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INSIDE THIS ISSUE

PRIMARY CARE COMPENSATION UPDATE

PCPs' earnings continue edging upward, but compensation plan structures are changing substantially

By Bonnie Darves, a Seattle-area health care journalist.

Compensation for US primary care physicians continues to rise steadily, even if the increases haven't been particularly impressive. Three leading physician compensation surveys all reported compensation upticks in family medicine, internal medicine, and pediatrics over the last 18 months, with the annual increases over the previous year ranging from approximately 1% to 4%, depending on the specialty and the survey.

Here is a quick look at the compensation surveys' big-picture findings in primary care compensation:

American Medical Group Association (AMGA) 2016 Medical Group Compensation and Productivity Survey

Specialty	Median compensation
Family medicine	$234,706
Internal medicine	$249,588
Pediatrics	$235,257

Medical Group Management Association (MGMA) 2016 Physician Compensation and Production Report

Specialty	Median compensation
Family medicine (no OB)	$230,456
Internal medicine	$247,319
Pediatrics	$231,637

Sullivan, Cotter and Associates 2016 Physician Compensation Survey

Specialty	Median total cash compensation
Family medicine	$226,000
Internal medicine	$233,715
Pediatrics-general	$225,121

Primary care physicians remain in demand throughout many areas of the country, even if the year-to-year compensation changes don't reflect a high-demand environment, according to Tom Dobosenski, president of the American Medical Group Association consulting practice and the AMGA's survey lead author. "Primary care compensation is going up, but not as fast as we expected in the last few years," Mr. Dobosenski said. "We thought that given the increasing focus on primary care in coordinating overall care delivery, compensation would go up at a faster rate. But we're just not seeing that."

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That is not to suggest that need for primary care physicians (PCPs) is declining, Mr. Dobosenski pointed out. Residents leaving training can expect to find competitively compensated positions in most regions, and those willing to practice in less-desirable areas will find opportunities plentiful. As a point of reference, the Association of American Medical Colleges' latest forecast shows a persisting PCP shortage of between 14,900 and 35,600 physicians by the year 2025. Despite the AAMC's prediction and the recognition that the aging population will strain the primary care delivery system, PCP compensation likely will increase steadily but not dramatically, all sources agreed.

"I think we can expect primary care compensation to continue increasing by 3% to 4% annually over the next few years," said Kim Mobley, a managing principal with Sullivan, Cotter and Associates. "It's hard to predict beyond that because of MACRA," she added, referring to the Medicare Access and CHIP Reauthorization Act. That legislation, which moves into high gear this year, calls for increasing payments to physicians who meet government-set performance-improvement targets and penalizing those who don't.

David Gans, a senior fellow for industry affairs at the MGMA, predicts that although PCP compensation will continue to rise, demand might start leveling off as practices reconfigure their care-delivery models. "There is still a substantial need for primary care physicians, but at the same time, we're seeing practices develop more effective ways to utilize nurse practitioners and physician assistants," he said. "That's starting to reduce demand for PCPs in some markets."

Mr. Gans noted that practices are also eyeing ways to support closer collaboration between physician specialists treating chronic disease, and general internists or family physicians who focus on the elderly. As health care moves toward value-based payment structures, PCPs who are experienced or interested in such emerging care models will find opportunities plentiful, he said. Overall, primary care specialties collectively continue to garner higher compensation increases than many other specialties, Mr. Gans noted, because of their pivotal role in care-delivery innovation.

Kent Moore, senior strategist for physician payment at the American Academy of Family Physicians, concurred. "We're seeing steady growth in family physician income, because there is increasing recognition of the value of primary care," he said. Mr. Moore cited the MGMA-reported 18% cumulative compensation increase in primary care specialties over the last five survey years — compared with 11% for the physician specialties collectively — as evidence of this recognition. "The MGMA 2016 survey report showed primary care physicians' median income was more than $250,000. That's still woefully below subspecialty income, but it does show improvement," he said.

On a regional level, primary care compensation variation followed the same basic pattern it has for the last decade, sources noted. PCPs in the South, Midwest, and North Central regions are still the highest earners, followed by those in the West. PCPs in the Northeast tend to have the lowest compensation overall. In a noticeable departure, however, the AMGA survey found that pediatricians in the Northeast had the highest median compensation in the country, at $245,861, followed by $239,612 in the West.

At the upper end of the earnings spectrum, the MGMA reported that primary care physician compensation was highest in Alaska, Wisconsin, and Arkansas in 2015. Those in Nevada, Maine, and Maryland earned the least. In the Sullivan Cotter survey, PCPs in Nebraska had the highest compensation. Interestingly, the MGMA survey found PCP compensation generally higher in private practices than in hospital systems, while the AMGA reported that in family medicine and internal medicine, large groups — those with more than 300 providers, per the survey's categories — paid more than smaller groups.

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It's important to keep in mind that PCPs new to practice likely will not be compensated at the median level. Many practices, on principle, set starting compensation for new graduates substantially below the surveys' reported median levels. Ms. Mobley said that primary care physicians new to practice generally earn between the 10th and 25th percentile. The Sullivan Cotter survey reported the following 25th percentile compensation: $191,683 in family medicine, $198,751 in internal medicine, and $181,914 in pediatrics.

Signing bonuses in the realm of $15,000 are still common for new primary care graduates, sources noted, and some employers provide assistance with education loans. "We're seeing a lot of hospitals help new primary care physicians with education debt by providing access to lower-interest loans," Ms. Mobley said.

