

The Economic Impact of Physicians in the District of Columbia

State Report

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Table of Contents

Executive Summary	3
Economic Impact Analyses	6
Economic Impact for the District of Columbia	10
Output	10
Jobs	10
Wages and Benefits	10
Taxes	11
Broad Specialty	11
10 Specialties	12
Comparator Industry Analysis	14
Output	14
Jobs	14
Wages and Benefits	15
Appendix. Methodological Overview	16
1.1 2015 AMA Masterfile	17
1.2 2015 Medical Practices Data	19
1.3 2015 IMPLAN	32
1.4 Data Analysis	34

Executive Summary

Physicians are a critical component of the health care system, providing care to patients across a variety of settings and within a multitude of specialties and subspecialties. Through the care provided to their patients, physicians can have a positive and lasting impact on the health of their patients and the community as a whole. However, the breadth of a physician’s impact reaches far beyond just the provision of patient care. Physicians also play a vital role in the state and local economies by creating jobs, purchasing goods and services, and supporting state and community public programs through generated tax revenues.

This report focuses on physicians, both doctors of medicine (MDs) and osteopathy (DOs), who are primarily engaged in the practice of medicine (i.e., patient care activities as compared to those who focus on research or teaching). Physicians work in a wide range of practice types/sizes: private or group practices in offices and clinics or within a hospital. A recent American Medical Association (AMA) survey of physicians found that in 2016, the single specialty group accounted for the largest share of physicians (42.8%), while 24.6% practiced in multi-specialty groups, 16.5% were in solo practice and 7.4% were direct hospital employees.¹ Movement toward hospital-owned practices and employment directly by a hospital appears to have slowed since 2014 and the percentage of physicians who either worked in a practice with at least some hospital ownership or were direct hospital employees was 32.8% in both 2014 and 2016. With this in mind, this report focuses on all patient care physicians, regardless of whether they are office- or hospital-based.

Given the rapidly changing health care environment, it is critical to quantify the economic impact physicians have on society. This report provides data that can be used by key health care policymakers, legislators and thought leaders. It also demonstrates how physician practices both ensure the health and well-being of communities as well as support local economies and enable jobs, growth and prosperity.

¹ Kane KC. Updated Data on Physician Practice Arrangements: Physician Ownership Drops Below 50 Percent. Accessed at: <https://www.ama-assn.org/sites/default/files/media-browser/public/health-policy/PRP-2016-physician-benchmark-survey.pdf>.

This report provides estimates of the total economic impact of patient care physicians on the economy of the District of Columbia, across four vital economic barometers:

- Output,
- Jobs,
- Wages and benefits, and
- State and local tax revenue.

Total economic impact = direct + indirect economic impacts. The direct impact is the value of the four vital economic barometers that are produced from physicians while indirect impact includes the same barometers which are generated by the industries that are supported by physicians.

In addition, this report examines the economic impact across three broad specialty groups (i.e., primary care, non-surgical and surgical) as well as 10 specialties selected based on frequency and data availability (i.e., anesthesiology, cardiology, family medicine, general surgery, internal medicine, obstetrics/gynecology, orthopaedic surgery, pediatrics, psychiatry and urology).² Furthermore, this report provides the economic impact of select comparator industries (i.e., higher education, nursing and community care facilities, legal services and home health), in order to allow for an assessment of the economic impact of patient care physicians relative to these select industries.

Physician economic impact varies across states and is dependent upon the number of physicians in each state as well as other factors, such as the general economy and the health care environment in particular. As of December 2015, there were 736,873 patient care physicians within the 50 states and the District of Columbia.³

Of these, 4,528 physicians practiced in the District of Columbia.

² Section 1.2 of the Appendix provides more details on how these 10 specialties were selected.

³ This count is based on AMA Masterfile data as of December 2015. Based on that data, there were 1,022,483 post-residency MD and DO physicians with a preferred mailing address in one of the 50 states and the District of Columbia. We identified 755,802 physicians as providing patient care and an additional 57,696 as having an unknown type of professional activity (the remainder were either no longer active, or were engaged in other activities such as research or teaching). We imputed professional activity for those physicians for whom it was missing. Through this methodology an additional 36,887 physicians were identified as providing patient care, yielding a total number of 792,689. Of these, 55,816 had a missing state for their office and were excluded from the final analysis. For further detail on methods, see the Appendix.

