The Authority on Provider Financial Arrangement Thought Leadership

JOURNAL OF PROVIDER COMPENSATION

The Official Journal of the American Association of Provider Compensation Professionals

A Look at How Academic Medical Centers May Be Better Poised to Handle the Physician Shortage Crisis

Kevin Obletz, JD, CVA – Partner, HealthCare Appraisers & Nicole Jacobsen, JD, MBA, LLM – Director, HealthCare Appraisers

Introduction to the Physician Shortage

Healthcare, like any other industry, is subject to simple supply and demand pressures. Unlike many other industries, however, healthcare is subject to a highly regulated environment that introduces a variety of complexities that disrupt standard supply and demand principles. This disruption has matriculated into perhaps one of the most pressing issues the healthcare industry has seen in recent years: a staggering number of physician shortages.

There are numerous factors causing the physician shortage, including (i) the increasing number of physicians retiring and nearing retirement age – the number of people aged 65 or over is expected to grow by about 47% by 2032 – and (ii) the increasing likelihood of physician burnout, which was largely exacerbated by the COVID-19 Pandemic.[1] Regardless of ultimate reason, however, statistics make painstakingly clear that the present demand for healthcare services far outweighs the supply of physicians. Further, this supply-demand relationship does not appear to be set to improve any time soon. A recent study conducted by the Association of American Medical Colleges ("AAMC") predicts that the United States could see a shortage of 37,800 to 124,000 physicians by the year 2034.[2]

Academic Medical Centers ("AMCs") are perhaps feeling the effect of this current and impending physician shortage more than any other healthcare entity. Not only are AMCs competing against other hospitals and healthcare systems for the same pool of new physicians to join their medical staff, but one study has shown that up to 38% of physicians practicing in an academic setting will leave within 10 years, requiring AMCs to competitively recruit an even higher number of qualified physicians to their facilities.[3] A recent article on the topic indicates that academic physicians, often junior faculty or associate professors, tend to join other types of physician practices, in addition to leaving the practice of medicine altogether.[4] While competing for new physicians to alleviate physician shortages may seem hard enough to navigate, it is imperative that AMCs remain fully staffed with physicians who are able to satisfy the additional requirements for operating graduate medical education ("GME") programs (*e.g.,* the Common Program Requirements set forth by the Accreditation Council for Graduate Medical Education).[5] In this sense, AMCs are also under pressure to simply retain their current medical staff.

This article discusses how the current governmental regulations largely affect the physician shortage in the United States, takes a deeper look at the ongoing difficulty for AMCs in the context of these governmental regulations and other fraud and abuse laws, and seeks to provide helpful

[1] Robeznieks, Andis. (2022). To overcome doctor shortage, get rid of obstacles to primary care, https://www.ama-assn.org/practice-management/sustainability/overcome-doctor-shortage-get-rid-obstacles-primary-care, accessed on January 18, 2023.
[2] IHS Markit Ltd. *The Complexities of Physician Supply and Demand: Projections From 2019 to 2034*. Washington, DC: AAMC; 2021.
[3] Alexander, H. & Lang, J. (2008). The Long-term Retention and Attrition of U.S. Medical School Faculty. *AAMC Analysis in Brief*, 8(4), 1-2.
[4] Parikh MD, MPP, Ravi (2022). This Is Why Young Academics Are Leaving for Industry, https://www.medscape.com/viewarticle/968974?reg=1, accessed on April 3, 2023.
[5] Such Common Program Requirements can be found at https://www.acgme.org/What-We-Do/Accreditation/Common-Program-Requirements/, accessed on April 3, 2

guidance for individual AMCs in an effort to diminish the effects of the physician shortage on their programs and in their facilities. [6]

What are AMCs and How Does the Physician Shortage Impact these Organizations?

As current physicians phase out of practice, the natural response is to look towards those coming into practice as replacements. In order to become licensed and able to practice as a physician in the United States, most states require that medical school graduates complete a residency program to further develop their medical skills in a specific specialty. This additional education completed after graduation from medical school is referred to as graduate medical education (*i.e.,* GME), and includes internship, residency, and fellowship programs offered at AMCs across the country. As the Joint Commission International outlines, an AMC is "a tertiary care hospital that is organizationally and administratively integrated with a medical school."[7] As such, AMCs are the primary educational facilities for physicians-in-training to complete their GME in residency programs.

