2017 REVIEW

OF PHYSICIAN AND ADVANCED PRACTITIONER RECRUITING INCENTIVES

24TH EDITION
1994-2017

An Overview of the Salaries, Bonuses, and Other Incentives Customarily Used to Recruit Physicians, Physician Assistants and Nurse Practitioners

MERRITT HAWKINS
an AMN Healthcare company

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For additional information about this survey, please contact:

Phillip Miller
(800) 876-0500
phil.miller@amnhealthcare.com
MerrittHawkins.com

Merritt Hawkins / Corporate
8840 Cypress Waters Blvd. #300
Dallas, Texas 75019
(800) 876-0500

Merritt Hawkins / Eastern Regional Office
100 Mansell Ct, E, Ste 500
Roswell, GA 30076
(800) 306-1330

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 practitioners. Now celebrating our 30th 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' **24th annual Review** of the search and consulting assignments 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. 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 and white papers 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**, **American Academy of Surgical Administrators**, **Association of Managers of Gynecology and Obstetrics** and **Subcommittees of the Congress of the United States**.

The 2017 Review is based on the 3,287 permanent physician and advanced practitioner search assignments that Merritt Hawkins' and AMN Healthcare's sister physician staffing companies (Kendall & Davis and Staff Care) had ongoing or were engaged to conduct during the 12-month period from April 1, 2016, to March 31, 2017.

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 formal contracts or incentive packages used by hospitals, medical groups and other facilities in real-world recruiting assignments. Unlike other physician compensation surveys, *Merritt Hawkins' Review of Physician and Advanced Practitioner Recruiting Incentives* tracks physician starting salaries and other perquisites, rather than total annual physician compensation. It therefore reflects the incentives physicians are *offered* to attract them to a new practice settings rather than what physicians in general may actually earn.

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 assignments and provides an indication of which medical specialties are currently in the greatest demand and the types of medical settings into which physicians are being recruited.

Following are several key findings of the Review.

Key Findings

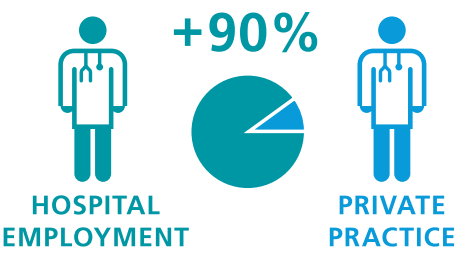
Merritt Hawkins' 2017 Review of Physician and Advanced Practitioner Recruiting Incentives reveals a number of trends within the physician and advanced practitioner recruiting market, including:

- **For the eleventh consecutive year, family physicians topped the list of Merritt Hawkins' 20 most requested recruiting assignments, underscoring the continued urgent demand for primary care physicians in an evolving healthcare system.**
- Combined, advanced practitioners, including physician assistants (PAs) and nurse practitioners (NPs), were third on the list of Merritt Hawkins' most requested recruiting assignments, their highest position ever and up from number five last year.
- Urgent care physicians moved to 12th on the list of Merritt Hawkins' most requested searches, up from 20 two years ago, highlighting growing consumer demand for "convenient care" services.

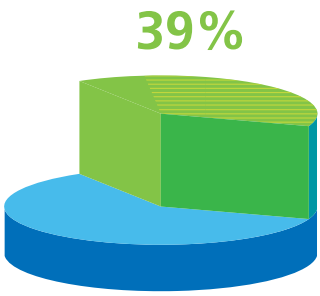
- **For only the second time in the 24 years Merritt Hawkins has conducted the Review, psychiatrists were second on the list of our most requested recruiting assignments, reflecting a severe shortage of mental health professionals nationwide.**
- Among medical specialists, pulmonologists are in particularly strong demand, due to the continued prevalence of chronic obstructive pulmonary disorder (COPD), the third leading cause of death in the United States.

- **Radiologists, absent from Merritt Hawkins' list of top 20 search assignments for several years prior to 2016, entered the top ten for the first time since 2007, signaling an increase in diagnostic imaging procedures, a more limited candidate pool, and the proliferation of teleradiology services.**

- Orthopedic surgeons, neurologists, dermatologists, gastroenterologists, cardiologists and other specialists also remain in steady demand, underscoring the growing need for medical specialists caused by an aging population.
- Anesthesiology, absent from Merritt Hawkins' top 20 search assignments since 2010, returned in 2017, suggesting an increase in procedures requiring anesthesia and a more limited candidate pool.



- **Over 90 percent of Merritt Hawkins' searches feature employment of the physician, rather than the private practice model. Physician employment is seen as necessary to implementation of value-based, capitated systems and to attracting today's physician candidates.**



- **The use of value/quality-based payment incentives for physicians rose. Thirty-nine percent of physician production bonuses tracked in the 2017 Review featured a value/quality-based component, up from 32% in 2016.**
- Despite the rise in value/quality based incentives, volume-based incentives, particularly Relative Value Units (RVUs), continue to be the most frequently utilized physician productivity metric. The 2017 Review indicates that value-based incentives only account for about four percent of overall physician compensation.
- 55% of Merritt Hawkins' recruiting assignments tracked in the 2017 occurred in communities of 100,000 or more, indicating that demand for physicians is not confined to traditionally underserved rural areas.

Following is a breakout of the characteristics and metrics of Merritt Hawkins' 2016/17 recruiting assignments.

Merritt Hawkins' 2017 Review of Physician and Advanced Practitioner Recruiting Incentives:

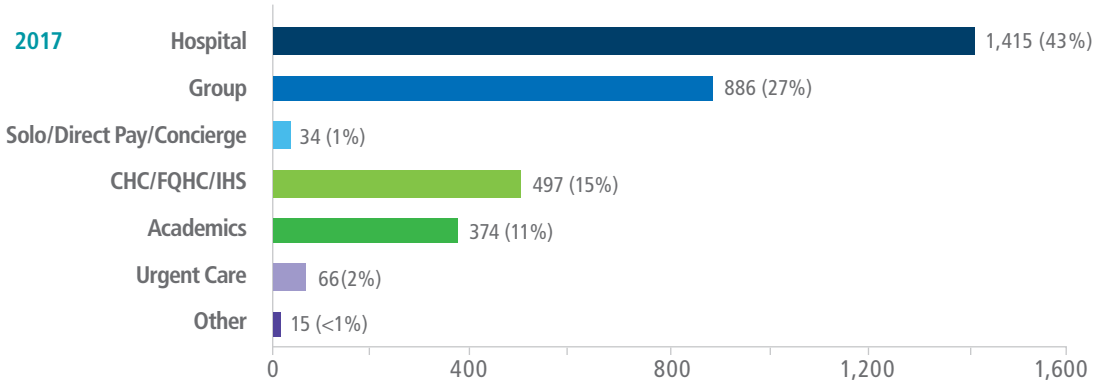
Recruiting Assignment Characteristics and Metrics

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

1 Total Number of Physician/Advanced Practitioner Search Assignments Represented

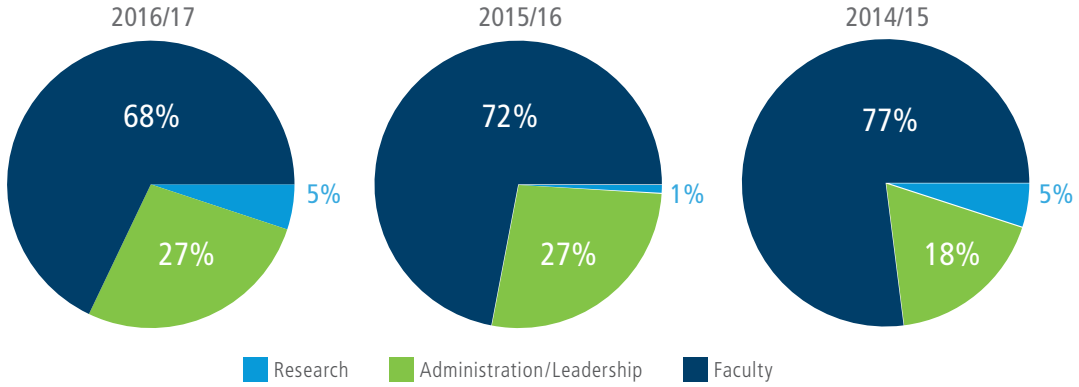
The Review is based on the 3,287 permanent physician and advanced practitioner search assignments Merritt Hawkins/AMN Healthcare's physician staffing companies had ongoing or were engaged to conduct during the 12 month period from April 1, 2016 to March 31, 2017.

2 Medical Settings of Physician Search Assignments



	2016/17	2015/16	2014/15	2013/14	2012/13
Hospital	1,415 (43%)	1,639 (49%)	1,596 (51%)	2,006 (64%)	1,975 (64%)
Group	886 (27%)	628 (19%)	625 (20%)	401 (13%)	493 (16%)
Solo/Direct Pay Concierge	34 (1%)	181 (5%)	125 (4%)	17 (<1%)	29 (1%)
CHC/FQHC/IHS	497 (15%)	434 (13%)	406 (13%)	378 (12%)	305 (10%)
Academics	374 (11%)	367 (11%)	252 (8%)	188 (6%)	153 (5%)
Urgent Care	66 (2%)	80 (2%)	33 (1%)	N/A	N/A
Other	15 (<1%)	13 (1%)	59 (2%)	30 (1%)	20 (1%)

If Academics, what type of position? *(Of 374 Academic positions)*

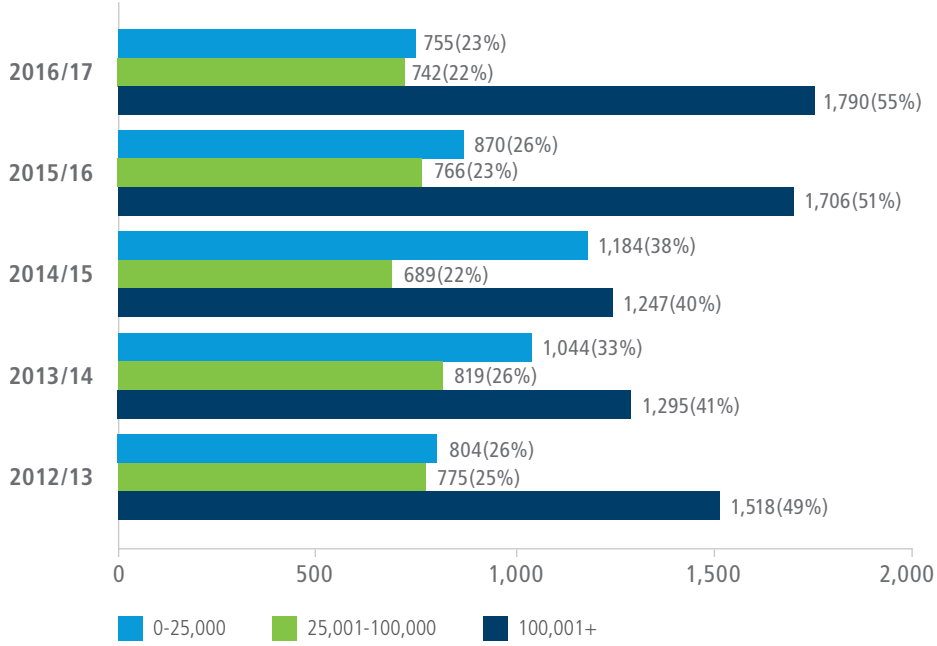


3 States Where Search Assignments Were Conducted

(Searches also conducted in the District of Columbia and Canada.)

