Hawkins/Physicians Foundation's 2018 Survey of America's Physicians.*
- *That number increased to 48% in April, 2020, according to Merritt Hawkins/Physicians Foundation data.*
- *Telehealth helps expand access to physicians, but cannot replace many of the in-person procedures, tests, and treatments required by increasingly older and sicker patients.*

Drivers Still in Place

Almost all of the factors driving physician supply and demand will remain in place post-Covid-19. Some, including increased levels of ill health (physical and psychological) caused by Covid-19 and the economic disruption it has created, will be exacerbated. Added to this will be a spike in physician utilization as patients seek surgeries, tests, and routine treatments that they put off during the pandemic.

Economics and Patient Safety Keys to Renewed Physician Demand

It is the economy, however, that will largely determine how rapidly demand for physicians resumes. As the pandemic subsides, demand for physicians will increase in a "V" shaped curve where the economy recovers the quickest and people regain employer-based insurance and discretionary income. In areas where economic recovery is slow, demand for physician will likely resume in more a gradual "U" shaped curve.

Also critical to a rebound in physician demand will be patient confidence. Patients will need to be assured that returning to outpatient and inpatient settings is safe, and that the risks of non-treatment outweigh the risks of treatment. Many hospitals, medical groups and other settings have implemented or are putting systems in place to ensure patient safety. The pace at which these systems are implemented may vary depending on the availability of PPE, Covid-19 test kits, and contact tracing programs in specific regions and at specific facilities. The more rapidly they are put in place, the more likely it is that patient utilization – and demand for physicians – will increase.



AAMC Revises Physician Shortage Projections Upward

On June 26, 2020, the AAMC released its most recent physician workforce projections in its study *The Complexities of Physician Supply and Demand: Projections From 2018-2033*. Citing an aging population, an aging physician workforce, the effects of Covid-19, and other factors, the AAMC revised its physician shortage projections upward. It now projects a shortage of up to 139,000 physicians by 2033, up from its 2019 projection of up to 122,000 too few physicians by 2032.

Physician Workforce Volatility Post-Covid-19

In the April, 2020 survey conducted by Merritt Hawkins with The Physicians Foundation, doctors were asked how they will respond to Covid -19 (see table below):

As these numbers indicate, the majority of physicians (66%) indicated they will continue to practice in their current manner. However, a significant number (32%) indicated they will make a change to their practice style, either seeking a different job (14%), opting out of patient care (6%), closing their practice temporarily (7%) or retiring (5%). Three percent will seek mental health care, though the number is 8% for those treating Covid-19 patients.

TODAY, MORE THAN EVER, PHYSICIAN RETENTION IS THE KEY

For this reason, it is important that hospitals, medical groups and other

healthcare organizations focus on their physician engagement and retention strategies, so that they maintain their staffs when patient demand for services resumes. Those that are successful in creating deeper connections with their physicians as a result of the shared mission, sacrifices and stress of Covid-19 will be well positioned to address the myriad challenges that will be presented by a post-pandemic healthcare system.

2020 INCENTIVE REVIEW: FINDINGS AND METRICS

As was stated above, the context in which physician recruiting takes place today is being reshaped by Covid-19, as is almost everything else in healthcare.

Most of the data tracked in the 2020 Review pre-dates Covid-19, but nevertheless provides useful insights into current and potential physician recruiting trends. One of these insights is that the market for primary care physicians is changing.

AS A RESULT OF THE COVID-19 EPIDEMIC, I HAVE OR WILL:

Seek a different practice	14%
Find a job that does not involve direct patient care	6%
Close my practice temporarily	7%
Retire	5%
Leave private practice and seek employment with a hospital or other entity	4%
Take out a loan	15%
Seek physical healthcare	2%
Seek mental healthcare	3%
Continue practicing as I am	66%

Source: A Survey of Physicians and Covid-19. Merritt Hawkins and The Physicians Foundation. April, 2020.

THE PRIMARY CARE PARADIGM IS EVOLVING

For the 14th consecutive year, family medicine was Merritt Hawkins' most requested search engagement, the 2020 *Review* indicates.

Despite this fact, demand for family physicians has declined. In the 2014/15 *Review* period, Merritt Hawkins conducted a record high of 734 family medicine searches. That number declined to 448 searches in 2020 *Review*, a decrease of 40% (see left chart below).

One reason for this shift is that some patients are turning away from the traditional office-based primary care model. According to a November, 2018 report from the Health Care Cost Institute, visits to primary care physicians dropped by 18% between 2012 and 2016. In 2012, 51% of office visits for patients under 65 were to primary care physicians. That number declined to 43% in 2016, according to the

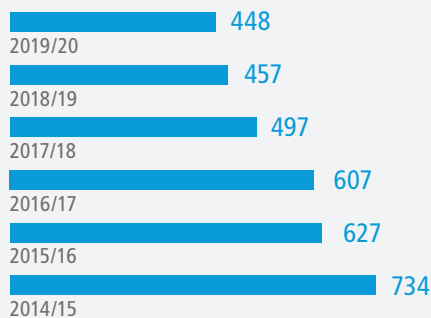
report. Young people, in particular, appear less inclined to see a primary care physician (see right chart below):

There was a corresponding 129% increase in office visits to NPs and PAs from 2012 to 2016, according to the report, indicating that the manner in which patients access the healthcare system is evolving. Convenient care venues such as urgent care centers and retail clinics, commonly staffed by NPs and PAs, are becoming key entry points into the health system. A growing number of younger people are using these sites (as well as telemedicine) as their main source of primary care, eroding market share for traditional, office-based primary care physicians.

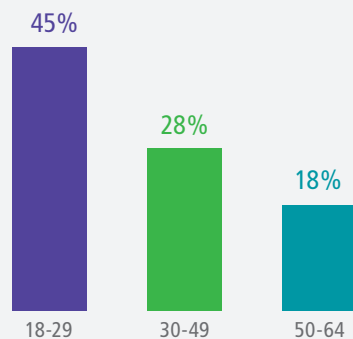
COVID-19 AND INDEPENDENT PRIMARY CARE PRACTICES

While many primary care practices have seen an influx of Covid-19 patients, many also have seen a corresponding decrease in other types of patients who

MERRITT HAWKINS FAMILY MEDICINE SEARCH ENGAGEMENTS BY YEAR



ADULTS WHO HAVE NO PRIMARY CARE PHYSICIAN



Source: Health Care Cost Institute/ Kaiser Health News/ Washington Post. 10/8/2018

remain reluctant to enter physician offices. The financial strain, particularly on independently owned primary care practices that may not have the resources of hospital-owned or investor-owned practices, has been severe in some cases.

Though many primary care physicians sustained some income by pivoting to telehealth, this has not offset income losses, particularly for primary care physicians with a high volume of older, Medicare patients who do not have the technical resources or knowledge to engage in telehealth. A majority of private practices have therefore curtailed most physician recruiting activity since the virus emerged.

It is probable that some independently owned primary care practices will have to merge with hospitals or larger medical groups to survive post-Covid-19, further eroding the viability of the private practice model which has been in decline for years.