In order to fulfill these GME requirements and enter a residency program, students must enter into the National Residency Matching Program and compete for residency slots at AMCs around the country.[8] Residency program slots are funded by the Centers for Medicare & Medicaid Services ("CMS"), and the amount of funding provided by CMS directly dictates the number of residency spots available for AMC programs.[9] Such funding was largely unchanged from 1997 until recently, when it was expanded with the *Fiscal Year 2022 Inpatient Prospective Payment System* ("IPPS") final rule, which will allowed for 200 new Medicare-funded residency slots, in total, for qualifying hospitals per year, for five years. This equates to 1,000 new residency slots available beginning July 1, 2023. [10]

The number of students graduating from U.S. medical programs has increased year-over-year at a rate that continuously outpaces the number of residency slots available.[11] In 2022, 47,675 students entered the National Residency Matching Program.[12] The number of residency slots

---

[6] To be clear, this article does not intend to offer solutions to the looming physician shortage crisis as a whole, as any viable solutions will require action and successful coordination and cooperation amongst a multitude of different public and private entities. The authors do not wish to speculate on the action or inaction of any such parties.

[7] Academic Medical Center Hospital Accreditation, https://www.jointcommissioninternational.org/accreditation/accreditation-programs/academic-medical-center/, accessed on January 18, 2023.

[8] The Matching Algorithm, https://www.nrmp.org/intro-to-the-match/how-matching-algorithm-works/, accessed on January 18, 2023.

[9] Hospitals are able to fund additional residents, and a study performed by the Government Accountability Office in 2021 (*Physician Workforce Caps on Medicare-Funded Graduate Medical Education at Teaching Hospitals*, GAO-21-391 (Washington, D.C.: May 21, 2021), found that approximately 70% of hospitals trained more residents than Medicare-funded residents. However, it is important to note that many of the physician shortage areas are near rural hospitals, and rural hospitals often lack the funding for additional residents themselves. As such, this article largely focuses on Medicare-funded residency slots. GAO: 70% of teaching hospitals are self-funding residency slots, https://www.aha.org/news/headline/2021-06-22-gao-70-teaching-hospitals-are-self-funding-residency-slots, accessed on January 18, 2023.

[10] Centers for Medicare & Medicaid Services. (December 17, 2021). *CMS Funding 1,000 New Residency Slots for Hospitals Serving Rural & Underserved Communities* [Press release]. https://www.cms.gov/newsroom/press-releases/cms-funding-1000-new-residency-slots-hospitals-serving-rural-underserved-communities.

[11] According to Kaiser Family Foundation, the total number of medical school graduates in the U.S. jumped from 20,467 in 2010 to 27,325 in 2020. Total Number of Medical School Graduates, https://www.kff.org/other/state-indicator/total-medical-school-graduates, accessed on January 18, 2023.

[12] The National Resident Matching Program. (2022). *NRMP Releases the 2022 Main Residency Match Results and Data publication, the most comprehensive data resource for the Main Residency Match.* https://www.nmrp.org/about/news/2022/06/nrmp-releases-the-2022-main-residency-match-results-and-data-publication-the-most-comprehensive-data-resource-for-the-main-residency-match/. Accessed on January 18, 2023.

available for those students to begin their required GME to obtain a license and practice as a physician was only 39,205.[13] This left 8,470 medical student graduates without a residency slot in 2022. Further complicating that shortfall, the year 2021 alone saw approximately 117,000 physicians leaving the workforce. As such, the 1,000 additional slots are not enough.[14]

Is there hope for the residency slot shortage? Perhaps. In March 2021, the U.S. Senate introduced the *Resident Physician Shortage Reduction Act of 2021*, which proposed an increase to "the number of residency positions eligible for graduate medical education payments under Medicare for qualifying hospitals" (the "Reduction Act") to the tune of 75 additional residency slots per hospital during the period beginning in fiscal year 2023 through 2029.[15] Another U.S. Senate introduction, the *Training Psychiatrists for the Future Act* (the "Future Act"), proposes to expand the psychiatry GME program by 400 slots.[16] Neither the Reduction Act nor the Future Act has yet to gain traction.

While the introductions of these bills are promising to alleviate a portion of the shortage, it does not appear that the physician shortage is going to abate any time soon. Additionally, competition to employ existing and incoming physicians is becoming more aggressive, albeit subject to various fraud and abuse laws that require fair market value ("FMV") compensation, such as the Stark Law and federal Anti-Kickback Statute. With this understanding and context, the questions become relatively straightforward: "How do AMCs retain both (i) their residents – residents the AMCs have just trained for three-plus years – as physician staff and (ii) their current physician teaching staff overseeing resident training?"