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

4 Number of Searches by Community Size



5 Top 20 Most Requested Searches by Medical Specialty

	2016/17	2015/16	2014/15	2013/14	2012/13
Family Medicine (includes FP/OB)	607	627	734	714	624
Psychiatry	256	250	230	206	168
Internal Medicine	193	233	237	235	194
Nurse Practitioner	137	150	143	128	69
OB/GYN	109	112	112	70	77
Hospitalist	94	228	176	231	178
Emergency Medicine	90	70	80	89	111
Physician Assistant	87	66	63	61	50
Dermatology	83	71	44	30	22
Radiology	80	40	24	22	35
Pediatrics	76	76	71	92	87
Urgent Care	74	80	33	16	16
Gastroenterology	66	58	43	54	37
Pulmonology	62	46	38	18	24
Cardiology	62	33	36	32	38
Orthopedic Surgery	61	81	106	58	57
Neurology	61	101	60	61	71
General Surgery	44	58	63	58	74
Anesthesiology	43	28	16	14	10
Otolaryngology	42	44	52	32	40

6 Other Specialty Recruitment Assignments

Addiction Medicine
Addiction Psychiatry
Adolescent Medicine
Adult Medicine
Adult Reconstructive Orthopedic Surgery (Total Joint)
Advanced Practice Midwife
Allergy & Immunology
Ambulatory Care
Anatomic Pathology & Clinical Pathology
Audiologist
Bariatric Surgery
Breast Surgery
Cardiac Anesthesiology
Cardiothoracic Surgery
Certified Registered Nurse Anesthetist
Clinical Genetics
Clinical Social Worker
Colon & Rectal Surgery
Cornea and Refractive Ophthalmology
Corneal and Contact Management
Critical Care-Intensivist Medicine
Dentistry
Dermatopathology
Developmental/Behavioral Pediatrics
Electrophysiology
Endocrinology
Facial Plastic Surgery
Female Pelvic Medicine and Reconstructive Surgery
Foot and Ankle Surgery
Geriatric Medicine
Geriatric Psychiatry
Gynecologic Oncology
Hand Surgery
Head and Neck Otolaryngology
Headache & Neuropathic Pain
Hematology
Hepatology
Hospice and Palliative Medicine
Infectious Disease
Laborist
Mammographer
Maternal & Fetal Medicine
Medical Genetics
Medical Oncology
Medical Toxicology
MOHS-Micrographic Surgery
Musculoskeletal Radiology
Neonatology
Nephrology
Neuro-Interventional Radiology
Neurological Surgery
Neuromuscular Medicine
Neuromusculoskeletal Medicine & OMM
Nocturnist
Nurse Manager
Occupational Medicine
Occupational Vision
Oculoplastic Ophthalmology
Oncology
Ophthalmology
Ophthalmology, Glaucoma
Optometry
Optometric Technician
Oral & Maxillofacial Surgery
Orthopedic Spine Surgery
Orthopedic Trauma Surgery
Pain Management
Pain Medicine
Pathology
Pediatric Cardiology
Pediatric Critical Care Medicine
Pediatric Emergency Medicine
Pediatric Endocrinology
Pediatric Hematology-Oncology
Pediatric Intensivist
Pediatric Neurology
Pediatric Orthopedic Surgery
Pediatric Otolaryngology
Pediatric Pulmonology
Pediatric Radiology
Pediatric Rheumatology
Pediatric Surgery
Pediatric Urology
Pharmacy
Physical Medicine & Rehabilitation
Plastic and Reconstructive Surgery
Preventive Medicine
Psychologist
Radiation Oncology
Reproductive Endocrinology
Retina Surgery
Rheumatology
Sleep Medicine
Social Worker
Sports Medicine
Surgical Critical Care (Trauma Surgery)
Surgical Oncology
Teleradiology
Thoracic Surgery
Undersea and Hyperbaric Medicine
Urology
Vascular & Interventional Radiology
Vascular Neurology (Stroke)
Vascular Surgery
Vision Therapy

7 Administrative, Academic and Executive Titles Include:

- Administrative Director
- Assistant Dean
- Associate Dean for Educational Affairs
- Associate Professor
- Associate Vice President, Physician Advisors
- Business Manager
- Chair, Clinical Sciences and Medical Education
- Chair, Department of Anesthesiology
- Chair, Department of Dermatology
- Chair, Department of Medical Education
- Chair, Department of Ophthalmology & Visual Sciences
- Chair, Pediatric Anesthesia
- Chair of Surgery
- Chief Executive Officer
- Chief Financial Officer
- Chief Medical Officer
- Chief of Adolescent Medicine
- Chief of Anatomic Pathology
- Chief of Breast Pathology
- Chief of Cardiothoracic Surgery
- Chief of Cardiovascular Medicine
- Chief of Cell Biology
- Chief of Cytopathology
- Chief of Dermatology
- Chief of Gastroenterology
- Chief of Hematology and Oncology
- Chief of Pediatric Cardiology
- Chief of Pediatric Critical Care Medicine
- Chief of Pediatric Endocrinology
- Chief of Pediatric Genetics
- Chief of Plastic Surgery
- Chief of Regional Pain Anesthesia
- Chief of Service Line
- Chief of Trauma Surgery
- Chief Operating Officer
- Clerkship Director, Family Medicine
- Clerkship Director, Internal Medicine
- Clinical Instructor
- Dean, College of Medicine
- Director, Blood and Cancer Institute
- Director/Chief of Heart Failure
- Director of Nursing
- Director of Pediatric Echo
- Executive Vice President of Clinical Quality
- Facilities Director
- Full Professor
- Medical Director
- Medical Director of Air Care Program
- Medical Director of Physical Medicine and Rehabilitation
- Medical Director of Student Health
- Office Manager
- Pediatric Residency Program Director
- Practice Manager
- Program Director/Family Medicine and Internal Medicine
- Residency Program Director
- Senior Medical Director
- Service Line Director
- System Wide Director of Infection Prevention
- Vice Chair, College of Medicine
- Vice Chair, Medicine
- Vice Chair, Pathology
- Vice Dean of Clinical Affairs
- Vice President, Medical Outcomes

8 Income Offered to Top 20 Recruited Specialties

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

Family Medicine	Low	Average	High
2016/17	$110,000	$231,000	$400,000
2015/16	$135,000	$225,000	$340,000
2014/15	$112,000	$198,000	$330,000
2013/14	$140,000	$199,000	$293,000
2012/13	$130,000	$185,000	$437,000

Internal Medicine	Low	Average	High
2016/17	$170,000	$257,000	$600,000
2015/16	$195,000	$237,000	$320,000
2014/15	$100,000	$207,000	$260,000
2013/14	$145,000	$198,000	$360,000
2012/13	$130,000	$208,000	$325,000

Psychiatry	Low	Average	High
2016/17	$120,000	$263,000	$450,000
2015/16	$195,000	$250,000	$370,000
2014/15	$172,000	$226,000	$325,000
2013/14	$150,000	$217,000	$350,000
2012/13	$165,000	$218,000	$300,000

Nurse Practitioner	Low	Average	High
2016/17	$85,000	$123,000	$181,000
2015/16	$92,000	$117,000	$197,000
2014/15	$78,000	$107,000	$129,000
2013/14	$70,000	$106,000	$150,000
2012/13	$75,000	$105,000	$150,000

OB/GYN	Low	Average	High
2016/17	$175,000	$335,000	$700,000
2015/16	$210,000	$321,000	$500,000
2014/15	$140,000	$276,000	$450,000
2013/14	$215,000	$288,000	$380,000
2012/13	$225,000	$286,000	$350,000

Dermatology	Low	Average	High
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
2013/14	$300,000	$394,000	$500,000
2012/13	$235,000	$371,000	$425,000

Hospitalist	Low	Average	High
2016/17	$200,000	$264,000	$400,000
2015/16	$180,000	$249,000	$390,000
2014/15	$170,000	$232,000	$300,000
2013/14	$145,000	$229,000	$350,000
2012/13	$150,000	$227,000	$350,000

Radiology	Low	Average	High
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
2013/14	$225,000	$323,000	$500,000
2012/13	$250,000	$323,000	$500,000

Emergency Medicine	Low	Average	High
2016/17	$250,000	$349,000	$450,000
2015/16	$250,000	$304,000	$425,000
2014/15	$300,000	$345,000	$434,000
2013/14	$220,000	$311,000	$400,000
2012/13	$210,000	$288,000	$450,000

Pediatrics	Low	Average	High
2016/17	$170,000	$240,000	$400,000
2015/16	$165,000	$224,000	$308,000
2014/15	$100,000	$195,000	$275,000
2013/14	$130,000	$188,000	$240,000
2012/13	$145,000	$179,000	$300,000

Physician Assistant	Low	Average	High
2016/17	$80,000	$120,000	$150,000
2015/16	$92,000	$114,000	$180,000
2014/15	$80,000	$107,000	$145,000
2013/14	$71,000	$105,000	$150,000
2012/13	$85,000	$118,000	$160,000

Urgent Care	Low	Average	High
2016/17	$140,000	$219,000	$300,000
2015/16	$195,000	$221,000	$275,000
2014/15	$175,000	$210,000	$254,000
2013/14	$190,000	$204,000	$218,000
2012/13	$185,000	$203,000	$225,000

Gastroenterology	Low	Average	High
2016/17	$300,000	$492,000	$800,000
2015/16	$300,000	$458,000	$600,000
2014/15	$275,000	$455,000	$600,000
2013/14	$240,000	$454,000	$560,000
2012/13	$291,000	$441,000	$600,000

Orthopedic Surgery	Low	Average	High
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
2013/14	$350,000	$488,000	$700,000
2012/13	$275,000	$465,000	$750,000

Pulmonology/ Critical Care	Low	Average	High
2016/17	$225,000	$390,000	$530,000
2015/16	$275,000	$380,000	$500,000
2014/15	$260,000	$331,000	$386,000
2013/14	$230,000	$358,000	$425,000
2012/13	$225,000	$351,000	$500,000

Neurology	Low	Average	High
2016/17	$220,000	$305,000	$400,000
2015/16	$220,000	$285,000	$500,000
2014/15	$180,000	$277,000	$350,000
2013/14	$180,000	$262,000	$400,000
2012/13	$180,000	$300,000	$400,000

Cardiology (non-invasive)	Low	Average	High
2016/17	$300,000	$428,000	$500,000
2015/16	$250,000	$493,000	$700,000
2014/15	$200,000	$279,000	$400,000
2013/14	$400,000	$442,000	$500,000
2012/13	$250,000	$447,000	$550,000

General Surgery	Low	Average	High
2016/17	$300,000	$411,000	$710,000
2015/16	$275,000	$378,000	$500,000
2014/15	$160,000	$339,000	$415,000
2013/14	$270,000	$354,000	$515,000
2012/13	$240,000	$336,000	$550,000

Cardiology (invasive)	Low	Average	High
2016/17	$350,000	$563,000	$700,000
2015/16	$475,000	$545,000	$700,000
2014/15	$450,000	$525,000	$650,000
2013/14	$350,000	$454,000	$550,000
2012/13	$300,000	$461,000	$675,000

Anesthesiology	Low	Average	High
2016/17	$249,000	$376,000	$520,000
2015/16	$360,000	$397,000	$450,000
2014/15	$270,000	$361,000	$400,000
2013/14	$350,000	$383,000	$475,000
2012/13	$345,000	$380,000	$460,000

Otolaryngology	Low	Average	High
2016/17	$200,000	$468,000	$1,000,000
2015/16	$305,000	$403,000	$700,000
2014/15	$150,000	$334,000	$450,000
2013/14	$250,000	$372,000	$500,000
2012/13	$300,000	$404,000	$700,000

9 Average Salaries for Top Five Most Requested Specialties by Region

	Northeast	Midwest/Great Plains	Southeast	Southwest	West
Family Practice	$208,000	$236,000	$224,000	$242,000	$226,000
Psychiatry	$241,000	$257,000	$273,000	$268,000	$270,000
Internal Medicine	$213,000	$260,000	$251,000	$295,000	$256,000
Nurse Practitioner	$120,000	$128,000	$115,000	$124,000	$124,000
OB/GYN	$335,000	$352,000	$340,000	$370,000	$300,000

10 Average Salaries for Top Five Most Recruited Specialties by Setting

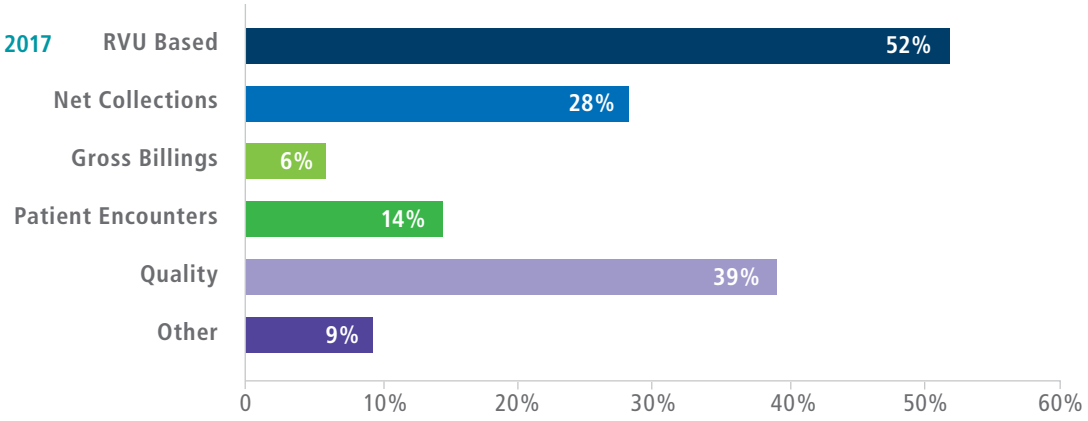
	Academics	Community Health Center	Group	Hospital	Solo
Family Practice	$204,000	$213,000	$222,000	$232,000	$245,000
Psychiatry	$230,000	$240,000	$263,000	$280,000	N/A
Internal Medicine	$225,000	$224,000	$225,000	$257,000	$243,000
Nurse Practitioner	$106,000	$119,000	$109,000	$125,000	N/A
OB/GYN	$371,000	$322,000	$329,000	$363,000	$288,000

11 Type of Incentive Offered

	Salary	Salary with Bonus	Income Guarantee	Other
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%)
2013/14	633 (20%)	2,335 (74%)	127 (4%)	63 (2%)
2012/13	525 (17%)	2,323 (75%)	217 (7%)	32 (1%)

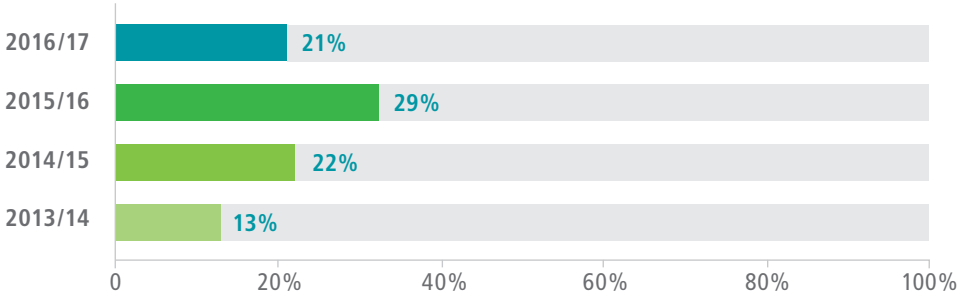
12 If Salary Plus Production Bonus, on Which Types of Metrics Was the Bonus Based?