Productivity levels off

Trends in PCP productivity — how much physicians work based on the RVUs (relative value units) they generate — are showing significant shifts in recent years. With the exception of pediatrics, the surveys found that productivity, still a key component in compensation structures despite rapid movement toward quality-based methodologies, is leveling off. The AMGA survey reported flat productivity in family medicine and internal medicine last year compared to 2015, at a median of roughly 4,900 RVUs annually for both specialties. The AMGA also reported an unusual decline in pediatrics RVUs, from a 5,411 median in 2015 to 5,299 in 2016.

As with previous AMGA surveys' findings, family physician productivity in the Southern region far outpaced other regions, at a median of 6,855 RVUs, compared to 4,784 in the lowest-productivity Western region. The internal medicine regional productivity spread between those two regions was less pronounced, at 4,548 and 5,211 median RVUs (Western and Southern, respectively).

Over the past five years, the Sullivan Cotter surveys show flattening productivity in family medicine and internal medicine, with essentially no increase from 2011 to 2016 in median RVUs. The surveys report a steady productivity increase in pediatrics, from 4,971 median RVUs in 2011 to 5,309 in 2016.

The MGMA survey reported national median RVUs of 4,928 in family medicine, 4,698 in internal medicine, and 4,902 in pediatrics. Pediatrics was the only primary care specialty in which productivity measurably increased from 2015 to 2016 in that survey.

Compensation components shifting

Physician practices and employers still use RVUs to gauge PCP productivity and determine incentive compensation, but to a lesser extent than in the past. With the growing use of care quality-based and patient-experience metrics, and the pronounced trend toward direct physician employment, predominantly productivity-based compensation is declining. In primary care, more than half of groups use base salary as a mainstay in setting compensation, survey data suggested, and most use performance and quality measures to set incentive compensation.

The Sullivan Cotter survey found that for PCPs, base salary accounted for 76% (mean) of total cash compensation, and performance and patient-experience combined, 18%. In the AMGA survey, the most common incentive-compensation determinants not tied to direct productivity were patient satisfaction and clinical outcomes.

In a relatively new development, practices are incorporating patient-panel size as a component of PCP incentive payment, as an alternative to encounter or services volumes. Ms. Mobley said that she expects panel size will become an increasingly important component of compensation, as practices try to move toward population-based care models. In the Sullivan Cotter survey, 14% of practices now use panel size as a compensation component, and in the groups that measure panel size, the component accounted for 9% of total cash compensation.

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WHAT'S NEW AT NEJM GROUP?

Study on How Physicians Respond to Online Job Postings

Online job postings are a critical tactic in sourcing physicians in today's competitive talent marketplace. And while it is clear that most physician employers use this marketing tool to find qualified candidates, there is little guidance available on how to make online job postings more effective.

Online job postings are advertisements whose primary purpose is to encourage a candidate to respond to an employer's solicitation. In order to learn what attributes of an online job posting physicians are most likely to respond to, NEJM CareerCenter contracted with MedPanel to conduct a blind independent study.

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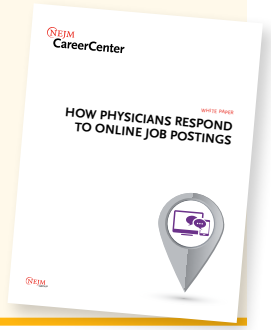

Upcoming Recruiter Meetings and Medical Conventions

American Society of Clinical Oncology (ASCO)*
June 2–6, 2017
Chicago, IL

ID Week*
October 4–8, 2017
San Diego, CA

American Society of Nephrology (ASN) Kidney Week*
November 2–4, 2017
New Orleans, LA

American Heart Association (AHA)*
November 12–14, 2017
Anaheim, CA

*Call (800) 635-6991 or email ads@nejmcareercenter.org for more details on bonus convention distribution of your paid recruitment ad in selected NEJM issues at these physician conventions.

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Simply run your paid line or display recruitment ad of any size in any of the three issues listed below, and your ad will be reprinted at no additional costs in a special booklet mailed to more over 30,000 physicians.†

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NEJM ISSUE: September 7, 2017
CLOSING DATE: August 18, 2017
AUDIENCE: CD, D, END, FM, GE, HEM/ONC, HOSP, ID, IM, NEP, N, ORS, ENT, PUD, DR, RHU, and U. Final-year residents and fellows and doctors in practice 1–3 years
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CAREER GUIDE: Residents and Fellows, October
NEJM ISSUE: October 5, 2017
CLOSING DATE: September 15, 2017
AUDIENCE: All specialties — about 100. Final-year residents and fellows
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CAREER GUIDE: Residents and Fellows, November
NEJM ISSUE: November 9, 2017
CLOSING DATE: October 20, 2017
AUDIENCE: All specialties — about 100. Final-year residents and fellows
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The AMGA 2016 survey reported a median panel size of 1,823 patients in family medicine, 1,808 in internal medicine, and 1,926 in pediatrics.

Even with the now prevalent use of performance measures in determining primary care compensation, primary care practices are struggling to figure out how to reward quality without negatively affecting productivity, Mr. Dobosenski observed. "Everyone is trying to find the magic pill in terms of compensation package structure, to align with a future reimbursement scenario that will be more about value and less about volume," he said. "In general, practices know that volume needs to be less important in primary care, and that panel size and patient access need to be more important. But they're not sure how to structure compensation to support that."

Interestingly, in a recent AAFP member survey about value-based payments, one third of respondents indicated that they "did not know where these payments were sent," Mr. Moore said, and one-third indicated that the payments "were sent to their employers, not directly to the practicing physician."