COVID-19, PRIMARY CARE AND THE RISING USE OF TELEHEALTH

The coronavirus pandemic is likely to accelerate consumer demand for convenience and for alternatives to office-based primary care such as telehealth. In fact, it has already done so. As was referenced above, 48% of physicians now indicate they treat patients through telehealth, up from 18% in 2018, and this number is very likely rising.

About 20% of all office, outpatient and home health expenses could be converted

to telehealth by the end of 2020 across Medicare, Medicaid and commercially insured populations, an amount totaling \$250 billion, according to a McKinsey & Co study (*Washington Post*, June 2, 2020).

Joseph Kvedar, M.D., President of the American Telemedicine Association and Professor of Dermatology at Harvard Medical School, noted in an article in *Medscape* how rapidly physicians and patients have embraced telehealth. He indicated that the Brigham and Women's/Massachusetts General Hospital-affiliated Partners Healthcare System, a network of about 7,000 physicians, accounted for only 1,600 virtual patient encounters in February, 2020. In April, 2020, that number had jumped to 242,000 (*Medscape*, June 11, 2020).



TELEHEALTH APPLICATIONS AND PATIENT ACCEPTANCE

This trend is mirrored at many other healthcare systems, with some seeing number of telehealth visits up by a factor of 50 or more year-over-year. Of those, most are expecting telehealth to become a sustained care pathway that will account for 30% to 55% of their primary care

visits. The variance will depend on the system's telehealth platform, clinical training for providers utilizing the platform, and a cultural reset for both physicians and patients adapting to the new structure.

The most immediate application of telehealth includes medical checks, treatment protocol follow-up, and management of such chronic diseases as asthma or diabetes, as well as other forms of care where a "high touch" approach is not essential.

For patients, conversion to telehealth can depend on their first user experience. How well the technology allows communication to the full care team, and whether it promotes bi-directional communication, can determine whether patients embrace a delivery format that is new to them. The overall patient experience, which may be shaped by features such as translators and online scheduling, also may determine whether patients accept telehealth. Those patients who have already used technology for remote monitoring may be more apt to convert to telehealth visits.

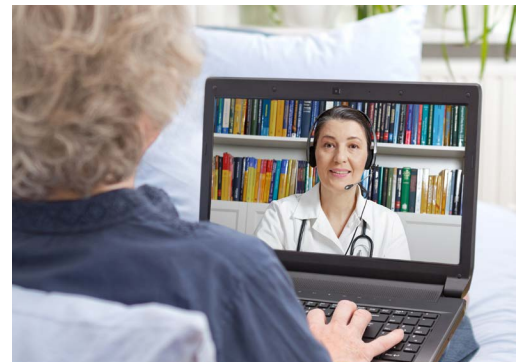
The increased use of telehealth will affect the way in which physicians are compensated, a topic examined later in this *Review*.

THE CONTINUED RELEVANCE OF PRIMARY CARE POST COVID 19.

The 2020 *Review* indicates that starting salaries for primary care physicians remained flat over the last year or decreased. Family medicine starting salaries have been flat for three years at about \$240,000, the 2020 *Review* shows, while starting salaries

for internal medicine physicians and pediatricians declined by 3.4% and 8.7% respectively year-over-year.

However, this is not to suggest that primary care is losing its relevance as the healthcare system evolves. On the contrary, primary care physicians play a critical role in the care coordination of older patients, many of whom have multiple chronic illnesses that need to be tracked and managed. This aspect of their role will increase significantly as the population ages.



Primary care physicians also are essential to the implementation of value-based reimbursement models and to the integrated systems built on these models, such as accountable care organizations (ACOs). In these models, primary care physicians are the quarterbacks of the care delivery team, ensuring tasks are allocated appropriately and resources are managed efficiently. Rather than focus on individual transactions, ACOs and other primary-care led delivery models promote disease prevention and the care of large population groups. The principles of value-based care and population health management cannot be applied without a robust network of primary care doctors.

These principles include continuity of patient care, which is vital to achieving

better outcomes and to ensuring population health. Care continuity will become even more important as a result of Covid-19, since the pandemic will require more patient monitoring, more care coordination and therefore more primary care physicians.

COVID-19 CHANGES MADE PERMANENT

Merritt Hawkins anticipates that primary care practices, spurred by the coronavirus epidemic, will make changes to become more accessible to patients through telehealth, through more efficient scheduling, through expanded hours and other operational changes.

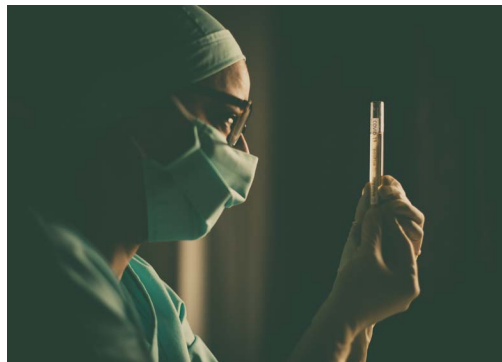
To fully make this pivot, changes to reimbursement and HIPAA-related policies initiated during the pandemic that allowed for greater use of telehealth should be made permanent. These changes are discussed in more detail in Merritt Hawkins' white paper *Telehealth: History, Current Applications and Growth in Light of Covid-19*.

FROM FIXED FTEs TO FLEXIBILITY

Because of their continued key role as care coordinators, advocates of prevention, and providers of care continuity, primary physicians will play a foundational role in the healthcare system post-Covid-19 and the market for their services will, in the long-term, be robust.

In addition, given that Covid-19 will likely be a significant healthcare risk factor for one to two more years, or until a vaccine is

developed and enough of the population has access to testing, it can be expected that primary care physicians will play a major role in surge protection as utilization peaks or outbreaks hit specific markets.



They also will play a key role in testing, providing preventive care and coordinating the patient journey through Covid-19 detection, treatment and recovery. As utilization ebbs and peaks in response to the virus, a contingent labor/flex staffing model is likely to become more prevalent at healthcare systems. This will allow systems to pivot away from a staffing model based on a fixed number of FTEs to a more flexible model that promotes cost containment as volumes become harder to predict.

The difficulty is that it has yet to be determined how to pay physicians under this type of model, in conjunction with their normal practice load. It is likely that physicians will continue to see more peaks and valleys in their patient schedules than they would prefer, which will have to be addressed if they are to stay afloat financially. Private practices are likely to be on their own in this effort as government support will eventually end, assuming such support was enough to sustain them initially.

COVID-19 AND THE MARKET FOR SPECIALISTS

As was noted above, 78% of the physician searches Merritt Hawkins was engaged to conduct during the 2020 *Review* period were for specialist physicians, up from 67% five years ago.

The types of physicians who are in the most demand can be gauged by the number of search engagements Merritt Hawkins conducts by specialty in a given *Review* period. For example, the 2020 *Review* indicates Merritt Hawkins conducted more searches for family physicians than for any other type of specialty over the last 12 months, suggesting demand for family physicians remains strong.