(of 2,359 searches offering salary plus bonus, multiple responses possible)



	RVU Based	Net Collections	Gross Billings	Patient Encounters	Quality	Other
2016/17	52%	28%	6%	14%	39%	9%
2015/16	58%	22%	2%	8%	32%	8%
2014/15	57%	23%	2%	9%	23%	4%
2013/14	59%	21%	5%	11%	24%	9%
2012/13	57%	25%	3%	6%	39%	9%

13 If quality factors were included in the production bonus, about what percent of the physician's bonus determined by quality? *(of 922 searches featuring quality metrics as part of the bonus)*



14 Searches Offering Relocation Allowance

	2016/17	2015/16	2014/15	2013/14	2012/13
Yes	3,132 (96%)	3,173 (95%)	2,623 (84%)	2,845 (90%)	2,821 (91%)
No	155 (4%)	169 (5%)	497 (16%)	313 (10%)	276 (9%)

15 Amount of Relocation Allowance
(Physicians only)

	Low	Average	High
2016/17	$2,500	$10,072	$44,000
2015/16	$2,500	$10,226	$30,000
2014/15	$2,000	$10,292	$50,000
2013/14	$1,000	$9,849	$25,000
2012/13	$1,000	$9,555	$25,000

16 Amount of Relocation Allowance
(NPs and PAs only)

	Low	Average	High
2016/17	$2,500	$8,063	$25,000
2015/16	$2,500	$8,649	$25,000
2014/15	$2,500	$9,436	$35,000
2013/14	$3,500	$6,904	$10,000

17 Searches Offering Signing Bonus

	2016/17	2015/16	2014/15	2013/14	2012/13
Yes	2,501 (76%)	2,576 (77%)	2,280 (73%)	2,212 (70%)	2,199 (71%)
No	786 (24%)	766 (23%)	840 (27%)	946 (30%)	898 (29%)

18 Amount of Signing Bonus Offered
(Physicians only)

	Low	Average	High
2016/17	$2,500	$32,636	$275,000
2015/16	$1,000	$26,889	$350,000
2014/15	$2,500	$26,365	$275,000
2013/14	$1,000	$21,773	$150,000
2012/13	$1,500	$22,069	$200,000

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

	Low	Average	High
2016/17	$2,500	$8,576	$25,000
2015/16	$2,500	$10,340	$40,000
2014/15	$2,500	$8,791	$20,000
2013/14	$1,000	$7,786	$20,000

20 Searches Offering to Pay Continuing Medical Education (CME)

	2016/17	2015/16	2014/15	2013/14	2012/13
Yes	3,116 (95%)	3,243 (97%)	2,966 (95%)	2,875 (91%)	2,789 (90%)
No	171 (5%)	99 (3%)	154 (5%)	283 (9%)	308 (10%)

21 Amount of CME Allowance Pay Offered
(Physicians only)

	Low	Average	High
2016/17	$500	$3,613	$30,000
2015/16	$100	$3,633	$35,000
2014/15	$500	$3,649	$35,000
2013/14	$1,000	$3,515	$54,000
2012/13	$1,000	$3,444	$50,000

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

	Low	Average	High
2016/17	$400	$2,126	$5,000
2015/16	$400	$2,140	$3,950
2014/15	$1,000	$2,241	$5,000
2013/14	$1,000	$2,450	$5,000

23 Searches Offering to Pay Additional Benefits

	2016/17	2015/16	2014/15	2013/14	2012/13
Health Insurance	98%	98%	99%	97%	94%
Malpractice	98%	99%	99%	99%	96%
Retirement	95%	96%	96%	94%	87%
Disability	91%	97%	92%	86%	83%
Educational Forgiveness	25%	26%	25%	26%	22%
Housing Allowance	N/A	N/A	5%	4%	6%
Other	<1%	<1%	<1%	<1%	2%

24 If Educational Loan Forgiveness was Offered, What Was the Term?
(of 823 searches offering educational loan forgiveness)

	2016/17	2015/16	2014/15	2013/14	2012/13
One Year	40 (5%)	45 (5%)	61 (8%)	90 (11%)	48 (7%)
Two Years	191 (23%)	155 (18%)	104 (13%)	173 (21%)	183 (27%)
Three Years	592 (72%)	671 (77%)	619 (79%)	557 (68%)	449 (66%)

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

	Low	Average	High
2016/17	$10,000	$80,923	$260,000
2015/16	$10,000	$88,068	$300,000
2014/15	$2,500	$89,479	$250,000
2013/14	$4,000	$77,000	$336,000
2012/13	$1,000	$71,733	$210,000

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

	Low	Average	High
2016/17	$35,000	$56,442	$100,000
2015/16	$30,000	$61,667	$100,000
2014/15	$30,000	$54,286	$100,000
2013/14	$20,000	$40,000	$60,000

Trends and Observations

Merritt Hawkins' annual Review of Physician and Advanced Practitioner Recruiting Incentives, now in its 24th year, tracks three key physician recruiting trends, as well as various advanced practitioner recruiting trends.

1. Based on the physician recruiting assignments Merritt Hawkins is contracted to conduct, the 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

Merritt Hawkins' *2017 Review of Physician and Advanced Practitioner Recruiting Incentives* examines the permanent physician and advanced practitioner recruiting assignments Merritt Hawkins' and AMN Healthcare's physician staffing divisions had ongoing or were engaged to conduct during the 12 month period from April 1, 2016 to March 31, 2017.

These search assignments reflect the types of physicians and advanced practitioners that hospitals, medical groups, Federally Qualified Health Centers (FQHCs), academic medical centers, government entities, and other organizations are seeking nationwide. They also reflect which types of physicians may be particularly difficult to recruit, necessitating the assistance and additional resources of a physician recruiting firm.

Physician and advanced practitioner recruiting takes place in the context of the nation's vast, complex and evolving healthcare system, on which Americans now spend over $3 trillion a year, or more than the entire economies of all but six countries. The healthcare system has been in a virtually unparalleled state of evolution in recent years and reached an even more tumultuous state in the months prior to completion of this Review.

THE YEAR OF LIVING UNCERTAINLY

Since Merritt Hawkins completed its last Review in 2016, the direction of the U.S. healthcare system has hung in the balance. The outcome of the 2016 presidential election appeared to precipitate the repeal and replacement of the Affordable Care Act (ACA).

However, the Republican-sponsored American Health Care Act (AHCA) now sits with the Senate, and as of the publication of this Review the ACA remains intact and continues to provide insurance coverage for some 20 million people. Whether this will continue to be the case remains in doubt, and where the healthcare system is concerned, 2017 may be characterized as the "year of living uncertainly."

Not knowing the ultimate direction the healthcare system will take – whether it will continue under the current dynamic, adopt a more free-market approach, or follow some other course – may impact the strategic decision making of various stakeholders, including hospital systems, medical groups, third party payers, and others.

It is highly probable, however, that the day-to-day process of patient care will continue on its current trajectory and that a variety of ongoing trends that have been reshaping healthcare delivery will continue to gain momentum.

SURFACE VOLATILITY VS. UNDERLYING TRENDS

Like a reef beneath cresting waves, the fundamental dynamics driving changes in the healthcare industry are unlikely to shift despite the surface volatility caused by healthcare-related legislation.

These dynamics include:

- The movement from volume-based payments to value-based payments. The final ruling detailing provisions of the Medicare and CHIP Reauthorization Act (MACRA), released in October, 2016, offers physicians more breathing space to participate in Medicare's new Quality Payment Program (QPP). However, there appears to be no political impetus to roll back QPP, which will play a major role in converting physician reimbursement from volume-based to value-based metrics.
- Other value-based reimbursement mechanisms, including mandatory bundled Medicare payments for hip and knee surgeries and other procedures, financial penalties to hospitals for safety incidents, and penalties for readmissions also will drive the transition from fee-for-service to fee-for-value.
- Population health management, in which integrated health systems seek to address the social determinants of health, will expand as a care delivery paradigm, in part due to value-based payments that reward prevention and appropriate utilization of resources.
- The growth of convenient care, including the proliferation of urgent care centers, retail clinics, telemedicine, home-health monitoring, and free-standing

emergency centers will continue, as the healthcare industry responds to consumer preferences for enhanced access to care.

- Hospital consolidation, and hospital ownership of medical practices, both necessary to compete under emerging reimbursement models, will continue. Hospital ownership of physician practices increased by 86% from 2012-2015 as hospitals acquired 31,000 physician practices in the U.S. In 2012, about one in seven physician practices were owned by a hospital. By mid-2015, one in four medical practices, or 67,000 practices, were owned by a hospital (*Modern Healthcare, September 7, 2016*).
- Major medical groups also will continue to expand. Mayo Clinic has announced a $70.5 million expansion of its Jacksonville, Florida campus and a $217 million expansion of its Rochester, Minnesota campus, demonstrating the reach and growth of today's medical groups/health systems (*Associated Press, March 22, 2017*).
- Care will increasingly be delivered by interdisciplinary teams of clinicians, headed by physicians, in which each clinician practices to the top of his or her training, rather than in silos. The team approach is necessary to enhance quality and to meet the rising challenge of patient demand, which requires more efficient use of clinician time and expertise.

To these underlying trends should be added perhaps the most enduring constant of them all: ***the continued central position that physicians occupy in the healthcare system.***

PHYSICIANS ARE THE FULCRUM

Despite the growing importance of various types of healthcare professionals, including nurse practitioners (NPs), physician assistants (PAs), pharmacists, therapists, nurses, home health aides, community care coordinators, and others, physicians continue to be the indispensable caregivers at the heart of the healthcare system.

Consider that physicians:

- Handle over 1.2 billion patient visits a year, in offices, emergency departments and other settings (*Centers for Disease Control and Prevention*).
- Control 87% of all personal spending on healthcare through hospital admissions, test orders, prescriptions, procedures, treatment plans and related activities (*Boston University School of Public Health*).
- Generate $1.6 trillion in economic output collectively.
- Account for $2.2 million in economic output individually.
- Support 14 jobs each (*National Economic Impact of Physicians. American Medical Association/IMS Health, March, 2014*).
- Generate an average of $1.5 million for their affiliated hospitals in net revenue annually (*Merritt Hawkins 2016 Survey of Physician Inpatient/outpatient Revenue*).

The healthcare delivery system has been engaged in a process of evolution for decades, from the "golden age" of fee-for-service in the Sixties, Seventies and Eighties, to the proliferation of managed care in the Nineties, to the increasingly corporatized and value-driven system in place today.

Through each of these stages, little has been accomplished -- be it a hospital admission, prescription order, test, treatment plan, surgery or hospital discharge -- without the direction or supervision of a physician.

The healthcare sector now employs one in nine people in the U.S., up from one in 12 in 2000, and 35% of the nation's job growth since 2007 has come in healthcare (*New York Times, April 22, 2017*). Virtually all of this employment growth and the economic impact it generates is tied directly or indirectly to the activities of physicians.

That is unlikely to change in the foreseeable future and explains why the services physicians provide are at a premium.

Given the importance of physicians, one of the key factors driving healthcare accessibility, cost, and quality is physician supply. Any examination of current physician recruiting trends must include a look at this critical issue.

IS THERE A DOCTOR IN THE HOUSE?

The current state of physician supply in the U.S. continues to be the subject of debate. Do we have too many physicians, too few, or, as Goldilocks might phrase it, is the number of physicians "just right?"

Academics and policy makers associated with the *Dartmouth Atlas of Healthcare* look at national physician-to-population ratios and conclude that physician supply is sufficient and that there is no need to train additional doctors. Their counterparts at the Association of American Medical Colleges (AAMC) examine demographic trends and come to the opposite conclusion (see *JAMA, March 20, 2017* for contrasting views on this topic from these two sources).

Hospitals, medical groups, search firms and others charged with recruiting physicians are likely to fall into the AAMC's camp. Physician recruiting has evolved from an informal, ad hoc process several decades ago to a multi-billion dollar industry today. Hospitals and large medical groups employ thousands of "in-house" physician recruiting professionals, while thousands also are employed by search firms and staffing agencies. These professionals use physician job boards, their own web sites, direct mail, conventions, social media and countless phone calls to comb the country for appropriate physician candidates.

One of the benefits of being a physician today (or one of the drawbacks, depending on one's point of view) is the constant barrage of job offers and recruiting solicitations doctors receive. According to *Merritt Hawkins' 2015 Survey of Final-Year Medical Residents,* 63 percent of physicians in their last year of training received 51 or more job solicitations, while nearly half (46 percent) received over 100. Consider that this aggressive recruitment takes place in an economy where many college graduates and post-graduates struggle to find suitable employment.

At the "street level" (as opposed to the theoretical level of physician supply and demand studies) physician recruiting is a challenging, time and resource-intensive endeavor simply because the demand for doctors considerably outstrips the supply. The challenge is compounded by the dynamics of today's market, which require the "right" physician – one who can work well within the team approach and valued-driven payment structures.