What AMCs can do to be Competitive

Resident Physicians

AMCs are in the unique position to offer residents their first glimpse at life beyond residency, and first impressions created through a positive work environment may entice residents to seek employment with their employing AMC post-residency. In the context of the medical setting, a positive work environment may be narrowed down to two things: the provision of high-quality patient care and an outstanding residency experience. The provision of quality patient care could, and should, be a recruitment and retention strategy for AMCs, especially for residents who appreciate the value of both quality patient service and AMC reputation. Similar to quality of care, an AMC that provides its residents with the best resident experience will likely be better positioned to retain that physician post-residency. Prioritizing an appropriate work/life balance, recognizing the potential for physician burnout and taking steps to prevent it, and providing interaction with high-quality instructors (who would in turn become the residents' colleagues post-residency) are all ways to provide an unbeatable experience and secure post-residency employment.

Although non-monetary considerations are persuasive, AMCs should, naturally, still seek to offer residents competitive pay packages with robust benefits…of course within the bounds of regulatory permissibility. Additionally, opportunities to earn compensation in excess of standard resident salaries, such as permitting, and even encouraging, "moonlighting," or clinical shifts or services outside of the scope of their full-time resident responsibilities, may be attractive to

[13] *Id.*

[14] Gamble, Molly. (2022). Healthcare workforce lost 333,942 providers in 2021. *Becker's Hospital Review.* https://www.beckershospitalreview.com/workforce/healthcare-workforce-lost-333-942-providers-in-2021.html, accessed on January 18, 2023.

[15] S.834 - 117th Congress (2021-2022): Resident Physician Shortage Reduction Act of 2021. (2021, March 18). https://www.congress.gov/bill/117th-congress/senate-bill/834

[16] S.5041 - 117th Congress (2021-2022): Training Psychiatrists for the Future Act. (2022, September 29). https://www.congress.gov/bill/117th-congress/senate-bill/5041

residents seeking to maximize their income. Depending upon the particular facts and circumstances, the FMV compensation for any such moonlighting activities may well exceed the compensation earned by a resident for their underlying employment responsibilities.

Academic Physicians

Academic physicians are involved in a variety of activities that are not necessarily directly profitable for their employers; namely, didactic teaching, research, and direct supervision of residents. It is imperative for AMCs to recognize the value in remaining competitive employers in the marketplace, and to therefore design compensation plans that do not "penalize" physicians for any unprofitable aspects of their job responsibilities. Implementing compensation plans that most closely align with those of W-2 non-academic physicians, which would allow for certain upside potential, can help in this regard.

As an illustrative example, assume a physician is employed by an AMC and required to devote part of their full-time effort to non-clinical/didactic instruction of residents, in addition to their clinical duties. In this scenario, a compensation plan that provides for a fixed annual payment for the non-clinical/didactic time and variable compensation for the provision of clinical services could maximize an academic physician's earning potential. This becomes especially true when the variable compensation for clinical services includes considerations for when clinical duties are performed with and without residents, thereby accounting for any potential decrease in productivity as a result of resident supervision. In such case, a "normalizing" adjustment might be made to productivity metrics, such as work relative value units (*e.g.,* compare the physician's productivity with and without resident supervision to determine if any noticeable shortfall, and applying some sort of "drag factor" to account for the lag caused by resident supervision). In addition, AMCs should take advantage of site of service allowances, such as CMS's "primary care exception," which allows a supervising physician to bill for (or otherwise be fully credited for providing) certain activities even when not in the presence of the residents.[17] It should be noted that credit to the physician should not be duplicative (*i.e.*, not accounting for both a "drag factor" and credit under the primary care exception simultaneously).

There is no one-size-fits-all approach to compensating academic physicians and each program should take special care to ensure their compensation packages are structured to optimize physician compensation while also remaining commercially reasonable and consistent with FMV. Designing a competitive compensation platform for Physicians practicing in Academia to align with the unique AMC services has a two-fold effect: it can help retain and maintain satisfied physicians, which may likely trickle down to the resident physician experience.