The overall findings in the District of Columbia are as follows:

- **Total Output:** In the District of Columbia, physicians created a total of \$8.0B in direct and indirect economic output (i.e., sales revenues) in 2015. On average, each physician supported \$1,758,834 in output.
- **Jobs:** In 2015, physicians supported 34,349 jobs (including their own), the total of direct and indirect positions. On average, each physician supported 7.59 jobs.
- **Wages and Benefits:** Physicians contributed \$4,406.0M in direct and indirect wages and benefits for all supported jobs in 2015. On average, each physician supported \$973,050 in total wages and benefits.
- **Tax Revenues:** Physicians supported \$210.3M in local and state tax revenues in 2015. On average, each physician supported \$46,440 in local and state tax revenues.

Economic Impact Analyses

Economic impact analyses (EIAs) track the reach of revenues, jobs, spending and taxes generated by an activity as they flow through the local economy. EIAs incorporate both direct and indirect benefits.

Direct Benefits

Direct benefits, in the context of the patient care physician “industry”, include: 1) medical revenues generated in the course of patient care (i.e., the value of output); 2) jobs created by the physician industry; 3) wages and benefits of physicians and employees who are hired to support the delivery of patient care; and 4) taxes that are paid by physicians and the positions that they create.

Indirect Benefits

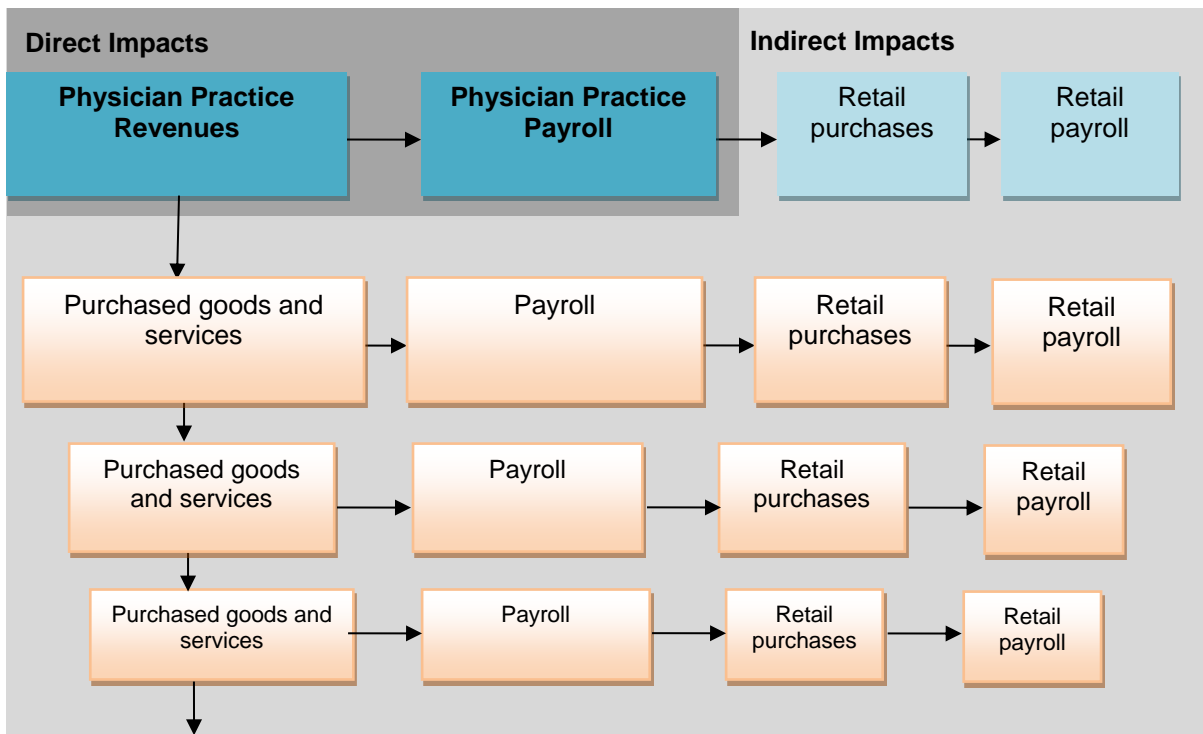
Economic activities supported by patient care physicians outside of their own industry represent the **indirect** benefits. These *business-to-business* effects include the supplies/equipment purchased by physicians, practice administrative services, cleaning/property maintenance services, and clinical and laboratory services.