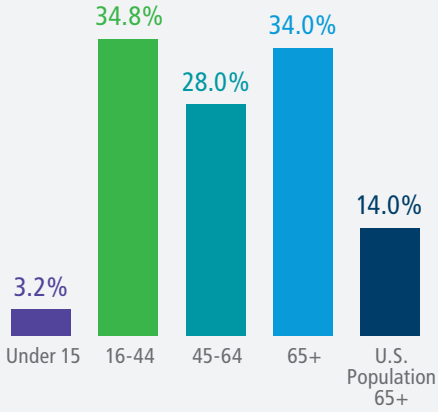
Recruiters experience this fact every day, which is supported by the following data and trends:

POPULATION GROWTH AND AGING

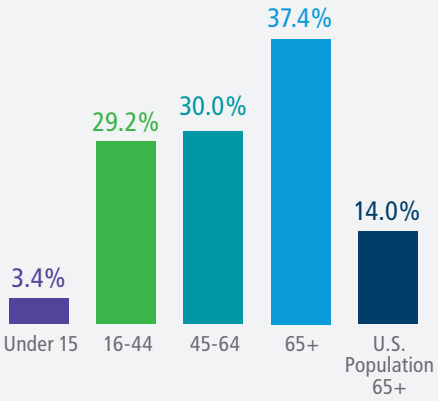
From 2015 to 2030 the U.S. population will increase by 12%, from 310 million to 349 million people, adding a population larger than Poland's. Americans aged 65 or older will increase by 55% in that time, with about 10,000 people turning 65 every day (*U.S. Census Bureau*).

As the following graphs illustrate, population aging is a key driver of healthcare utilization, as older people account for a proportionately much higher volume of services than do younger people.

IN-PATIENT PROCEDURES BY AGE GROUP



NUMBER OF DIAGNOSTIC TREATMENTS/TESTS BY AGE

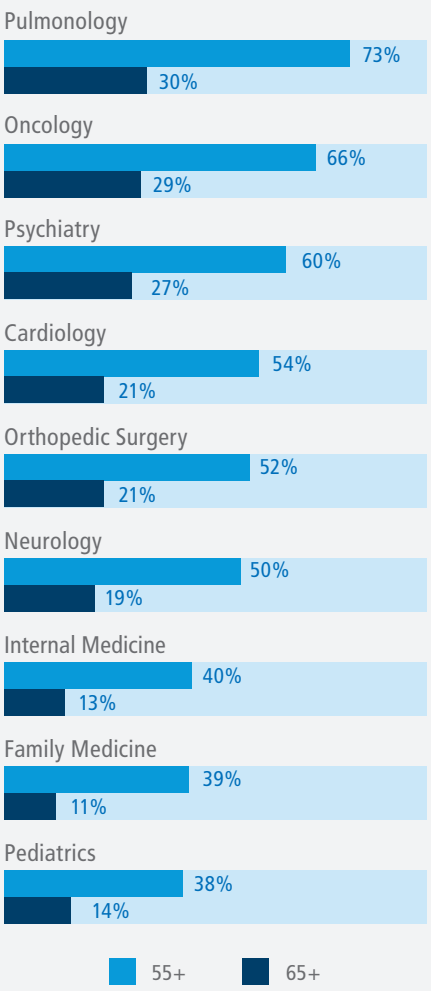


Source: Centers for Disease Control and Prevention

PHYSICIANS REACHING RETIREMENT AGE

Like the general population, the physician workforce also is aging. One third of all currently active doctors will be 65 or older in the next ten years. The chart below indicates that some specialties are aging out faster than others:

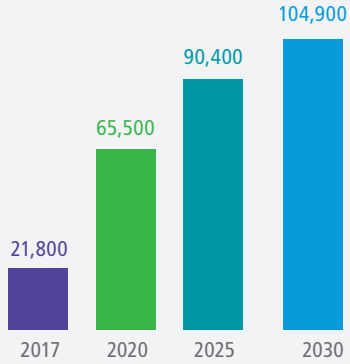
PERCENT OF PHYSICIANS 55 OR OLDER BY SPECIALTY



Source: AMA Physician Master File

These general population and physician demographic trends, along with changes in physician practice patterns, provide the basis for the AAMC's March, 2017 physician supply forecast, which projects a deficit of up to 104,900 doctors by 2030 (see following chart):

CURRENT PHYSICIAN SHORTAGE PROJECTIONS



Source: IHS, Inc./AAMC. 2017 Update: The Complexities of Physician Supply and Demand: Projections from 2015 to 2030

EXPANDING INSURANCE COVERAGE

Demand for health services is driven in part by the ability of patients to pay for such services. The ACA expanded healthcare coverage by some 20 million people, fueling demand for physicians. This demand could be reduced depending on the ultimate fate of the ACA.

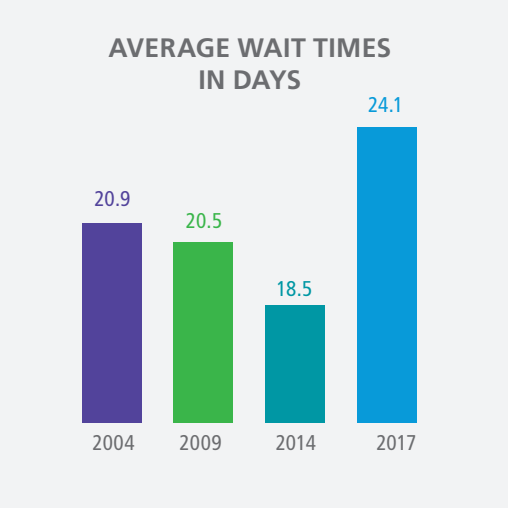
However, even if the ACA is repealed and millions of people lose coverage, the AAMC projects it would only decrease future demand by some 6,000 to 10,000 physicians.

Shortages also could not be ameliorated by redistributing where physicians are located. According to the AAMC, if people in medically underserved areas could access physicians at the same rate as the rest of the population, 34,900 to 96,800 physicians would be required immediately to meet demand.

PHYSICIAN APPOINTMENT WAIT TIMES ARE GETTING LONGER

Physician supply projections tend to deal in abstract formulas based on physician-to-population ratios, demographics and other somewhat intangible metrics. Physician supply also can be gauged on a more practical level in an experiment that anyone can conduct by calling physicians to schedule an appointment.

Merritt Hawkins conducts such an experiment in its periodic *Survey of Physician Appointment Wait Times and Medicare and Medicaid Acceptance Rates* in which researchers call physician offices in 15 major metro areas to determine wait times for a new patient appointment for a non-emergent condition. Our 2017 version of this survey shows that physician appointment wait times have increased by 30% since 2014 (see chart):



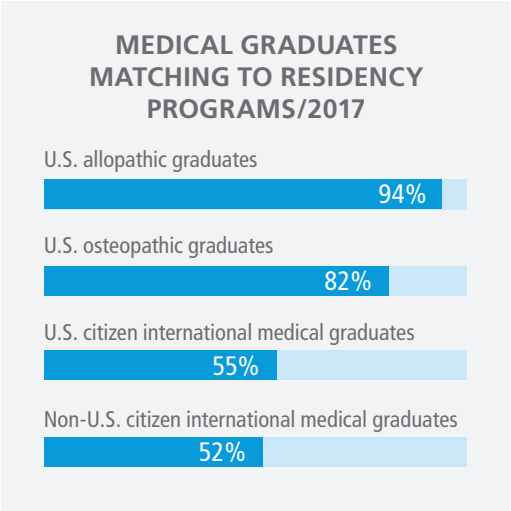
Source: Merritt Hawkins Survey of Physician Appointment Wait Times 2017

The 2017 survey included for the first time physician appointment wait times in 15 mid-sized metro areas of between 88,000 and 143,000 people. Wait times in these areas, which generally have fewer physicians per capita than major metro areas, were 33% longer than the 15 large markets examined in the survey.

RESIDENCY IS THE BOTTLENECK

The AAMC has responded to the growing physician shortage by a concerted effort to increase U.S. medical school enrollment, an effort that has succeeded. MD degree enrollment has increased at U.S. medical schools by 27.5 percent, from 16,488 matriculants in 2002 to 21,030 in 2016 (*JAMA, March 20, 2017*). But residency positions have only increased by about 8% in that time, due primarily to the cap Congress put on Medicare spending for physician training in 1997.

As a result, many more medical school graduates apply for residency programs under the National Residency Matching Program than there are positions to accommodate them (see chart below):



Source: National Resident Matching Program

As these numbers indicate, even some U.S. allopathic graduates do not find slots either in the initial or the supplemental

match, while the rate among those who do not match is much higher for osteopathic graduates, U.S. citizen graduates of international schools, and foreign graduates of international schools.

Until this situation is resolved, physician recruiting will take place in a market characterized by a high level of demand in various specialties and a low level of supply.

Merritt Hawkins' 2017 Review offers insights into which types of physicians are in particularly high demand (see below):

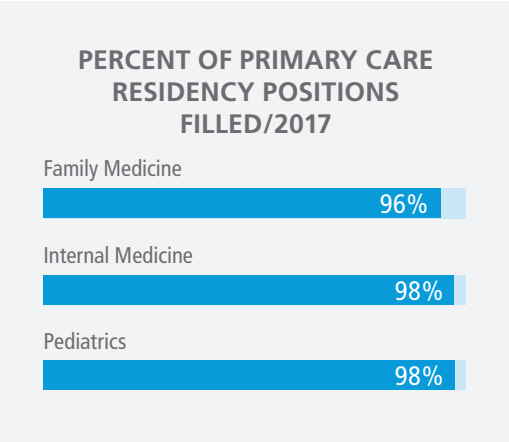
PHYSICIAN DEMAND: PRIMARY CARE, FAMILY MEDICINE, INTERNAL MEDICINE, PEDIATRICS, OBSTETRICS/ GYNECOLOGY

Family Physicians Are Number One, Eleven Times Running

For the eleventh consecutive year, family medicine was Merritt Hawkins' most requested search assignment, by far the longest period any one specialty has held this position.

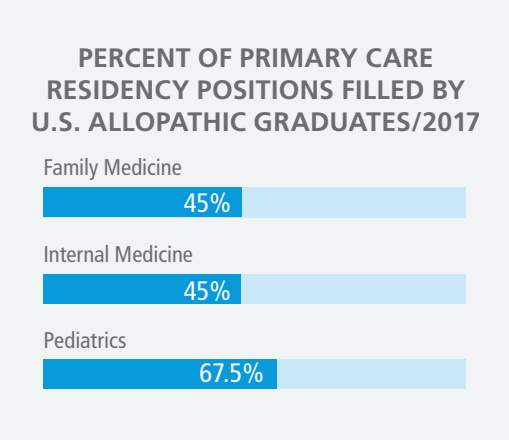
Demand for primary care physicians, including family physicians, general internists and pediatricians, is driven in part by population growth. From 1987 to 2010, the U.S. population grew by 28%, going from 242 million to 310 million people in 23 short years, according to the U.S. Census Bureau.

The supply of family physicians was limited during much of that time due to a decline in the number of medical school graduates selecting family medicine as a specialty, leaving many family medicine residency slots unfilled. That has recently changed, and residency positions in primary care now are almost entirely filled (see following chart):



Source: National Resident Matching Program

It is telling, however, that relatively few U.S. medical school graduates show an interest in primary care, as the chart below indicates:



Source: National Resident Matching Program

Due to the relatively low compensation in primary care, and the perceived high level of personal time commitment required by these specialties, primary care is increasingly the province of international medical graduates (IMGs).

Evolving healthcare delivery models are an additional demand driver for primary care physicians. In the population health management model, primary care-led teams coordinate care for defined population groups, such as blocks of Medicare patients,

under a global payment model where the health system (and, increasingly, its physicians) assume risk.

Implementation of this model will likely be accomplished through inter-professional care teams, in which collaborative practice techniques will replace the current approach, where clinicians often train in silos.

Today the model is being implemented through a growing number of accountable care organizations (ACOs), large medical groups, hospital systems, major employers, insurance companies and other organizations. The primary care-led team in population health management typically consists of the providers illustrated below.

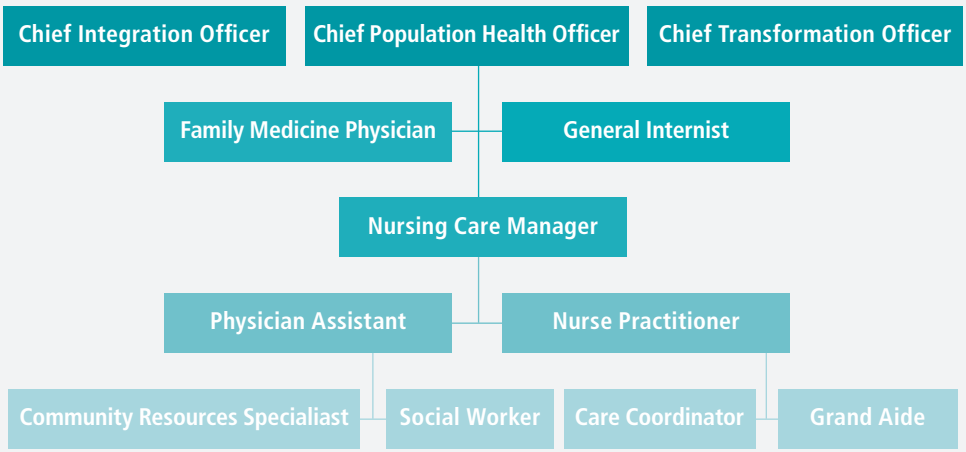
Primary care physicians such as family physicians top the list of most in-demand doctors in part because of their key role as quarterbacks of the delivery team. Through the patient management and care coordination they provide, quality goals are achieved within an environment of defined financial resources. Primary care physicians then are rewarded for the savings they realize, the quality standards they achieve and for their managerial role.