WHO LEADS IN “ABSOLUTE DEMAND?”

It is to be expected, however, that specialties that have a comparatively high number of practicing physicians, such as family medicine, will generate a comparatively high number of searches. But how does the picture look if specialties are ranked by number of search engagements/job openings as a percent of all active physicians in a given specialty, or by what Merritt Hawkins calls “absolute demand?”

The following list ranks demand for particular types of physicians in this manner.

MERRITT HAWKINS TOP 10 SEARCH ENGAGEMENTS AS A PERCENT OF ALL PHYSICIANS IN VARIOUS SPECIALTIES (PATIENT CARE ONLY)

	2019/20
1. HEM/ONC.	1.1%
2. RADIOLOGY	0.8%
3. PSYCHIATRY	0.6%
4. UROLOGY	0.6%
5. CARDIOLOGY	0.5%
6. FAMILY MEDICINE	0.5%
7. GASTROENTEROLOGY	0.5%
8. NEUROLOGY	0.5%
9. OB/GYN	0.4%
10. DERMATOLOGY	0.4%

As this ranking indicates, in terms of “absolute demand,” hematologists/ oncologists were the most in demand type of physician during the 2020 *Review* period, while family medicine physicians were tied for fifth on the list. By this standard, it can be argued that it is generally specialist physicians who are the most highly sought after.

PROCEDURES (AND RECRUITING) STALLED BY COVID-19

The coronavirus pandemic, however, has caused an abrupt reduction in demand for many types of specialists. Hospitals and health systems put elective procedures on hold to prepare for a surge of Covid-19 cases, while many patients were reluctant to enter hospitals and other environments where they might contract the virus.

By mid-May, 2020, 94 million adults had delayed medical care as a result of Covid-19, according to the Census Bureau (*Washington Post*, June 2, 2020).

Medical groups performing a high volume of so-called non-essential procedures have been unlikely to recruit additional physicians during the pandemic. For example, small to mid-sized dermatology groups and ophthalmology groups, many of which are still independent, are not seeing the volumes they need to add staff. Demand also has been reduced for specialists doing a high volume of routine procedures. Gastroenterologists who perform routine colonoscopies, for example, are unlikely to have seen volumes that would justify staff increases.

Demand has even been down in trauma surgery during the pandemic, because fewer people have been on the road, at work or otherwise exposed to risk. Similarly, ER volumes have been down at many hospitals, as patients opted to cope with problems themselves rather than risk a trip to the emergency room.

COVID19 WILL SPUR DEMAND FOR SOME SPECIALISTS

Once the pandemic has been contained and the healthcare system adjusts to new realities and the need for emergency preparedness, it can be expected that demand for hospitalists, infectious disease specialists, emergency medicine physicians, and pulmonary/critical care specialists will be particularly strong. All of these types of specialists will be needed to both maintain population health should cases of Covid-19

persist and to prepare for the next pandemic or public health emergency.

COVID-19 AND INFECTIOUS DISEASE SPECIALISTS

The coronavirus pandemic could spur a particular increase in demand for infectious disease (ID) specialists.



In the 1970s, advances in medicine led to the perception that ID would cease to be a medical specialty in strong demand. This proved not to be the case. A rise in tuberculosis rates, the global HIV pandemic, the outbreak of Ebola in humans, and increasing Hepatitis C infection rates continued to drive demand for ID specialists.

Most often observed in settings with high poverty, mental illness, addiction, and incarceration, ID requires complex care coordination. New therapies for cancer and transplants have resulted in more immunocompromised patients with susceptibility to ID. Specialists in ID are important to the effort to address hospital-acquired infections. Deaths due to drug resistant pathogens are predicted to rise rapidly over the next several decades and there will be a dwindling supply of new antibiotics to address this challenge.

All these factors were in play before the emergence of Covid-19, which has dramatically highlighted the need for more ID specialists.

Unfortunately, the number of physicians entering ID has steeply declined in recent years. Between the 2009-2010 and 2016-17 fellowship matches, the number of adult ID programs filling all their positions dropped by 41% and the number of applicants decreased by 31%. In 2015, fewer than half of U.S. ID fellowships filled their incoming classes.

These stark supply and demand trends suggest that the looming shortage of ID specialists should be addressed by policy makers before the next pandemic strikes.

PSYCHIATRY: COVID-19 TO CONTRIBUTE TO A PUBLIC HEALTH CRISIS

For over 10 years, Merritt Hawkins has been noting in these *Review* the critical shortage of psychiatrists nationwide, a theme expanded upon in our white paper *Psychiatry: The Silent Shortage*.

Demand for psychiatrists and other behavioral health workers is likely to spike considerably as a result of Covid-19, exacerbating what already was a nationwide shortage of these professionals.

An April, 2020 survey by the Kaiser Family Foundation found that almost half of all U.S. adults (45%) say the pandemic has affected their mental health, while 19% say it has had a “major impact.” (*The Impact of Coronavirus on Life in America*. Kaiser Family Foundation. April, 2020).



Prescriptions for anti-anxiety drugs spiked 34% between February 16 and March 15, and also increased for antidepressants (18.6%) and anti-insomnia drugs (14.8%), according to a report from Express Scripts (*America's State of Mind: U.S. Trends in Medication Use For Depression, Anxiety & Insomnia*). Companies like Ginger and TalkSpace that deliver virtual mental health care have seen a massive surge in demand for services during the pandemic, with increases of 50% to 65% in February and March, 2020 (*Open Minds/Strategy and Innovation Institute*. April 23, 2020).

The 2020 *Review* marks the fifth consecutive year that psychiatry has been our second most requested physician search (third overall, after family medicine and nurse practitioners) having progressively moved up from the 13th spot in 2000/2001, a reflection of continued demand for the specialty.

Today it is widely acknowledged that the shortage of mental health professionals, including psychiatrists, has developed into a public health crisis.

In March, 2017, the National Council of Behavioral Health (NCBH) released a report indicating that 77% of U.S. counties are experiencing a severe shortage of psychiatrists. (*HealthLeaders*, March 30,

2017). In Texas, 185 out of 254 counties lack a general psychiatrist, according to a study completed by Merritt Hawkins on behalf of the North Texas Regional Extension Center.

Maintaining and expanding access to psychiatric services will be one of the primary challenges facing healthcare policy makers and providers in the post-Covid-19 environment.

PROJECTED SHORTAGES IN OTHER SPECIALTIES

It also can be anticipated the demand for routine and non-routine procedures performed by a wide range of surgical, diagnostic, and internal medicine subspecialties will resume. Given the physician supply and demand factors outlined above, particularly population aging, specialists will be needed to perform everything from skin biopsies to heart surgeries, none of which can be put off indefinitely without disastrous consequences.

In addition, the growing number of nurse practitioners (NPs) and physician assistants (PAs) in the in the U.S. have significantly supplemented the primary care workforce, but are less able to supplement the workforce of specialist physicians, since they are not trained in many of the procedures that specialists commonly provide.

