Compensating Physicians for Graduate Medical Education Services

A growing and aging population is increasing the gap between physician demand and supply in the United States. A recent study published by the Association of American Medical Colleges ("AAMC") indicates there will be a shortage of between 37,800 and 124,000 physicians by 2034. While some of the increased demand for healthcare services can be met by increasing utilization of nurse practitioners, physician assistants, and other advanced practice clinicians, expanding the output of graduate medical education ("GME") programs will also be key to reducing the shortage.

GME refers to the period of training in a particular medical specialty (residency) or subspecialty (fellowship) following medical school. Residents and fellows undergoing GME typically require some form of oversight and proctoring by board-certified physicians. The physicians who supervise and train these students dedicate significant time and energy to the GME programs. However, determining how to compensate physicians for these supervision and teaching services can be a difficult exercise, as physicians are often able to bill and collect, generate compensated work RVUs ("WRVUs"), or log hours towards their clinical compensation model while simultaneously teaching residents and fellows. The following section describes various ways of compensating physicians participating in GME programs.

Resident/Fellow Teaching Compensation Methodologies

Hourly Rate Method

One common method of compensating physicians that provide teaching services to residents or fellows in GME programs is via hourly rates. Hourly rates for GME teaching services are often bifurcated into two categories: 1) didactic/administrative hourly rates and 2) direct supervision hourly rates.

Didactic/Administrative Hourly Rates

Didactic/administrative hourly rates are typically paid for hours of teaching/GME administrative time when the physician is not simultaneously seeing patients and generating collections, WRVU credit, or other clinical compensation sources. These hours are often related to teaching time before and after clinic, resident and fellow recruiting, evaluation, program planning, lectures, case discussions, simulations, and general meetings. For administrative / didactic hours, a fully loaded fair market value ("FMV") hourly rate commensurate with the physician's medical specialty can typically be paid, under the assumption the physician is not generating any other compensation during this time.

Direct Supervision Hourly Rates

Conversely, direct supervision hourly rates are typically paid for hours during which the physician is being shadowed by residents / fellows while simultaneously providing patient care. When supervising physicians round, perform procedures, or treat patients in a clinical setting, they may already be generating clinical compensation via professional collections, WRVU credit, time-based

salary, etc. during the teaching time. As such, paying the supervising physician a full didactic/administrative hourly rate for the shadowing time could be interpreted as a double payment for the same hour of services. However, paying the supervising physicians an adjusted incremental hourly rate for the shadowing time may still be appropriate, as pausing to explain concepts to the shadowing students while simultaneously providing patient care may cause a lag in clinical productivity, resulting in the supervising physicians generating fewer collections or WRVU-based compensation than they would when not being shadowed. For example, if the supervision of residents/fellows causes a 20% productivity lag for the proctoring physician during direct supervision hours, the physician could be paid 20% of a fully-loaded teaching rate for the shadowing hours to account for the lost productivity/clinical compensation the proctoring physician incurs when being shadowed by residents or fellows.

While productivity lags are often observed during direct supervision time, every GME situation is unique. In determining compensation for direct supervision hours, an analysis should be conducted to determine if a productivity lag exists, as in some cases, more experienced residents or fellows could actually increase the productivity of the supervising physician if they are able to perform tasks independently and increase efficiency.

WRVU Credit Method

As an alternative to the hourly rate method, VMG has observed hospitals increasing compensated physician WRVUs generated during direct supervision by the productivity lag percentage. In other words, if a physician independently produces 24 WRVUs per shift, and only 20 WRVUs per shift while being shadowed, the hospital could apply a 20% increase to WRVUs produced during a direct supervision shift to assign the proctoring physician credit for the estimated lost productivity incurred due to the teaching services provided.

Stipend Per Full-Time Resident/Fellow Proctored Method

Under this compensation method, the physicians are paid a flat monthly or annual teaching rate for direct supervision services (and sometimes for didactic / administrative services) based on the number of resident or fellow FTEs for which the Physician is directly responsible. This method is often the easiest to administer but presents unique challenges in developing a fixed FMV rate without an assumption of the monthly physician teaching hours provided per resident FTE or the productivity lag (or lack thereof) for physicians who are also paid on WRVUs.

Conclusion

Compensating physicians for GME services continues to be a hot topic for hospitals and health systems. While there are multiple ways to structure physician compensation payments for GME services, it is important to ensure the compensation structure and amounts are consistent with FMV, commercially reasonable, and do not overlap with any other payments.

Sources

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2. Accreditation Council for Graduate Medical Education.

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