Health system consolidation is a further driver of demand for family physicians and other primary care doctors. Whereas in the past, an individual acute care facility might recruit two or three primary physicians at a time, consolidated systems may recruit 20 or 30 in order to create the primary care networks needed to treat large population groups. Instead of recruiting reactively to fill a void or to respond to demand, health systems now are recruiting proactively to meet the needs of covered lives, and, in a growing number of cases, to manage their own health plans.

It also is primary care physicians who are the providers of choice for evolving, non-traditional practice settings and styles, including urgent care and retail centers, virtual patient care, concierge, quality review, and others.

Because the health system now is primary care-led, demand for family physicians and other primary care physicians is likely to remain strong.

COMPOSITION OF THE PRIMARY CARE-LED TEAM



THE VANISHING GENERAL INTERNIST

Though Internal Medicine residency slots are largely filled during the Match, as referenced above, this has not led to a significant increase in the number of practicing general internists. Only about 20 to 25 percent of internal medicine residents go on to practice general internal medicine today, compared to 54 percent in 1998, according to the American College of Physicians (ACP). The great majority go on to specialize or practice inpatient medicine as hospitalists.

The supply of physicians willing to practice true inpatient/outpatient general internal medicine therefore is extremely constrained, making this one of the most challenging searches in the market today. Rural hospitals that do not have hospitalist programs and seek general internists have a particularly difficult time attracting candidates.

Though the number of searches Merritt Hawkins conducted for general internists declined as ranked in the 2017 Review relative to the last three years, demand remains robust as general internal medicine ranked as our third most requested search last year.

PEDIATRICS, BIRTHRATES, AND CHANGING PHYSICIAN DEMOGRAPHICS

Demand for pediatricians is driven in part by birth rates, which have been in decline among U.S. women in the last several decades. In 1957, the U.S. averaged 123 births per 1,000 women of child bearing age. That average declined dramatically to 63 births by 2015 (*Wall Street Journal, June 17, 2015*). The 2015 number was an increase over 2014, when the rate was 62.5 births, the first increase since 2007. Some experts anticipated the "baby bump" would continue, but birth rates declined again in 2016.

Nevertheless, there are still about 4 million births in the U.S. annually, and immigration adds to the number of children in the population. Demand for pediatrics has held steady over the last five years in part for this reason and also due to shifting physician demographics. Approximately 73% of pediatric residents are women, who are coming to dominate the specialty. This trend is reducing overall pediatric FTEs, as female physicians are more likely to work part-time than are males, keeping demand for pediatricians robust.

OBSTETRICS/GYNECOLOGY IN THE TOP TEN

Demand for Obstetrics/Gynecology, sometimes included in primary care, also is driven by birth rates as well as by population growth among females. Nearly half the counties in the U.S. do not have a single Ob/Gyn, while 56 percent do not have a single nurse midwife, according to the American College of Nurse-Midwives.

The American Congress of Obstetricians and Gynecologists (ACOG) reports that

the number of residents going into Ob/Gyn has remained virtually the same since 1980 at about 1,205. ACOG projects there will be 6,000 to 8,800 too few Ob/Gyns by 2020 as the number of women in the U.S. is expected to climb by 18% between 2010 and 2030 (*Columbus Dispatch, August 28, 2016*). The majority of Ob/Gyns who are 55 or older are men. However, about 4 in 5 first year Ob/Gyns are women, which, as in pediatrics, reduces overall FTEs.

It should be noted that both male and female Ob/Gyns today express interest in a "controllable lifestyle" and are less inclined to be on call, giving rise to the use of "laborists" whose sole function is to attend deliveries in the hospital. In addition, a growing number of Ob/Gyns are entering subspecialties such as gynecologic oncology, reproductive endocrinology and infertility, reducing the number available for routine care and deliveries. While seven percent of Ob/Gyn residents entered a subspecialty in 2000, 19.5% did so in by 2012 (*Columbus Dispatch, August 28, 2016*).

Based on these trends, Ob/Gyn remains among Merritt Hawkins' top ten most requested recruiting assignments and the specialty is likely to be in strong demand for the foreseeable future.

PSYCHIATRY SECOND ON THE LIST TWO YEARS RUNNING

Psychiatry has been among Merritt Hawkins' top 20 most requested recruiting assignments for a number of years, gradually moving up from number 13 in 2001 to number three in our 2015 Review.

In the 2016 Review, psychiatry was ranked as Merritt Hawkins' second most requested search assignment – the first time psychiatry held this position in the 23 years Merritt Hawkins had compiled its Review to that point. This ranking holds in the 2017 Review, underscoring the alarming shortage of psychiatrists that is developing in many parts of the country.

In March, 2017, the National Council of Behavioral Health (NCBH) released a report compiled by a 27-member panel of experts drawn from providers, payers, government agencies and psychiatric associations. The report indicates there is a national shortage of psychiatrists that is about to spiral out of control, with 77% of U.S. counties reporting a severe psychiatrist shortage.

Joseph Parks, MD, medical director of the NCBH, was quoted as follows:

> *"Two-thirds of primary care physicians report that they have trouble getting psychiatrist services for their patients. So, they go to the emergency rooms. There has been a 42% increase in the number of patients going to the emergency room for psychiatric services in the past three years, but most of them are not staffed with psychiatrists. They try to get into an inpatient bed, but hospitals have been closing their psychiatric units because they can't find psychiatrists to hire and staff to run them. It is truly becoming a crisis." (HealthLeaders, March 30, 2017).*

In June, 2016 it was reported that for the first time the largest share of healthcare spending in the U.S. is on mental health disorders. An estimated $201 billion dollars was spent on mental disorders in the U.S. in 2013, the most recent year data is available, followed by heart disease, trauma, cancer and pulmonary conditions (*HealthLeaders News, June 14, 2016*).

Approximately one in five adults in the U.S (43.8 million people, or 18.5% of the population) experience mental illness in a given year, with only 41% receiving mental health services. Among adults with a serious mental illnesses, just 62.9% received health services in the past year, according to the National Alliance on Mental Illness, while nearly one in 20 adults in America -- or 13.6 million people -- live with a serious mental illness. The mental health challenges facing the VA system have been widely noted as they struggle to cope with high incidences of post-traumatic stress syndrome and high suicide rates among veterans.

In a particularly telling statistic, emergency department visits for suicidal thoughts more than doubled during a recent seven year period according to a 2017 Agency for Health Research and Quality (AHRQ) statistical brief (*HealthLeaders, March 3, 2017*).

In some areas, primary care physicians attempt to address burgeoning demand for mental health services, but a report by the Commonwealth Fund indicates that more than 8 in 10 family doctors in the US say they are not adequately prepared to care for severely mentally ill patients. According to the report, just 16 percent of doctors said their offices had the capacity to care for those with serious mental illnesses, the lowest of any developed country besides Sweden (*The Hill, December 8, 2015*).

The supply of psychiatrists, already constrained, is soon going to diminish significantly. There currently are some 30,000 psychiatrists in active patient care in the U.S., 60% of whom are 55 years old or older, with many set to retire.

As Merritt Hawkins has consistently observed in these Reviews, the shortage of psychiatrists is an escalating crisis of more severity than shortages faced in virtually any other specialty. With many psychiatrists aging out of the profession, and with a preference among psychiatrists for outpatient practice settings, it is becoming increasingly difficult to recruit to inpatient settings.

Because psychiatric disorders are so frequently misdiagnosed, patients often require extensive time with psychiatrists when their conditions eventually are diagnosed correctly, further increasing demand.

For additional information on the shortage of psychiatrists see Merritt Hawkins' white paper *Psychiatry: The Silent Shortage*.

PULMONOLOGISTS LEAD IN "ABSOLUTE DEMAND"

It is to be expected that specialties that have a comparatively high number of practicing physicians, such as family

medicine and internal medicine, will generate a correspondingly high number of searches. But how does the picture look if specialties are ranked by number of search assignments as a percent of all active physicians in a given specialty--or by what Merritt Hawkins calls "absolute demand?"

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

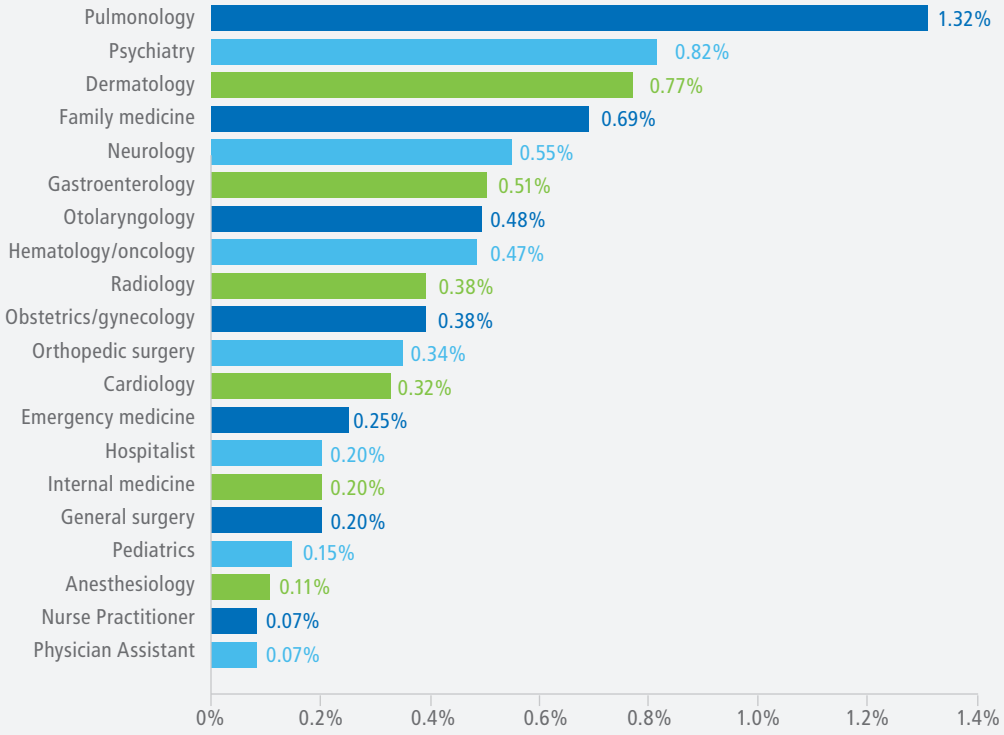
Considered this way, demand for specialties such as pulmonology, dermatology, and neurology can be viewed as being in particularly high demand, while some specialties, such as family medicine and psychiatry, are in high demand as ranked by both number of searches Merritt Hawkins conducts and by searches as a percent of all physicians in their respective specialties.

COPD DRIVES DEMAND FOR PULMONOLOGISTS

As calculated by "absolute demand," pulmonologists are by a large margin the most in-demand type of physician ranked in the 2017 Review. Demand for pulmonologists is driven by aging patient demographics and by the continued rise of chronic obstructive pulmonary disorder (COPD). Over 11 million Americans have been diagnosed with COPD and millions more may have it but do not know it. COPD now is the third leading cause of death in the U.S. after heart disease and cancer, according to the American Lung Association.

The graph on the next page indicates COPD prevalence in various states.

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



COPD PREVALENCE IN ADULTS BY STATE/2015

HIGHEST PREVALENCE

West Virginia	12.1%
Kentucky	11.5%
Tennessee	9.9%
Alabama	9.6%
Illinois	8.3%

LOWEST PREVALENCE

Colorado	3.8%
Utah	3.8%
Minnesota	4.0%
North Dakota	4.3%
Connecticut	4.7%

Source: American Lung Association

The number of pulmonology searches Merritt Hawkins conducted increased by 35% in the 2017 Review relative to 2016. A shortage of pulmonologists is likely to become particularly acute given that 73 percent of pulmonologists are 55 or older.

ADDITIONAL SPECIALISTS IN HIGH DEMAND

Using the metric of "absolute demand" indicates that a number of other specialties also are in high demand and that shortages are not limited to primary care, though that is the area that tends to be the focus of policy maker and public attention.

The number of dermatology searches Merritt Hawkins conducted in the 2017 Review period grew by 17% over 2016, while neurology, gastroenterology, otolaryngology, hematology/oncology, and orthopedic surgery also remained in strong demand. Based on demographic trends, demand is likely to continue in these specialties, because it is specialists who care for the ailments of the elderly, including neurological problems such as Alzheimer's Disease, cancer, and organ deterioration or failure.

According to a 2015 study published in *Neurology*, there will be shortage of 3,380 neurologists by 2025, while the Lewin Group projects a shortage of 1,550 gastroenterologists by 2020.