The Health Resources and Services Administration (HRSA) report *National and Regional Projections of Supply and Demand for Internal Medicine Subspecialty Practitioners* and its similar report on

supply and demand for surgical specialist physicians projected that a variety of specialists will be in short supply by 2025.

The chart on page 30 indicates HRSA's shortage projections in several of these specialties.

These projections pre-date the 2020 coronavirus pandemic and may have to be revised to incorporate the economic damage done by Covid-19, which likely will reduce the ability of patients to pay for specialty services in the short to mid-term. Nevertheless, they underline the growing distance between the demand for specialty physicians generated by an aging population and the supply of such physicians, which will continue to be a long-term trend.

More information on the shortage of specialty physicians is included in the Merritt Hawkins white paper *Physician Supply Considerations: The Emerging Shortage of Specialists*.

ROLE OF NPs AND PAs TO EXPAND POST-COVID-19



The number of search engagements Merritt Hawkins conducted for nurse

NATIONAL ESTIMATES OF PHYSICIAN SUPPLY, DEMAND AND DEFICITS/INTERNAL MEDICINE SUBSPECIALTIES AND SURGICAL SPECIALTY PHYSICIANS BY 2025

	Supply	Demand	Deficit/2025
Allergy and Immunology	4,140	4,620	-480
Cardiology	28,560	35,460	-7,080
Dermatology	13,100	13,530	-430
Gastroenterology	15,540	17,170	-1,630
Hematology/Oncology	18,100	19,500	-1,400
Pulmonology	14,110	15,510	-1,400
General Surgery	30,760	33,730	-2,970
Neurological Surgery	4,930	5,130	-1,200
Ophthalmology	16,510	22,690	-6,180
Orthopedic Surgery	24,350	29,400	-5,050
Cardiothoracic Surgery	3,600	5,410	-1,800
Urology	8,830	12,460	-3,630
Vascular Surgery	3,410	3,930	-520

Source: HRSA Regional Projections of Supply and Demand for Internal Medicine Subspecialty Practitioners/Surgical Specialty Physicians. December, 2016.

practitioners (NPs) and physician assistants (PAs) increased by 54% year-over-year, the 2020 *Review* indicates, highlighting the extremely strong demand for advanced practice professionals.

There are over 265,000 NPs practicing in the U.S. today, according to the American Association of Nurse Practitioners (AANP), 78% of them delivering primary care.

There are over 120,000 PAs practicing in the U.S., about one-third of them in primary care and two-thirds in specialty areas, according to the American Academy of Physician Assistants (AAPA).

NPs and PAs are playing a growing role in team-based care (many were trained in this

model), in some cases handling 80 percent or more of the duties physicians perform, allowing doctors to focus on the most complex patients and procedures. Their ability to educate patients, ensure patient compliance, reduce costs and enhance patient satisfaction makes them an ideal resource for value-based delivery systems operating in global payment structures.

Increasingly, NPs and PAs are viewed as appropriate leaders of the team-based care model, capable of coordinating the efforts of all members of the team, from physicians to community care coordinators. They also are being groomed for those leadership positions considered critical to the transition to

quality-based care, including chief quality officer, director of population health management, and others.

PAs have prescriptive authority in all 50 states, while NPs now can practice independently of physicians in over 20 states and the District of Columbia, with scope of practice expected to expand. NPs and PAs provide the bulk of care at the growing number of urgent care and retail centers and also have been a fixture at Federally Qualified Health Centers (FQHCs) for years. Their presence and role is likely to be determined on a state-by-state level, as each state has discretion to impose its own level of NP and PA management, oversight and autonomy.

AIDING POST-COVID-19 BACK TO WORK EFFORTS

As the nation emerges from the coronavirus pandemic, NPs and PAs are likely to play an even more active role in Covid-19 related patient testing, monitoring, compliance and education. The pandemic saw an influx of NPs and PAs to Covid-19 hot spots, and their active role in treating virus patients may support ongoing efforts to enhance NP and PA scope of practice laws. Expanded scope of practice would be likely to further drive demand for NPs and PAs, particularly in rural areas where direct physician supervision may be impractical.

In addition, thousands of businesses, from real estate offices to factories to distribution centers, now require systems for getting employees back to work while ensuring their safety. NPs and PAs can help

design, implement and staff these efforts, ensuring employee screenings, temperature checks, quarantining efforts and overall management of the process.

However, a significant recruiting challenge is arising in this area as many NPs and PAs are choosing to specialize, making it more difficult to find providers to fill primary care roles.

For more information on this subject see Merritt Hawkins' white paper, *NPs and PAs: Supply, Distribution and Scope of Practice*.

RECRUITMENT SETTINGS AND COVID-19

Types of Healthcare Facilities Currently Recruiting Physicians

Following is a review of the types of settings into which Merritt Hawkins recruited physicians during the 2019/20 *Review* period and how their physician recruiting policies may be affected by Covid-19.

Hospitals

The 2020 *Review* indicates that 36% of Merritt Hawkins' search engagements over the last year featured a hospital setting, up from 34% the previous year.

Hospitals lost some \$200 billion dollars over the first quarter of 2020 directly or indirectly as a result of the coronavirus pandemic. Hospital visits began to recover in the first half of May, 2020, but were still down by 40% year-over-year (*Washington Post, June 2, 2020*). Consequently, "cash in hand" and patient and staff safety have been the first priorities of hospitals

during the pandemic, ahead of physician recruiting or any other consideration.

Virtual Recruiting During the Pandemic

Nevertheless, some hospitals have proceeded with their physician recruiting efforts during the pandemic, in some cases successfully identifying and signing candidates through virtual channels, forgoing traditional on-site interviews. For more information on this topic see Merritt Hawkins' guidance paper, *Maintaining Physician Recruiting Efforts in the Wake of the Coronavirus*.

MAJOR SYSTEMS WEATHERING THE COVID-19 STORM?

Larger hospital systems with the most diversified network of physicians, inpatient and outpatient venues, integrated electronic health records (EHR), stable management and relatively robust financial resources are in the best position to weather the Covid-19 storm and to ramp up recruiting efforts once the virus is contained. Those systems that already operated under a risk-based reimbursement model or which had mature telehealth programs in place pre-Covid-19 are particularly well positioned today.



As was referenced earlier in this *Review*, physician retention should be a primary staffing priority for hospitals during the pandemic. By solidifying bonds with physicians during the crisis, hospitals can reduce turnover and will be able to manage post-Covid-19 challenges, which may include recruiting additional physicians.

COVID-19 CREATES MORE STRAIN FOR RURAL FACILITIES

Since 2010, at least 128 rural hospitals have closed nationwide, with an additional 450 (or 21% of all rural hospitals) facing financial strain. Should these hospitals close, more than 21,500 beds could be lost. Prior to the pandemic, rural hospitals were already facing dwindling occupancy rates with an average occupancy of 52% in 2016, well below the healthy benchmark of 75% (*The Covid-19 Pandemic and Rural Hospitals – Adding Insult to Injury. Health Affairs May 3, 2020*).

As Alan Morgan, head of the National Rural Health Association, stated in the *Health Affairs* article cited above: “If we’re not able to address the short-term cash needs of rural hospitals, we’re going to see hundreds of rural hospitals close before this crisis ends.”