Early Employment Offers with Early Signing Bonuses

Assuming that AMCs are successful at providing a positive work experience for both physician residents and teachers, AMCs can turn their attention to early recruiting. One advantage that AMCs have over other non-academic facilities is that resident physicians are already on staff at the AMC facility, allowing AMCs to recruit these residents before other facilities have direct access to such recruits. AMCs should take full advantage of this early access to candidates, especially when trying to secure in-demand specialties.

In securing a resident early in a residency program, the AMC may be able to offer resident physicians sign-on bonus packages that could be paid during the residency period, in exchange

[17] Centers for Medicare & Medicaid Services & Medicare Learning Network. (2017). *Guidelines for Teaching Physicians, Interns, and Residents*. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Guidelines-Teaching-Physicians-Text-Only.pdf, accessed on January 18, 2023.

for a commitment to employment for a set number of years after the residency program is complete. Any such upfront bonus compensation would need to be (i) subject to claw-back provisions for resident physicians who ultimately do not enter into employment, and (ii) commercially reasonable and consistent with FMV on a prospective basis when taken into account with the prospective compensation terms of the employment agreement.[18]

Conclusion

There is no simple solution to the ongoing physician shortage. Although legislation is underway to expand residency slots, that alone is not likely to be a total solution. However, as this article has demonstrated, AMCs may be able to grab a larger share of the diminishing physician pool by ensuring a pleasant residency experience, providing access to qualified and satisfied academic physician teachers, and offering creative and competitive compensation structures for both resident and medical staff physicians. Implementing these tactics, AMCs should be able to distinguish themselves in the competitive market.

Kevin Obletz, JD, CVA is a Partner at HealthCare Appraisers and Nicole Jacobsen, JD, MBA, LLM is a Director at HealthCare Appraisers.

[18] Dependent on the compensation structure chosen as well as the length of time between the payment of any bonus and the amortization period, it is important to note that the IRS has issued a memorandum stating that there is a three-year limitation on revising W-2 compensation. U.S. Department of the Treasury. Internal Revenue Service. (2013). *Assessment Period of Limitations for assessable Penalties under I.R.C. §§6721 & 6722*. https://www.irs.gov/pub/lanoa/pmta_2013-04.pdf

COPYRIGHT AND DISCLAIMER

This document, created by the American Association of Provider Compensation Professionals (the "AAPCP"), is protected under the U.S. copyright laws and the copyright laws of foreign countries under the Universal Copyright Convention and the Berne Convention. No part of this document, created by the AAPCP, may be reproduced or transmitted in any form or by any means, electronic or mechanical, including photocopying or recording, or by any information storage or retrieval system, without the express written permission of the AAPCP. Unauthorized uses and reproductions of this document, created by the AAPCP, will subject such unauthorized user to civil and criminal penalties as provided by the United States Copyright Laws.

The Journal of Provider Compensation contains discussion of various compensation and contracting concepts (the "Content"). All included information shall be permitted for use by AAPCP members in the course of a member's business. All instances of Content provided in the Content used in the course of member's regular business must reference the AAPCP as the source of such Content. At no time may a member publish any portion of this information in a public forum to others who are also not members of the AAPCP or provide this Content to any person or public list of which others on the receiving end are not members of the AAPCP.

The Content and underlying information is provided "AS IS" and the AAPCP disclaims all liability of any kind. The AAPCP may make changes to the Content at any time. The AAPCP assumes no responsibility of any kind, oral or written, express or implied, including but not limited to fitness for a particular purpose, accuracy, omissions, and completeness of the information. The AAPCP does not represent or warrant that the Content will be correct, accurate, timely, or otherwise reliable. The AAPCP shall in no event whatsoever be liable to a member or any other party for any indirect, special, consequential, incidental, or similar damages, including damages for lost data or economic loss, even if AAPCP has been notified of the possibility of such loss. This paragraph shall survive the termination of this Agreement and in no event will the liability of the AAPCP exceed the total amount paid by the Licensee under this Agreement or, if none, then the amount of one hundred dollars. If there is any dissatisfaction with the Content, the AAPCP member's sole remedy is to terminate this Agreement. This paragraph shall be enforceable to the maximum extent permitted by law.

This Content contains a general discussion of current issues and developments regarding provider compensation. The information provided does not and is not intended to constitute legal, accounting, or personal advice to any organization; instead, all information and content in this article are for general informational purposes only. Further, no organization should rely on the information within this as guidance for their organization because each organization's facts and circumstances may be separate and distinct. Finally, the Content focuses solely on the topics outlined in the Content itself.