The following data underscore why medical specialists remain in high demand, even though new delivery systems such as ACOs, which focus on prevention and appropriate resource utilization rather than volume of tests and procedures, are designed to inhibit the use of specialty services:

- As of January, 2016, there were an estimated 15.5 million cancer survivors in the U.S. comprising 4.8% of the population.
- This number is projected to increase by 31% to 20.3 million by 2026.
- Over the next decade, the number of cancer patients who have lived 5 years or more after their cancer diagnosis is expected to increase by 35% to 14 million (*National Cancer Institute*).
- 5.5 million people in U.S. have been diagnosed with Alzheimer's.
- This number is expected to increase to 16 million by 2050 (*Alzheimer's Association*).
- Each year, 5.4 million cases of non-melanoma skin cancer are detected.
- More new cases of skin cancer are detected every year than the combined cases of breast, prostate, lung and colon cancer.

- Approximately 87,110 cases of invasive melanoma will be diagnosed in 2017 (*Skin Cancer Foundation*).
- The number of total hip replacements among inpatients 45 and older increased from 138,700 in 2000 to 310,800 in 2010, and from a rate of 142.2 per 100,000 people to 257.0 per 100,000 people while demand for knee arthroplasties will jump by 673% by 2030 (*Centers for Disease Control and Prevention/AAMC)*.

For these and related reasons, the AAMC projects a shortage of up to 29,000 surgical specialists by 2030 (*JAMA, March 20, 2017*).

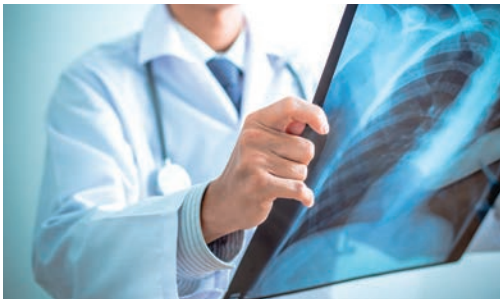
In addition, some specialists, including cardiologists, neurologists, pulmonologists/ critical care, and others are important to implementing the population health management model, due to the role they play in chronic disease management. Population health management seeks to reduce the time and disproportionate financial drain that patients with chronic disease have on the system through management of their care by both primary care and select specialist physicians.

Even with the proliferation of this model, it is unlikely that the health system can manage away demand for specialists or relieve it with other clinicians. Some maladies simply require a doctor, particularly when patients age.

RADIOLOGY CONTINUES ITS COMEBACK

In 2003, radiology topped the list of Merritt Hawkins' most requested search assignments.

Demand for radiology diminished over subsequent years due to a robust supply of residents entering the specialty, payment cuts for imaging services, and utilization suppression linked to both the 2007 recession and managed care, as well as the growing use of both domestic and offshore teleradiology services. In 2012, radiology dropped out of Merritt Hawkins' top 20 altogether.



It returned for the first time since then in the 2016 Review and built on its momentum in 2017, with a 100% increase in search assignments year-over-year. Renewed demand for radiologists was inevitable because imaging remains central to diagnostic and procedural work in today's healthcare system, in which very little transpires without an image. Given improvements in the economy and the effect of population aging on utilization, demand for radiologists was going to rise at some point. In addition, close to 50% of radiologists are 55 and older and attrition is beginning to reduce the candidate pool.

Rising demand for radiology also is notable as it suggests that even with the widespread use of teleradiology, which allows for the distribution of imaging studies to radiologists nationally and even internationally, healthcare facilities are again seeking the assistance of recruiting firms such as Merritt Hawkins to help them find radiologists. Demand now is at the level where facilities are seeking both more traditional, on-site radiologists and those working as teleradiologists. Teleradiology has gained momentum recently due to technological advancements that improve quality and the ability for radiologists to work remotely.

ANESTHESIOLOGY BACK IN THE TOP 20

Similarly, anesthesiology was absent from Merritt Hawkins' top 20 recruiting assignments since 2010, but returned to the list in the 2017 Review. Demand for anesthesiology was suppressed in part by the recession, which had a particularly inhibiting effect on elective procedures.

Demand also may have been limited by the ongoing effort to redirect healthcare away from a volume-based model toward a value-based model in which prevention and resource utilization are emphasized and the number of procedures requiring anesthesia is thereby reduced. Nevertheless, demand for procedures (elective and non-elective) driven by an improving economy and patient aging continues to be strong, creating more openings for anesthesiologists, particularly with large single specialty groups and academic medical centers.

20 YEARS OF HOSPITALIST MEDICINE

Two thousand sixteen marked the 20th anniversary of "hospitalist" medicine, which got its start in 1996. Since then, the number of hospitalists has grown from a few hundred to more than 50,000. Nine out of 10 hospitals of more than 200 beds now have hospitalists who provide inpatient care to patients, many of whom have complex problems (*New England Journal of Medicine, September, 15, 2016*).

There are no hospitalist residency programs yet, though hospitalists have access to a variety of fellowships. According to the Society of Hospital Medicine (SHM), hospitalist training is as follows:

HOSPITALISTS BY TRAINING

General internal medicine	76.7%
Family medicine	9.2%
Pediatrics	6.3%
Other specialties	7.8%

Source: SHM/Medscape, April 26, 2016

By developing inpatient expertise, hospitalists can reduce readmissions, reduce resource utilization and increase patient satisfaction, and therefore are one key to the transition to value-based care and global payments. Four in 10 hospitalists work in ACOs, underlining their role in emerging value-based, capitated delivery systems (*Medscape, April 26, 2016*). As referenced above, the hospitalist concept is extending to Ob/Gyn and also to surgery, neurology and other specialties.

Hospitalists have been among Merritt Hawkins' top five most requested searches for over five years, though the number of hospitalist searches Merritt Hawkins conducted in the 2017 Review period declined significantly from 2016. This may be a signal that some hospitals have reached full hospitalist staffing but is more likely a sign that staffing in the specialty is being more aggressively outsourced to

a growing number contract management groups that are entering the temporary (locum tenens) physician staffing arena.

For additional information on hospitalists see Merritt Hawkins' white paper *The Growing Use and Recruitment of Hospitalists*.

ROBUST DEMAND FOR EMERGENCY MEDICINE

According to the Centers for Disease Control (CDC), annual U.S. hospital emergency department visits now stand at 136.3 million. Of these, 40.2 million are injury related and 16.2 million lead to hospital admissions (*Becker's Hospital Review, October 7, 2016*). Over half of hospital admissions now come through the ED (*New York Times, May 20, 2013*), illustrating that EDs can be an important loss leader for hospitals and a compelling reason to keep EDs staffed appropriately.

Though the ACA is intended to reduce ED admissions by allowing more patients with insurance coverage to see office-based physicians, there is evidence that higher rates of insurance do not necessarily reduce ED visits. ED visits went up in Massachusetts in 2006 when access to coverage in the state was expanded, and a similar trend was observed in Oregon when access to Medicaid was expanded. Eighty-four percent of ED visits are generated by patients with insurance (*Becker's Hospital Review, October 7, 2016*), and many ED patients, both insured and uninsured, fall back on the ED when they cannot obtain convenient access to office-based physicians.

Demand for physicians who work in the ED, particularly for physicians board-certified in emergency medicine, therefore remains robust. The number of searches Merritt Hawkins conducted for emergency medicine physicians increased in the 2017 Review period by 12.5 percent over 2106. Demand in this specialty is expected to stay strong, in part due to the continued expansion of the "convenient care" trend (see following).

A MATTER OF CONVENIENCE: URGENT CARE AND RETAIL

Physicians who practice in urgent care settings represented Merritt Hawkins' 12th most requested recruiting assignment as tracked by the 2017 Review. Urgent care physicians first made the top 20 in the 2015 Review when they were ranked 20th.

Increased recruitment of urgent care physicians underscores the rise of a movement seen throughout the economy in which convenience and ease of access are paramount. Uber, Netflix, Amazon, Spotify and other services illustrate this trend, which is accelerating rapidly in healthcare.

In order to capture consumer preferences for convenient care, hospitals, large medical groups, health corporations and other organizations are developing outpatient sites of service, including urgent care centers, retail clinics, and free standing emergency rooms.

Providing urgent care services is no longer a secondary consideration filled by

moonlighting" primary care physicians – it is a distinct growth service line as the number of urgent care centers has increased from 6,400 in 2013 to over 7,100 today, occupying the following locations:

URGENT CARE CENTER LOCATIONS

Shopping centers/strip malls	34.1%
Freestanding buildings	33.2%
Mixed-use buildings	13.6%
Medical offices	19.1%

Source: Urgent Care Association of America/Becker's Hospital Review, February 11, 2016

The rapid growth of urgent care centers represents an unusual intersection between the interests of consumers, physicians, healthcare systems and investors, all of whom are embracing this expanding model of delivery.

Retail clinics located in pharmacies, retail chains and supermarkets also are growing rapidly. According to consulting firm Accenture, the number of retail clinics will exceed 2,800 by the end of 2017, up 47 percent since 2014. They will add capacity to see 25 million visits, up from 16 million in 2014.

Increased access to medical services, or "being everywhere, all the time," is part of a wider trend in which healthcare facilities are evolving away from a transactional model of care and toward an "experiential" model characterized by customer service, price transparency, provider ratings, and ease of use. With the understanding that consumers punish complexity and reward simplicity, healthcare is shifting to a retail model with a wider menu of niche providers to suit varying customer preferences.

The trend extends to free-standing EDs, of which there are now some 400 in the U.S. though growth in this sector is uncertain given certificate of need (CON) and other considerations (*Modern Healthcare October 4, 2016*).

Convenient care settings can be staffed by primary physicians and emergency medicine physicians, and by advanced practice PAs and NPs, which will further drive demand for these types of clinicians (see following). These settings also are pushing into areas beyond primary care, including vision, hearing and even behavioral health. For further information on convenient care see the Merritt Hawkins' white paper *Convenient Care: Growth and Staffing Trends in Urgent Care, Retail Medicine and Free-Standing EDs*.

NPs, PAs A KEY COMPONENT OF TEAM-BASED CARE

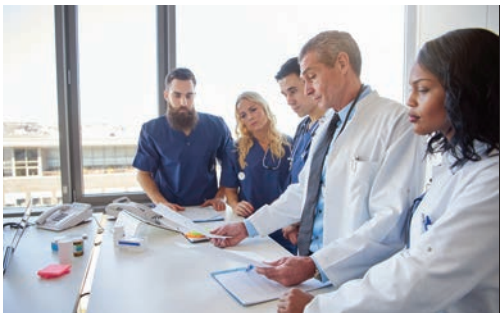
Combined, PAs and NPs represent Merritt Hawkins' third most requested search in the 2017 Review, up from fifth in 2016. This is the highest position PAs and NPs have held on the list, though neither was in the top 20 singly or combined six years ago.

There are over 110,000 PAs practicing in the U.S. today, about one-third of them in primary care and two-thirds in specialty areas, and over 190,000 NPs, about 85 percent in primary care and 15 percent in specialty areas.

PAs and NPs 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.

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. As referenced above, PAs and NPs provide the bulk of care at the growing number of urgent care and retail centers and also have been a fixture at FQHCs for years.

Given these considerations and the continued physician shortage, demand for PAs and NPs can be expected to accelerate. A significant recruiting challenge is arising in this area as many PAs and NPs are choosing to specialize though demand remains pronounced in primary care, a trend also seen among physicians.



For more information on PAs and NPs, see Merritt Hawkins' white paper, *NPs and PAs: Supply, Distribution and Scope of Practice* and the survey of PA employers Merritt Hawkins conducted on behalf of the American Academy of Physician Assistants (*2016 Survey of PA Recruiting and Employment Trends*).

RECRUITMENT SETTINGS

Types of Healthcare Facilities Currently Recruiting Physicians

HOSPITALS

According to the American Hospital Association (AHA), there are 5,564 hospitals in the U. S., broken out as follows:

HOSPITALS/U.S.

Total all registered	5,564
Community (non-federal)	4,862
Urban community	3,033
Rural community	1,829
Non-government/not-for-profit	2,845
For-profit	1,034
State and local government	983
Federal government	212
Nonfederal psychiatric	401
Nonfederal long-term	79
Community hospitals in a system*	3,198
Community hospitals in a network**	1,677

**AHA defines "system" as either a multihospital organization or a diversified single hospital system*

***AHA defines "network" as a group of hospitals, physicians or other providers/insurers/community agencies that work together. Network participation does not preclude system affiliation.*

Source: Fast Facts on U.S. Hospitals, American Hospital Association, 2017

These facilities total 35,061,292 admissions annually and generate over $936 billion in spending.

Hospitals have been challenged in recent years to evolve from a transactional model based on maximizing individual patient encounters and services to alternative models focusing on population health management and resource utilization in which reimbursement is capitated and quality-driven. They also are embracing consumer driven demand for convenience by expanding outpatient services and sites, in some cases playing catch up with retail and other settings that have been quicker to embrace the convenient care model. Accomplishing these goals requires integration and consolidation, and as the numbers above indicate, the great majority of hospitals now are part of a system or a network.

For these reasons, hospital physician recruitment is transitioning from an ad hoc approach in which individual staff openings for physicians are addressed, often reactively, to a strategic, proactive approach in which entire "physician platforms" may be put in place to catapult a system into the new world of population care and global payments.