The result may be further hospital consolidation with physician recruiting increasingly being conducted by large hospital systems recruiting multiple physicians at a time to implement population health management programs and to increase market share.

A DIFFERENT HOSPITAL PATIENT EXPERIENCE POST-COVID-19

At all hospitals, the patient experience is likely to change post-Covid-19, and may feature:

- *patient screenings for infections prior to appointments*
- *barriers/social distancing,*
- *limits on patient hospital visitations*
- *appointments spread over longer hours to spread traffic*
- *fewer forms of touch*
- *drive-up shots*
- *automobile-based physician / patient encounters.*

Maintaining revenue will be an ongoing challenge for hospitals until pre-Covid-19 levels of utilization return. Even with billions of federal dollars funneled to healthcare providers through the CARES Act and other stimulus, hospitals will be closely monitoring costs, increasing efficiencies, eliminating duplicate services and reducing investments in brick and mortar while pivoting to virtual delivery models.

PHYSICIANS DRIVE REVENUE

Despite these changes, a basic fact of healthcare economics remains. Physicians drive revenue to hospitals through patient admissions, the procedures they perform, the tests and treatments they order, and the drugs they prescribe. According to Merritt Hawkins' *2019 Physician Inpatient/*

Outpatient Revenue Survey, physicians generate an average of \$2.4 million in net revenue for their affiliated hospitals each year, with the amount varying by specialty (see chart below):

AVERAGE NET ANNUAL HOSPITAL REVENUE GENERATED BY PHYSICIANS BY SPECIALTY

	2019/20
CARDIOLOGY (INV.)	\$3,484,375
ORTHOPEDIC SURGERY	\$3,286,764
GASTROENTEROLOGY	\$2,965,277
FAMILY MEDICINE	\$2,111,931
OBGYN	\$2,024,193

Source: Merritt Hawkins 2019 Physician Inpatient/ Outpatient Revenue Survey

Hospitals will continue to engage in physician recruiting activities post-Covid-19 primarily to ensure patients in their service areas have access to the care they need. They also will do so to ensure they have the economic viability necessary to carry out their mission to provide care to their communities.

The coronavirus pandemic has, in fact, further confirmed how wedded the healthcare system is to the fee-for-service model, despite all of the rhetoric around adoption of quality/outcomes-based models. Similarly, despite the shift toward outpatient care, Covid-19 has illustrated that virtually every hospital in the country still is built on a foundation of in-patient revenue and is in a fragile position when inpatient volumes go down.

MEDICAL GROUPS

Thirty-two percent of Merritt Hawkins' search engagements tracked in the 2020 *Review* were conducted for medical group settings, up from 28% the previous year.

As is the case with hospitals, larger medical groups, such as Kaiser Permanente and Cleveland Clinic, which resemble hospital systems in that they employ thousands of physicians operating in both clinics and hospitals, may have the best chance of remaining viable in the post-Covid-19 environment.

Smaller, independent physician practices may be in a less tenable position. As was referenced above, physician practice revenue declined by 55% in the first quarter of 2020. Many solo and small group practice physicians have struggled during the pandemic and some have applied for financial relief through the Paycheck Protection Program (PPP).

PRACTICE ACQUISITION POST-COVID-19

It is anticipated that some small group practices will close as a result of Covid-19 while others will merge with larger group practices or be purchased by hospital systems or investor groups.

Healthcare systems are already fielding calls from a variety of medical groups that were uninterested in being acquired pre-Covid-19. Similarly, large to mid-sized medical groups are being contacted by individual physicians or small practices looking for a safe haven.

Based on the losses physician practices have sustained as a result of Covid-19, some markets could lose up to 35% or more of their most vulnerable group practices while a large percent of others will be acquired. Unlike in the past, however, hospital systems, large medical groups, or investors are unlikely to offer the physicians they acquire higher than average starting salaries. Due to the Covid-19 related revenue losses they have sustained, these entities are likely to offer starting salaries that are below previous averages

The physician recruiting model will therefore evolve further away from one or two search engagements conducted on behalf of small group practices and toward multiple search engagements for large groups and hospital systems that may include a managed services program (MSP) component.

ACADEMIC MEDICAL CENTERS



Eighteen percent of Merritt Hawkins' search engagements tracked in the 2020 *Review* were conducted for Academic Medical Center (AMC) settings, down from 20% the previous year but up from 11% in 2016/17 *Review* period.

Sixty-eight percent of these engagements were for faculty positions, 28% were for leadership positions and 4% were for research positions.

AMCs are hospitals and health systems with a close affiliation with a medical school. AMCs feature residency and often fellowship training programs and pursue clinical research in addition to direct patient care. They are also often considered to be tertiary care centers, because of their ability to treat a full range of complex conditions, in many cases by providing subspecialty care.

COVID-19 AND DISRUPTIONS IN MEDICAL EDUCATION

Some AMCs have been central to providing services during the pandemic, particularly in large urban centers that have been Covid-19 hot spots. Despite an influx of virus patients, however, AMCs have experienced revenue losses as elective and other procedures have been delayed or cancelled.

Covid-19 also has created disruptions in medical education and residency programs based at AMCs, causing programs to be restructured and potentially delaying the training process for new physicians. The pivot to telehealth can be a particular challenge in residencies, as faculty pay and duties have traditionally revolved around in-person instruction and shadowing. This topic is addressed in more detail in Merritt Hawkins' white paper *Will There Be a Doctor in the House?*

Given their size and diversity of service offerings, AMC's, like hospital systems, may be better positioned to weather the

pandemic than other entities. They typically also have other sources of funding besides patient volume, such as research grants and endowments, that can help sustain hiring efforts during economic downturns.



EXPANDING CLINICAL CAPABILITIES

Recruitment of faculty, research and leadership positions at AMCs has increased in recent years due to the expansion of medical education in the U.S. and the continued vital role AMCs play as tertiary care centers. In 2006, the Association of American Medical Colleges (AAMC) announced the goal of increasing medical school enrollment by 30%, and that goal has been accomplished.

In addition, academic centers are typically major hubs of care in their communities, and often are contending with sharp increases in demand for services. They are seeking to significantly expand clinical capabilities and teaching capabilities simultaneously and can be overwhelmed for this reason. It can be difficult for the board and other AMC leaders to reconcile the competing agendas of the health system side of the organization with the academic side.

ACADEMIC LEADERS POST-COVID-19

Notable in academic recruitment over the last several years has been an evolution in the type of academic leaders being sought, with less emphasis placed on publication history and associated funding, and more emphasis placed on an understanding of profit/loss business dynamics, conflict resolution, interpersonal relationships and collaboration throughout the organization.



Traditionally, AMCs have sought leaders offering a “triple threat,” with research, clinical and leadership skills. However, we have recently seen a transition in which some AMCs focus on recruiting “double threat” candidates while utilizing an existing leader who has strengths in one of the three areas to complement the new leader.

In addition, the average tenure of AMC Deans placed by Merritt Hawkins is a relatively short four years, as many centers are seeking a new breed of leader who can navigate the organization through transformative times.

Academic institutions also are making a concerted effort to diversify their

leadership, seeking to identify and develop female and minority leaders.

All these trends are likely to be accelerated in response to the pandemic, particularly as AMCs seek leaders who can help their organizations pivot toward telehealth and ensure that Covid-19 patient and staff safety protocols are put in place.

ACADEMIC ADVISORY COUNCIL

To help address these needs, Merritt Hawkins’ Department of Academics has expanded its resources, forming an Academic Advisory Council of nationally prominent academic medicine leaders to help set strategic goals and to source top candidates for academic leadership positions and to provide executive coaching.

The Advisory Council is composed of Tom Lawley, MD, former Dean of Emory Medical School; Philip Pizzo, MD, former Dean of Stanford Medical School; and Arthur Rubenstein, MD, former Dean of the University of Pennsylvania School of Medicine.

FEDERALLY QUALIFIED HEALTH CENTERS

Six percent of Merritt Hawkins’ search engagements tracked in the 2020 *Review* were conducted for Federally Qualified Health Center/Community Health Center or Indian Health settings, down from 9% the previous year.

With over 50 years of service, Federally Qualified Health Centers (FQHCs) have expanded rapidly in recent years and

now include approximately 1,400 centers providing services at over 10,000 sites nationwide.

Using a primary-care driven, preventive model now being adopted by other types of providers, FQHCs see over 28 million patients annually, while offering affordable, accessible care and seeing all patients regardless of their ability to pay.

Merritt Hawkins is proud to be the sole provider of permanent physician search services for the National Association of Community Health Centers (NACHC) and to support the vital mission of FQHCs in addressing the needs of medically underserved populations.

A KEY RESOURCE DURING COVID-19

FQHCs have been a key resource during the coronavirus pandemic, providing tests, triaging patients, and reducing the burden on hospitals. Ninety-percent of FQHCs are providing Covid-19 tests, with 67% offering walk-up or drive-through testing as of May 8, 2020 (*Impact of Coronavirus on Community Health Centers. Kaiser Family Foundation. May 20, 2020*).

FQHCs provide care to patient populations most likely to suffer from Covid-19. Over 90% of their patients are low income while 63% are ethnic minorities. Of patients tested at FQHCs, 28% have tested positive, double the national rate, according to the Kaiser Family Foundation. FQHCs also play a role in addressing the accelerated need for mental health services during the pandemic.

FUNDING AND STAFFING SHORTAGES EXACERBATED BY COVID-19

Nevertheless, many FQHCs have been hard hit by the pandemic. Health center organizations reported a 43% drop in the number of patient visits compared to before the pandemic, as many people across the country are avoiding non-essential trips to health care providers. The drop in visits comes even after health centers have been increasing the number of telehealth visits, with health centers conducting roughly half (51%) of visits virtually or over the phone, as tracked by the Kaiser Family Foundation.



Additionally, health centers report that 11% of staff are not working due to exposure to the coronavirus, lack of protective equipment, site closures, or family obligations, among other reasons. There have been 1,954 temporary health center site closures due to repercussions from the coronavirus as of May 8.

Though health centers have received \$1.98 billion in rapid response grants from the federal government, more assistance may be needed to sustain them. Funding and staffing shortages have traditionally been

the two most commonly cited challenges facing FQHCs. The same holds true for Indian Health facilities. Both these challenges have been made more difficult by the fallout from Covid-19.

As a result, most FQHCs and Indian Health facilities are unlikely to engage in significant recruiting activity until funding issues are resolved.

SOLO PRACTICE/PARTNERSHIPS/ CONCIERGE

Three percent of Merritt Hawkins' search engagements tracked in the 2020 *Review* were conducted for solo practice, partnership or concierge practice settings, up from 1% in 2016/17 *Review* period.

These settings generally feature practice ownership, in which physicians are being recruited to set up their own solo practice or to join another physician as an owner/partner. In some cases, these may be concierge/direct pay practices in which physicians contract directly with patients, bypassing third party payers, though not all concierge practices feature practice ownership.



Merritt Hawkins had seen some signs over the last year that small practice ownership might be making at least a minor rebound after many years of decline. However, Covid-19 has created financial and operational difficulties for many small, independent practices, further eroding the viability of this traditional practice model. Such practices are therefore unlikely to generate significant recruiting activity in the post-Covid-19 world.

COVID-19 WILL ACCELERATE THE EMPLOYED PHYSICIAN MODEL

The majority of the organizations recruiting physicians today – hospitals, medical groups, urgent care centers, FQHCs, academic centers, and others -- typically employ physicians rather than establishing them in private practices.

While it is hard to be precise given the hybrid nature of some physician contracts, the 2020 *Review* suggests that the great majority of physicians accepting new positions today – about 95% – will practice as employees and not as independent practice owners/partners. By contrast, in 2001, this number was approximately 60%.

Physician employment may be required to implement evidence-based treatment protocols, IT standardization, global payments and other hallmarks of value-based care. In order to establish a value-based organizational culture and a uniform compensation plan for hundreds and even thousands of physicians, employment is the model of necessity if not preference. Employing physicians also can help

hospitals comply with Stark and federal fraud and abuse statutes.

In addition, employment is the preferred practice model of many physicians today who do not want the attendant responsibilities, time constraints and stress of “running a business.” The challenges of physician recruiting become more daunting for those facilities unable or unwilling to offer physicians employment.

Covid-19 is likely to further accelerate this trend, as the pandemic has created financial and operational challenges which many independent practices have had difficulty addressing.

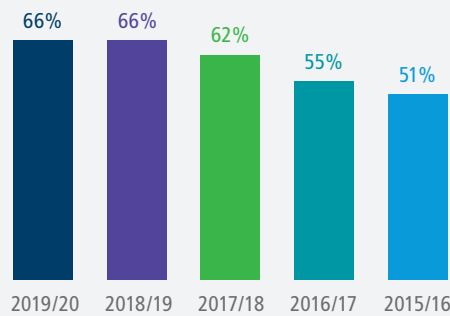
LARGER COMMUNITIES ARE DRIVING PHYSICIAN RECRUITMENT

Physician shortages, and, by extension, physician recruiting efforts, are often thought to be concentrated in smaller communities and rural areas. Merritt Hawkins’ 2020 *Review* underscores how this dynamic continues to change.

For the first 22 years Merritt Hawkins completed the *Review*, the number of search engagements we conducted in communities of 100,000 or more never exceeded 50%. That has not been the case over the last five years (see following chart):

As these numbers indicate, during the 2019/20 *Review* period, two-thirds of Merritt Hawkins’ search engagements (66%) were for communities of 100,000 people or more.

PERCENT OF MERRITT HAWKINS SEARCH ENGAGEMENTS IN COMMUNITIES OF 100,000 OR MORE



This trend further underscores how demand for medical specialists, who typically practice in larger communities, is driving a growing number of recruiting efforts. Physician shortages have by no means diminished in rural areas, but recruiting challenges and efforts have expanded into larger communities as well, particularly those seeking specialists.