Rather than recruiting two or three physicians, hospital systems will recruit or acquire the practices of 20, 30 or more physicians, at the same time building inter-professional clinical teams around them and the management to support them.

For smaller, rural facilities the challenge today is to maintain a viable business model, often by affiliating with larger entities. Approximately 70 rural hospitals have closed in the last ten years, while about 700 are at high risk of closing (see the Merritt Hawkins' white paper *Rural Physician Recruiting Challenges and Solutions* for additional information on rural physician recruiting trends). These facilities are seeking alternative approaches to care delivery, including the expanded use of telemedicine and advanced practitioners such as NPs and PAs.

Forty-three percent of Merritt Hawkins' recruiting assignments were conducted for hospitals in the 2017 Review, down from previous years, due in part to the growth and proliferation of other sites of service, including large medical groups (see chart on page 36):

PHYSICIAN-OWNED MEDICAL GROUPS

Physician-owned medical groups, which, like hospitals, are merging and consolidating to achieve economies of scale and to compete for contracts covering large patient populations, also are actively recruiting doctors.

The *2016 Survey of America's Physicians*, which Merritt Hawkins conducted on behalf of The Physicians Foundation, indicates that 48% of physicians now are in practices of 11 physicians or more, compared to 34% in 2012, underscoring the proliferation of large medical groups.

The list below of the ten largest physician-owned medical groups in the U.S. illustrates the scope and potential resources of large scale groups.

LARGEST U.S. MEDICAL GROUPS

1	**Kaiser Permanente Medical Group** *– 7,304 physicians*
2	**Cleveland Clinic** *– 1,999 physicians*
3	**Mercy Clinic** *– 1,735 physicians*
4	**Aurora Medical Group** *– 1,193 physicians*
5	**North Shore Long Island Jewish Group** *– 1,155 physicians*
6	**University of Washington Physicians Network** *– 1,124 physicians*
7	**I U Health Physicians** *– 1,076 physicians*
8	**UCLA Internal Medicine/Geriatrics** *– 1,005 physicians*
9	**Novant Medical Group** *– 1,003 physicians*
10	**Palo Alto Medical Foundation Clinic** *– 988 physicians*

Source: SK&A's 50 Largest U.S. Medical Groups, January 2015

Twenty-seven percent of Merritt Hawkins' search assignments tracked in the 2017 Review were conducted for medical groups, up from 19% in 2016.

However, as can be seen from the list of large medical groups above, the difference between "hospitals" and "medical groups" can be one of semantics, as large medical groups often have the same structures and capabilities as hospitals. Large medical groups can be favorably positioned in today's market because they have been the first to employ extensive networks of physicians, embrace quality metrics and drive change through the development of physician executives.

FEDERALLY QUALIFIED HEALTH CENTERS/INDIAN HEALTH SERVICE FACILITIES

With over 50 years of service, Federally Qualified Health Centers (FQHCs) are one of America's healthcare success stories, supported with funding by both sides of the political aisle. FQHCs have expanded rapidly in recent years and now include more than 1,300 centers providing services at over 9,000 sites nationwide.

Using a primary-care driven, preventive model now being adopted by other types of providers, FQHCs see over 24 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**.

Due in part to their rapid growth, FQHCs are experiencing severe staffing challenges, highlighted by the following numbers:

FQHC WORKFORCE CHALLENGES

- 95% of FQHCs have at least one clinical vacancy
- 69% are recruiting for at least one family medicine physician
- 56% report at least one behavioral health staff vacancy
- FQHCs have a higher average vacancy rate than hospitals.

Source: Staffing the Safety Net, National Association of Community Health Centers, March, 2016.

Fifteen percent of Merritt Hawkins' recruiting assignments in the 2017 Review were conducted for FQHCs or Indian Health Service (IHS) facilities, up from 13 percent in 2016. The IHS is the primary federal health care provider and health advocate for American Indians and Alaska Natives in 566 federally recognized tribes nationwide.

Merritt Hawkins was proud to have been selected by the IHS to conduct two national surveys; one of 380 IHS facility administrators and one of over 400 IHS facility physicians. Both surveys focused on IHS facility recruiting goals, incentives, methods and challenges with a view to expanding IHS physician and advanced practitioner recruiting capabilities.

Merritt Hawkins works with IHS facilities nationwide and anticipates these facilities will continue to expand their recruiting efforts to meet the needs of their constituents.

ACADEMIC MEDICAL CENTERS

Academic Medical Centers (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 also often are considered tertiary care centers, because of their ability to treat a full range of complex conditions and provide access to subspecialists. In 2013, the latest year for which data is available, approximately 400 U.S. hospitals were affiliated with a medical school. There are 145 accredited medical schools in the country, according to the Association of American Medical Colleges (*Becker's Hospital Review, January 25, 2017*).

Eleven percent of Merritt Hawkins' search assignments in 2017 were conducted for AMCs, the same as 2016, though up from 8% in 2015 and 6% in 2014, and Merritt Hawkins has worked with virtually all of the top AMCs in the U.S.

Recruitment of faculty, research and leadership positons 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.

First-year medical school enrollment in 2016-2017 is expected to exceed 21,370, a 30% increase above first-year enrollment in 2002-2003. This meets the target the Association of American Medical Colleges (AAMC) set in 2006 when it called for expanding medical schools as one means to address the physician shortage.

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.

Academic recruiting is further driven by the physician shortage, which has seen many faculty members lured to private practice by comparatively high income offers. Leaders of academic medical centers, including

Chairs, Department Chiefs and others, are being targeted for leadership positions by pharmaceutical companies, private health systems, and other organizations, contributing to a "talent drain" that has challenged some academic facilities. Combined with the need to replace an aging academic workforce, these trends have accelerated the pace of academic medical center recruitment (see the Merritt Hawkins' white paper *The Changing Landscape in Academic Recruiting* for more information on AMC recruitment trends).

In response, 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. **The Advisory Council is composed of Tom Lawley, MD, former Dean of Emory Medical School; Phillip Pizzo, MD, former Dean of Stanford Medical School; and Arthur Rubenstein, MD, former Dean of the University of Pennsylvania School of Medicine**. In addition, in 2016, AMN Healthcare acquired MillicanConsulting, a leading provider of academic medical center leadership recruitment, to further advance its academic search and consulting capabilities.

VETERANS AFFAIRS (VA) HOSPITALS

There are currently 157 hospitals in the U.S. operated by the Department of Veterans Affairs (VA) serving approximately 5.7 million patients.

VA hospitals are included in the "hospital and hospital owned group" category in the Review, but require a separate mention as they have significantly expanded their physician recruiting activities in the last three years.

Accelerated recruitment efforts have come as a response to highly publicized reports of long patient wait times at VA facilities and particular challenges in mental health. Merritt Hawkins is referenced in many of these media accounts because our *Survey of Physician Appointment Wait Times* demonstrates that long wait times to see a physician also are prevalent in the private sector.

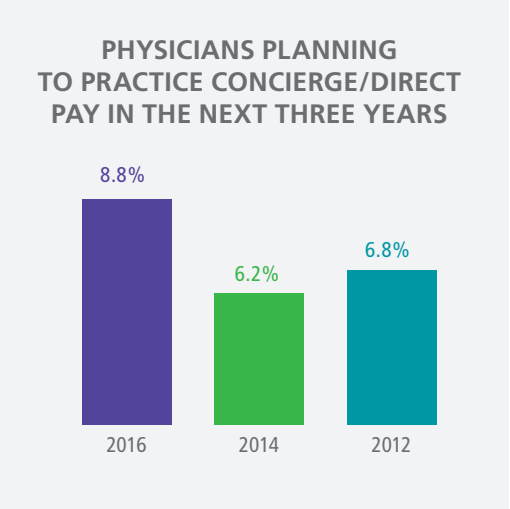
Based on the work we have done with a number of VA facilities nationwide, Merritt Hawkins was proud to be selected twice in 2015 to submit a **Statement of Record** to the **House Subcommittee Health Oversight Hearing on the Ability of Department of Veterans Affairs to Effectively Recruit, Onboard, and Retain Qualified Medical Professionals**. The two Statements outlined the challenges Merritt Hawkins has encountered when recruiting for VA facilities and included suggestions for how VA facilities can streamline and enhance their physician recruiting processes.

The VA has identified hundreds of physician recruiting opportunities at its facilities and is likely to remain an active participant in the physician recruiting market in the short and long-term.

SOLO PRACTICE/DIRECT CARE

In 2001, Merritt Hawkins conducted 22% of its searches for solo practice settings. Since then, market forces, regulatory compliance issues, and physician practice preferences have eroded the viability of the solo physician model. Only 1% of the searches Merritt Hawkins conducted in the 2017 Review period were for solo settings.

The future of solo practice may lie with the direct pay or concierge practice model in which physicians bypass third party payers and contract directly with patients. A growing number of physicians plan to adopt this model in the next several years (see following chart):



Source: 2016 Survey of America's Physicians. The Physicians Foundation/Merritt Hawkins

Most of the solo physician practice searches Merritt Hawkins conducted in the 2017 Review period were for direct pay/concierge settings.

OVER 90% OF NEWLY RECRUITED PHYSICIANS ARE EMPLOYEES

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 2017 Review suggests that the great majority of physicians accepting new positions today – over 90% -- will practice as employees and not as independent practice owners/partners. By contrast, in 2001, this number was approximately 40%.

Physician employment is deemed necessary to implement the integration, evidence-based treatment protocols, IT standardization, global payments and other hallmarks of value-based care. In addition, it is the preferred practice model of many physicians today who do not want the responsibilities, time restraints and stress of "running a business." The challenges of physician recruiting become more intense for those facilities unable or unwilling to offer physicians employment.

LARGE CITIES NOW DRIVING PHYSICIAN RECRUITMENT

Though it is well known that there is a maldistribution of physicians in the U.S., with doctor shortages particularly common in many rural areas, physician recruiting challenges are not limited to small or mid-sized communities. The 2017 Review indicates that Merritt Hawkins now conducts 55 percent of its search assignments in communities of 100,000 people or more, suggesting that healthcare facilities in large communities also may have difficulty recruiting physicians.

While demand for physicians in smaller communities has not diminished, it is being outpaced in some cases by demand

for doctors in larger areas. This makes rural physician recruitment even more challenging, as urban areas now offer physicians higher salaries and even loan forgiveness, undercutting two traditional recruiting advantages of rural areas.

Merritt Hawkins worked for clients in all 50 states and the District of Columbia and Canada during the Review period, underlying the national presence of physician recruiting needs and challenges.

SALARIES AND CONTRACT STRUCTURES

Merritt Hawkins' annual *Review of Physician and Advanced Practitioner Recruiting Incentives* tracks the starting salaries or income guarantees being offered to recruit physicians, as well as other recruiting incentives typically offered to doctors and advanced practitioners.

Average starting salary and income guarantee numbers represent the base only and are not inclusive of production 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, including production bonuses.

Merritt Hawkins' salary and income guarantee ranges are therefore indicators of the financial incentives needed to attract physicians already established in a practice or those coming out of residency training to a particular 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 in particular specialties, that is a strong indicator that demand in those specialties is particularly high (the opposite also is true). It therefore can be useful to use Merritt Hawkins' surveys in tandem with surveys tracking total physician earnings when developing physician compensation packages.

It also should be noted that in today's market the salary amount is just one metric to consider – it also is important to consider how salaries are structured.

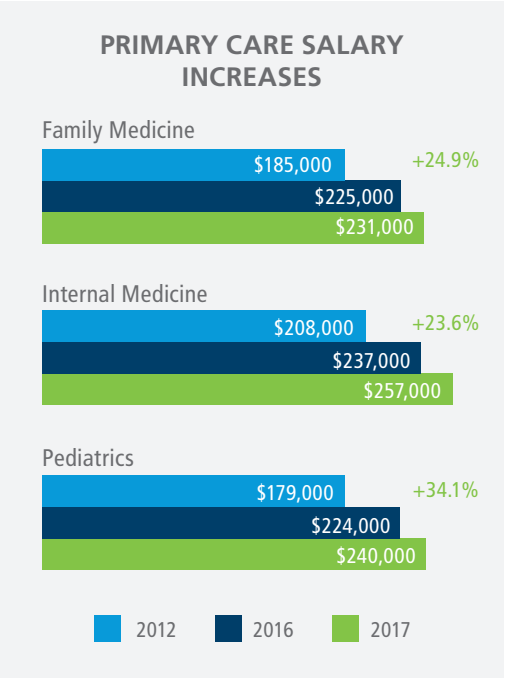
SALARIES IN PRIMARY CARE CONTINUE UPWARD

Average starting salaries for family medicine physicians as tracked by Merritt Hawkins' Review exceeded $200,000 for the first time in 2016, climbing to $225,000 from $199,000 in 2015. The average in the 2017 Review further increased to $231,000.

The chart on the following page shows increases in primary care starting salaries as tracked by the 2017 Review.

As referenced earlier in this report, primary care physicians are the key to implementing population health management and to establishing the patient-centered model of care, featuring a focus on prevention, education, and the appropriate use of resources within finite budgets. In the patient-centered medical home model and

other value-based models, primary care physicians receive additional compensation based on their role as care managers and care coordinators. These models are intended to enhance compensation for primary care physicians, acknowledging their expanded role, and to bring their compensation levels closer to that of specialists.