Merritt Hawkins worked for clients in 46 states and the District of Columbia during the 2020 *Review* period, underlying the national presence of physician recruiting needs and challenges.

AVERAGE STARTING SALARIES AND CONTRACT STRUCTURES

Merritt Hawkins’ *Review* tracks the starting salaries being offered to recruit physicians, as well as other recruiting incentives typically offered to doctors and advanced practitioners.

Average starting salaries represent the base only and are not inclusive of bonuses or other incentives. This is in contrast to

physician compensation numbers compiled by the Medical Group Management Association (MGMA), the American Medical Group Association (AMGA) and other organizations, which track overall average physician incomes, not starting salaries.

Merritt Hawkins' salary ranges are therefore indicators of the financial incentives needed to attract physicians already established in a practice or those coming out of residency to a practice opportunity, rather than indicators of physician average incomes.

If Merritt Hawkins' compensation numbers are equal to or exceed numbers of other surveys that track total physician earnings, that is a strong indicator that demand in those specialties is particularly high. It therefore can be useful to use Merritt Hawkins' data in tandem with surveys tracking total physician earnings when developing physician compensation packages.

PRE-COVID-19 NUMBERS

As was noted earlier, virtually all of the starting salary and other incentive-related data tracked in this *Review* are derived from Merritt Hawkins/AMN Healthcare recruiting engagements that were initiated before the widespread impact of the coronavirus epidemic.

We have outlined in the *Review* how the pandemic has altered the physician recruiting market and further note here that the market now is fluid and that recruiting incentives are in a state of flux.

Nevertheless, the 2020 *Review* offers benchmark data that still may be useful to hospitals, medical groups and other facilities seeking to recruit physicians and advanced practice professionals.

SALARIES IN PRIMARY CARE STALLED

Salaries for primary care physicians as tracked by Merritt Hawkins' *Review* displayed an upward trajectory for a number of years, reflecting the extremely strong demand for primary care doctors. Average salary offers made to family medicine physicians grew from \$185,000 in the 2012 /13 *Review* to \$231,000 in 2016/17, an increase of 25%. Similarly, average salaries for internal medicine physicians grew from \$208,000 to \$257,000 in the same period, an increase of 24%. Average salaries for pediatricians also grew, from \$179,000 in 2012/13 to \$240,000 in 2016/17, an increase of 34%.



The rate of increase has not been as steep since, and the 2020 *Review* provides a further indicator than starting salaries for primary care doctors are in a holding pattern. The average starting salary for family medicine physicians has been flat at

about \$240,000 for the last three years, the 2020 *Review* indicates. The 2020 *Review* also shows average starting salaries down 3.4% for internal medicine year-over-year and down 3.4% for pediatrics.

As is referenced above, competition for primary care physicians remains robust but is not at the same level of two or three years ago. The 2020 *Review* indicates that the number of search engagements Merritt Hawkins conducted for family medicine physicians, internal medicine physicians and pediatricians all were down year-over-year.

STARTING SALARIES IN PRIMARY CARE AND COVID-19

How starting salaries for primary care physicians are affected by Covid-19 will depend on how quickly the economy recovers and patient confidence in seeking health care is restored. In the current seller's market, salaries can be expected to remain flat, making this a relatively economical time to recruit primary care physicians.



As was noted earlier, primary care practices are pivoting toward telehealth. With telehealth reimbursement policies still

unresolved, it is uncertain whether primary care physicians will be able to sustain levels of reimbursement that were prevalent pre-Covid-19 even at such time as the economy is improved and utilization increases. In the short-term, they may not be able to do so. However, if reimbursement for in-person and telehealth services is equalized, primary care physicians may be able to increase productivity and therefore reimbursement in the longer-term.

This would be a favorable trend for hospitals that employ primary care physicians, as it would be likely to increase the down-stream revenue primary care doctors generate. Such revenue allows hospitals to increase primary care physician starting salaries.

As referenced above, it will be important for primary care physicians to respond to consumer demand for convenience post-Covid-19 to ensure patients see the value of having their own primary care physician.

STARTING SALARIES FOR SPECIALISTS

Over the last five years, starting salaries for medical specialists as tracked by Merritt Hawkins' *Review* have been up virtually across the board, though not always up year-over-year. These increases reflect the growing demand for specialty services driven by population aging and other factors cited in this *Review*.

The chart on page 42 indicates which specialties saw starting salary increases or decreases year-over-year as tracked by the 2020 *Review*.

SPECIALTIES SEEING YEAR-OVER-YEAR AVERAGE STARTING SALARY INCREASES/DECREASES

	2018/19	2019/20	INCREASE
ORTHOPEDIC SURGERY	\$536,000	\$626,000	+16.7%
RADIOLOGY	\$387,000	\$483,000	+9.3%
CRNA	\$197,000	\$215,000	+9.1%
PULMONOLOGY /CRITICAL CARE	\$399,000	\$430,000	+7.7%
HEM/ONC.	\$393,000	\$403,000	+2.5%
UROLOGY	\$464,000	\$477,000	+2.8%
PSYCHIATRY	\$273,000	\$276,000	+1.1%

	2018/19	2019/20	DECREASE
GASTROENTEROLOGY	\$495,000	\$457,000	-7.7%
CARDIOLOGY (NON-INV.)	\$441,000	\$409,000	-7.3%
NEUROLOGY	\$317,000	\$295,000	-6.0%
HOSPITALIST	\$268,000	\$254,000	-5.2%
ANESTHESIOLOGY	\$404,000	\$399,000	-1.2%
CARDIOLOGY (INV.)	\$648,000	\$640,000	-1.2%
DERMATOLOGY	\$420,000	\$419,000	-0.2%

Year-over-year fluctuations may sometimes result if Merritt Hawkins conducted an unusually large number of searches for a given specialty in a market where physician compensation is either atypically low or high. Overall changes in Medicare or other payer reimbursement rates also can be a factor.

Pre-Covid-19, however, the starting salary trend in most specialties has been upward, as utilization has increased, particularly in outpatient settings.

SPECIALTY STARTING SALARIES AND COVID-19

The coronavirus pandemic has significantly suppressed the number of elective and non-elective procedures being conducted in virtually all settings, with the potential exception of cancer centers, where treatments cannot be delayed. This is likely to keep starting salaries for specialists flat in the near-term.

Longer-term, many specialists will be moving some services, particularly consultative services, to telehealth, where reimbursement policies remain uncertain, as was noted above. Many specialty services, however, such as surgeries, cannot be conducted through telehealth, and specialists will have to rely on continued increased volumes to see corresponding increases in starting salaries. Given the supply and demand dynamics referenced earlier in this *Review*, increased volumes can be expected, but when they will occur is difficult to predict. As is the case with primary care physicians, now is a relatively economical time to recruit medical specialists.

PHYSICIAN CONTRACT STRUCTURES

Typically, physicians are offered employment contracts that feature a starting base salary that can be supplemented through a production bonus. Seventy-two percent of the search engagements Merritt Hawkins conducted in the 2020 *Review* period featured this type of contract structure. An additional 25% featured a straight salary while less than 1% featured an income guarantee.