However, it is difficult to say, what, if any, effect the proliferation of these models has had in the increases seen in primary care salaries as tracked by the 2017 Review. What is clear is that competition for primary care physicians, caused in part by the need to implement new delivery models, has driven starting salaries up past traditional ceilings formerly seen in primary care.

For family physicians, in particular, salary increases can be tied to the increased demand created by the growing number of urgent care centers and retail clinics, which are competing with other traditional providers for the services of family doctors.

The migration of many general internists into hospitalist roles has limited the supply of physicians willing to practice traditional internal medicine and increased salary offers to those who are willing to do so. Internists continue to have a small volume of procedural work and chronic care duties, which also pushes up their compensation. Salary increases for pediatricians may be driven in part by the types of organizations now recruiting them, which have evolved from smaller, single-specialty practices to hospitals and hospital systems that have the resources to offer more.

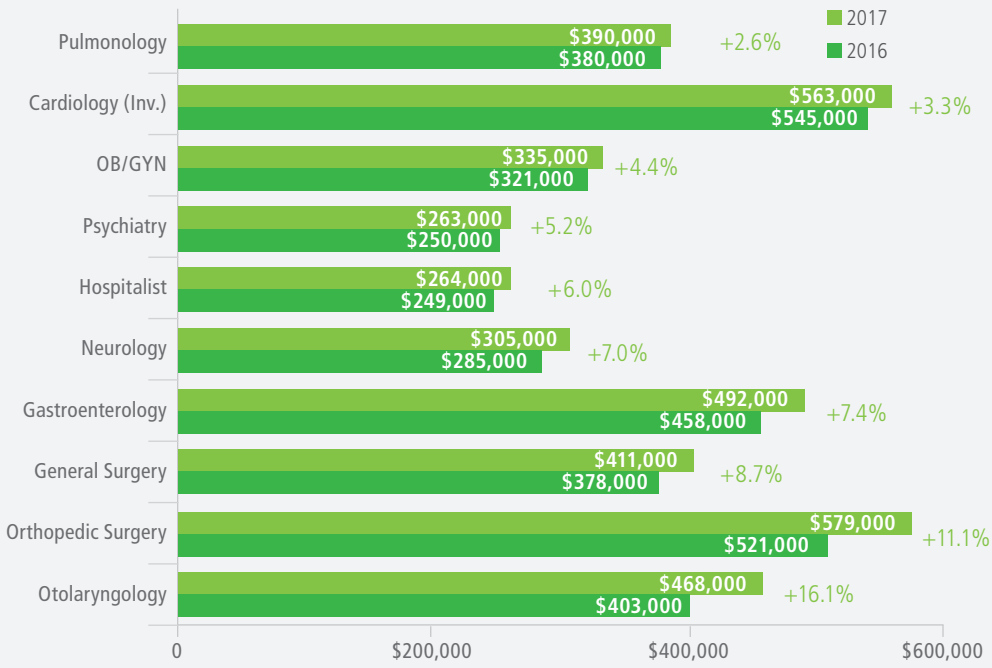
Given a system that still rewards procedures over consultation, growth in primary care salaries may be reaching its ceiling. However, large health systems that depend on primary care doctors and have the resources to increase salaries beyond those of traditional small group practices continue to push compensation upward.

SPECIALISTS ALSO SEE GAINS

As referenced above, demand for specialists is being driven by population aging and other factors. Rising demand has led to a corresponding rise in salary offers to some specialists, the 2017 Review indicates (see following chart)

Salary increases in psychiatry, pulmonology, neurology, OB/GYN, and orthopedic surgery can be tied to increases in demand for these types of physicians, as addressed earlier in this Review. Notable salary increases for other specialties listed above also are, in general, a response to the growing imbalance between the supply of specialty physicians and demand for their services.

SPECIALTIES SEEING YEAR OVER YEAR SALARY INCREASES



In addition, specialists continue to be high revenue-generators in a system that remains largely volume-driven. Given these factors, rising salaries for specialists are to be expected, even though concerted efforts are being made to tilt the healthcare system toward prevention, value, and the reduction of the medical tests and procedures typically conducted by specialists.

SALARIES FOR PAs AND NPs

Average salaries for NPs increased year over year, from $117,000 in the 2016 Review to $123,000 in 2017, an increase of 5%. The number of searches Merritt Hawkins conducted for NPs has increased dramatically over the last several years. It is anticipated that demand for NPs will continue given their role in team-based health and given the continued physician shortage.

Average salaries for PAs increased from $114,000 as tracked in the 2016 Review to $120,000 in 2017. In the *2016 Survey of PA Recruiting and Employment Trends* that Merritt Hawkins conducted in tandem with the American Academy of Physician Assistants, 90 percent of hospitals indicated they employ PAs, 60 percent are actively recruiting them, and 58 percent say that PAs at their facilities will take on expanded roles.

The majority of NP and PA searches Merritt Hawkins conducts are for primary care roles, with salary increases demonstrating the perceived value of these roles.

As referenced above, many sites of service, including urgent care centers, retail clinics and FQHCs, all of which are expanding aggressively, are recruiting PAs and NPs, boosting average salaries past the six-figure mark.

SALARIES BY REGION AND TYPE OF SETTING

The 2017 Review breaks out for the second year average starting salaries by region for Merritt Hawkins' top five most requested specialties, including family practice, psychiatry, internal medicine, nurse practitioner, and OB/GYN. The 2017 Review indicates that physician salaries tend to be lowest in the Northeast and highest in the Midwest and Southeast. The Midwest is generally considered to have comparatively high third party reimbursement and a comparatively large number of productive, independent physicians.

A high ratio of physicians per capita in the Northeast creates competition, suppressing salaries, as does a relatively high prevalence of managed care/capitated compensation plans, while a higher ratio of fee-for-service and a lower ratio of physicians per capita create higher salaries in the Midwest and Southeast.

The 2017 Review also tracks for the second year starting physician salaries in Merritt Hawkins' top five most recruited specialties by search setting, including hospital, medical group, academic, community health center and solo settings. Academic institutions and community health centers typically offer less than hospitals and medical groups based on budget and policy restrictions that limit what they may be able to offer.

QUALITY/VALUE-BASED INCENTIVES ADVANCE

In order to evolve away from a fee-for-volume system, ACOs, hospitals, medical groups, and other organizations are striving to create physician payment models 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.

At the same time, facilities that employ physicians want to ensure that they stay productive, and "productivity" still is measured by what are essentially fee-for-service metrics, including relative value units (RVUs), net collections and number of patients seen.

FINDING THE "GOLDILOCK'S ZONE"

The goal is to find the "Goldilock's zone" – physician payment models that encourage physicians to see the patients and generate the revenue that healthcare facilities still need, but that also reward doctors for adopting the behaviors and practices that will drive reimbursement in emerging value-based payment models.

For physicians, these models include the Medicare payment formula that replaced the sustainable growth rate (SGR) formula put into effect by the Medicare and CHIP Reauthorization Act (MACRA). MACRA mandates two ways for physicians to participate in Medicare's new payment formula, now referred to as the Quality Payment Program (QPP):

1. MIPS - Physicians can join the Merit-Based Incentive Payment System (MIPS) which combines three old incentive programs into one and gives doctors a quality score. If their scores are high, their Medicare reimbursement will go up. If they are low, they will be subject to reimbursement cuts. MIPS will rate physicians in four categories: quality of care, EHR meaningful use, use of healthcare resources, and activities undertaken to improve clinical practice.

2. APMs - Physicians also can elect to be part of an Alternative Payment Model (APM). APMs include ACOs, bundled payment programs, and patient centered medical homes (see Merritt Hawkins' white paper, *Physician and Hospital Reimbursement, From Lodge Medicine to MIPS* for an in-depth examination of changing physician compensation models).

A MIXED MESSAGE ON QUALITY

Merritt Hawkins' 2017 Review provides an indication of the extent to which physicians currently are compensated based on quality metrics. Seventy-two percent of searches tracked in the 2017 Review feature a salary with a production bonus, while the remaining 28% feature a straight salary, income guarantee or other arrangement. The great majority of hospitals and medical groups offer physicians the salary plus production bonus formula, while FQHCs and academic centers are more likely to offer straight salaries.

Of the 72 percent of searches offering a production bonus, 39 percent feature a bonus that was based in whole or in part on quality metrics such as patient satisfaction, adherence to treatment protocols, etc. This is up from 32 percent in 2016 and up from 23 percent in 2015.

The 2017 Review further indicates that the average amount of the bonus tied to quality was 21 percent, down from 29 percent in 2016. In the hypothetical case of a family physician earning a salary of $231,000 and achieving a $50,000 bonus, 21 percent of the bonus amount ($10,500) would be based on quality, equating to about four percent of the physician's total income ($281,000). This amount may not be sufficient to influence physician behaviors so that they fully embrace patient satisfaction scores, EHR meaningful use, and the other hallmarks of value-based payments. In the *2016 Survey of America's Physicians* that Merrit Hawkins conducted for the Physicians Foundation, only 43% of physicians indicated that any of their compensation was tied to value/quality. Of these, over 51% said value/quality payments comprised 10% or less of their total compensation.

Many healthcare systems are struggling with value-based reimbursement models and recently Geisinger Health, known as a pioneer in quality payments, abandoned tying compensation to directly to quality and moved their physicians to the straight salary model.

A volume-based metric (RVUs) was still the predominant metric used to calculate physician production bonuses in the 2017 Review, used in 52 percent of searches where production bonuses were featured, down from 58 percent in 2016. Other volume based metrics, such as net collections and number of patients seen, also continue to be used to determine production bonus amounts, suggesting that physician compensation metrics remain in a hybrid state poised between volume and value.

SIGNING BONUSES AND CME

Signing bonuses were offered in 76 percent of the recruiting assignments Merritt Hawkins conducted in 2017, down from 77 percent the previous year. Signing bonuses remain a standard recruiting incentive among hospitals and medical groups, though they typically are not part of incentive packages offered by AMCs, direct pay/concierge, Indian Health and other settings.

Signing bonuses offered to physicians in 2017 averaged $32,636, up from $26,889 in 2016. Signing bonuses offered to NPs and PAs averaged $8,576 down from $10,340 in 2016.

Certain other incentives, such as paid relocation, paid CME, health insurance and malpractice insurance are standard in the majority of Merritt Hawkins' physician search assignments. The average relocation allowance offered to physicians in 2017 was $10,072 compared to $10,226 in 2016, while the average CME allowance offered to physicians in 2017 was $3,613 compared to $3,633 in 2016.

The average relocation allowance offered to NPs and PAs was $8,063 in 2017, compared to $8,649 in 2016, while the average CME allowance was $2,126 compared to $2,140 in 2016.

Twenty-five percent of Merritt Hawkins' 2017 search assignments featured medical education loan forgiveness, compared to 26 percent in 2016. Educational loan forgiveness 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.

The term of educational loan forgiveness in 72 percent of searches in the 2017 Review was three years. Twenty-three percent of searches offered a two-year term, and five percent offered a one year term. The average amount of loan forgiveness offered to physicians was $80,923. The average amount of loan forgiveness offered to NPs and PAs was $56,442.

Conclusion

Merritt Hawkins' *2017 Review of Physician and Advanced Practitioner Recruiting Incentives* indicates that demand for primary care physicians remains particularly strong, as primary care doctors are seen as the keys to achieving quality and cost objectives necessary under emerging team and value-based delivery models.

For the second time in the 24 years Merritt Hawkins has conducted the Review, psychiatry ranked second among our top 20 most requested searches, underscoring the accelerating access crisis in this specialty.

Year-over-year increases in average salary offers tracked in the 2017 Review for primary care physicians and a variety of specialist demonstrate the continued shortage of physicians in virtually all major specialties.

In addition, demand for physicians is not localized to rural areas, as underlined by the fact Merritt Hawkins conducted 55 percent of its searches in the last year in communities of 100,000 or more.

Signaling the emergence of team-based care, the 2017 Review indicates that demand remains strong for non-physician clinicians such as NPs and PAs, who combined represented Merritt Hawkins' third most requested search in the previous year. In a clear indication that the "convenient care" movement is accelerating, physicians practicing in urgent care settings represented Merritt Hawkins' twelfth most requested search in the 2017 Review.

The 2017 Review indicates that employment remains the standard model for facilities recruiting physicians, with over 90% of Merritt Hawkins' searches featuring an employed setting. The Review also suggests physician compensation is moving toward value-based metrics, but is still predominantly volume-based.

While hospitals remain a key driver of physician recruitment, other settings, such as physician-owned medical groups, FQHCs, academic medical centers, and urgent care centers have increased their recruiting activities, creating a more diverse market for physicians.

As noted above, the general direction of the healthcare system remains uncertain, but demand for physicians appears to be an underlying constant.

For additional information about Merritt Hawkins' thought leadership resources and services, contact:

MERRITT HAWKINS
an AMN Healthcare company

Merritt Hawkins / Corporate
8840 Cypress Waters Blvd. #300
Dallas, Texas 75019
(800) 876-0500

Merritt Hawkins / Eastern Regional Office
100 Mansell Ct, E, Ste 500
Roswell, GA 30076
(800) 306-1330

24TH EDITION

An Overview of the Salaries, Bonuses, and Other Incentives Customarily Used to Recruit Physicians, Physician Assistants and Nurse Practitioners

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