Salaries with production bonuses are commonly offered by hospitals and medical groups, whereas the straight salary model is more frequently used by urgent care centers, FQHCs and academic settings. Income guarantees, which are essentially loans that must be repaid (but may be forgiven over time) generally are used to establish physicians in solo or small independent practices. Income guarantees were once the standard contract model,

when private practices were more prevalent than they are now, but they are rarely used today.

PRODUCTION BONUS STRUCTURES

Production bonuses determine the maximum income that physicians can potentially earn beyond their base salary. These bonuses are calculated using a variety of metrics, including:

- *Relative Value Units (RVUs)*
- *Net Collections*
- *Gross Billings*
- *Patient Encounters*
- *Quality*

All of these metrics, with the exception of quality, are volume-driven. The more work units (RVUs) physicians generate, the more net reimbursement they collect or gross billings they generate, the more patients they see, the higher their bonus. Today, RVUs are the primary way that employers measure physician volume-based productivity. RVUs were featured in 73% of physician employment contracts offering a salary and production bonus as tracked by Merritt Hawkins' 2020 *Review*.



The widespread use of RVUs highlights the extent to which physician compensation remains volume-based, though this is changing (see below).

PAYING PHYSICIANS FOR QUALITY/VALUE

In order to evolve away from the fee-for-volume model, ACOs, hospitals, medical groups, and other organizations are striving to create physician payment structures that reward doctors for providing value, which is measured by various metrics, including:

QUALITY/VALUE-BASED PHYSICIAN COMPENSATION METRICS

- *Patient satisfaction scores*
- *Adherence to treatment/quality protocols,*
- *Reduction of hospital readmissions/errors*
- *Group governance participation*
- *Cost reduction/containment*
- *Appropriate coding*
- *Implementation/use of electronic health records.*

Merritt Hawkins' 2020 Review provides an indication of the extent to which physicians currently are compensated on quality metrics.

Sixty-four percent of contracts tracked in the 2020 Review that featured a production bonus included quality as one of the metrics, up from 56% year-over-year

and up from 23% in the 2014/15 Review period. Quality therefore now is close to being a standard metric in physician contracts featuring a production bonus.

QUALITY AS A PERCENT OF TOTAL COMPENSATION

While the 2020 Review indicates that quality is becoming a more common determinant of physician production bonus amounts, a question arises as to the amount of *total* physician compensation that is tied to quality.

The 2020 Review tracks this amount directly for the third time. In instances where the production bonus includes quality metrics, the 2020 Review indicates that, on average, 11% of the physician's total compensation will be determined by quality, with no change year-over-year, though up from 8% two years ago. The majority of income for many physicians, therefore, is still determined by their base salary and by volume-driven production bonuses.

COVID-19 WILL CHANGE PHYSICIAN COMPENSATION FORMULAS

Covid-19 and the pivot toward telehealth is likely to change how physician productivity and quality are measured. In a post-Covid-19 environment, physicians may earn bonuses based on number of telehealth patient encounters they generate, participation in Covid-19 safety protocols, patient screening, testing and tracing. Like starting salaries, bonus structures are likely to remain fluid as the impact of the coronavirus pandemic plays out.

How telehealth will be reimbursed is still unresolved, but there appears to be a growing consensus that recently expanded reimbursement for telehealth eventually will be set at 75% to 95% of in-office rates. That will likely cause healthcare systems and other employers to measure physician telehealth production through a patient encounter or RVU system, most likely the latter. There also will be production metrics around telehealth service quality, number of repeat telehealth patients, referrals through virtual channels, telehealth call rotations taken in a timely manner, night and weekend coverage provided and patient satisfaction reviews conducted through an automated system.

SIGNING BONUSES AND CME

Signing bonuses were offered in 72% of the recruiting engagements Merritt Hawkins conducted in the 2020 *Review* period, up from 71% percent the previous year. Signing bonuses remain a standard recruiting incentive among hospitals and medical groups, though they may not be part of incentive packages offered by academic medical centers, direct pay/concierge, urgent care centers, some FQHCs, Indian Health and other settings.



Signing bonuses offered to physicians tracked in the 2020 *Review* averaged \$27,893, down from \$32,692 the previous year. Signing bonus amounts also are likely to be fluid in light of the coronavirus epidemic.

Signing bonuses offered to NPs and PAs as tracked in the 2020 *Review* averaged \$8,500, down from \$9,000 the previous year.

Certain other incentives, such as paid relocation, paid CME, health insurance and malpractice insurance are standard in the majority of Merritt Hawkins' physician search engagements. The average relocation allowance offered to physicians as tracked by the 2020 *Review* was \$10,533, while the average relocation allowance offered to NPs and PAs was \$7,067.

Virtually all of the incentive packages tracked by the 2020 *Review* (96%) offered a continuing medical education (CME) allowance. The average CME allowance for physicians tracked in the 2020 *Review* was \$4,166, while the average for NPs and PAs was \$2,313.

MEDICAL EDUCATION LOAN REPAYMENT

Twenty-four percent of Merritt Hawkins' 2019/20 search engagements featured medical education loan repayment, compared to 31% the previous year. Educational loan repayment entails payment by the recruiting hospital or other facility of the physician's medical school loans in exchange for a commitment to stay in the community

for a given period of time. This can be an effective incentive since average medical school debt now is in excess of \$190,000, according to the Association of American Medical Colleges (AAMC).

The average amount of loan forgiveness offered to physicians was \$101,590, virtually unchanged from the previous year. The average amount of loan forgiveness offered to NPs and PAs was \$68,333, up from \$61,250 last year. In 9% of contracts featuring educational loan forgiveness, the term was one-year, while 24% featured two-year terms and 67% featured three-year terms.

Conclusion

The 2020 coronavirus pandemic has changed the playing field in the physician recruiting arena, turning what was a buyer's market for physicians seeking practice opportunities into a seller's market for hospitals, medical groups and other healthcare facilities seeking to recruit physicians. As a result, for those healthcare facilities that are recruiting physicians or are planning to do so, conditions now are more favorable than they have been in years.

However, the longer-term dynamics of physician supply and demand remain in place and, over time, physician shortages are likely to once again emerge, driven by population aging, an aging physician workforce and other factors.

The pandemic is likely to spur demand for specialists on the front-lines of virus care, including emergency medicine physicians, pulmonologist/critical care physicians and infectious disease specialists. The need for psychiatrists, who were in short supply before the pandemic, also is likely to grow as a result of widespread behavioral health needs created by the virus.

The pivot to telehealth and the need to implement new care models that emphasize patient access and safety will affect how much physicians are paid and the way in which their contracts are structured. The pandemic also will accelerate the employed physician model and further reduce the number of smaller, independent physician practices nationwide.

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An Overview of the Salaries, Bonuses, and Other Incentives Customarily Used to Recruit Physicians, Physician Assistants and Nurse Practitioners and How These May Be Affected by the Coronavirus Pandemic