Induced Benefits

Additional indirect benefits (i.e., induced effects)⁴ arise when the employees of physicians and vendors, in turn, spend their earnings to support local businesses, which pay their employees and pay taxes (see **Figure 1**). With each cycle of spending there is some “leakage” (i.e., some spending goes outside the community, perhaps to a neighboring state, and, as a result, generates no additional local value). This leakage is not captured in the state-level analysis; however, it is captured in the national-level analysis (see the National Economic Impact of Physicians report).

⁴ Induced effects are included as a portion of “indirect” effects for brevity.

Figure 1. Economic Multipliers



Economic Impact Multipliers

Both the indirect and direct effects contribute to the “multiplier” used in an EIA. For patient care physicians, the total community impact is a *multiple* of the economic benefit that is generated directly from patient care activities. The multiplier reflects the number of times that each dollar generated in patient care activities circulates through the local economy, supporting local jobs and spending (as described earlier). There are separate multipliers for three of the four vital **direct benefit** economic barometers mentioned earlier.

- An **output multiplier** is used to calculate the total value (i.e., direct and indirect) of output created by an industry. Its value indicates the total economic output generated in an economy for every \$1 in direct output.
- A **jobs multiplier** is used to calculate the indirect number of full-time equivalent jobs supported for every \$1M in direct output created by an industry. The sum of direct and indirect jobs is the total number of full-time equivalent jobs supported by an industry.

- A **wages and benefits** multiplier is used to calculate the indirect wages and benefits supported for every \$1 in direct output. The sum of direct and indirect wages and benefits is the total wages and benefits supported by an industry.

Multipliers are specific to geographic areas and particular industries and their values can vary widely. Multipliers are larger when a dollar earned by a business (e.g., a physician practice) is spent in the community, supporting jobs and other local businesses (who pay their employees, who in turn buy more goods and services, etc.). Multipliers are smaller when business revenues are spent (leaked) outside the community or are spent on goods or services that support fewer local jobs.

In general, multipliers for small community areas will be smaller compared to larger areas as establishments in smaller areas must often look outside of their immediate communities to find inputs. As health care is often considered to be local, health care multipliers tend to be higher than those for many other industries as physicians and their staff tend to live in the community and their services support the local community.

The multipliers for the District of Columbia are as follows:

- Output multiplier: 1.411, indicating an additional \$0.41 of indirect output is generated for every \$1 in direct output (see the Appendix for a discussion of the observed changes in output multipliers from 2011 to 2015).
- Jobs multiplier: 2.267, indicating an additional 2.27 indirect full-time jobs are supported for every \$1M in direct output.
- Wages and benefits multiplier: 0.187, indicating an additional \$0.19 of indirect wages and benefits is generated for every \$1 in direct output.

Data Sources

This study employed three primary data sources: the 2015 AMA Masterfile, 2015 medical practices data from a leading data aggregator, and 2015 IMPact analysis for PLANning (IMPLAN). The AMA Masterfile's number of physicians by state was combined with national per-physician revenue and cost data (which was geographically adjusted by state) and IMPLAN's economic impact multipliers by state, to estimate values for the direct, indirect and total economic impact of the physician industry. See **Figure 2** for an overview of methods and the Appendix for specific methodology.

Figure 2. Overview of Methods



Economic Impact for the District of Columbia

Table 1 provides a snapshot of the economic impact of patient care physicians in the District of Columbia. Direct and indirect economic benefits for each measure contribute to the overall benefit. Total output, jobs, and wages and benefits are also presented by broad physician specialty (**Table 2**), as well as for 10 specialties (**Table 3**).

Table 1: Total Output, Jobs, Wages & Benefits, and State and Local Taxes Supported by Physicians in the District of Columbia, 2015

Economic Measure	Total	Per Physician
Number of Physicians	4,528	-
Output	\$8.0 billion	\$1,758,834
Jobs	34,349	7.59
Wages & Benefits	\$4,406.0 million	\$973,050
State and Local Taxes	\$210.3 million	\$46,440

Output

Physicians generated \$5,644.8M in direct output. The total output of patient care physicians sums the direct and indirect output generated by the industry. Physicians generated \$8.0B in total output, or an average of \$1,758,834 per physician.

Jobs

A total of 4,528 patient care physicians were practicing in the District of Columbia as of December 2015. The number of jobs directly created by patient care physicians (including the number of physicians themselves) in the state was 21,550. The total number of jobs supported by patient care physicians in the District of Columbia was 34,349; the average physician supported 7.59 jobs in the economy, including his or her own.

Wages and Benefits

Compensation (i.e., the wages and benefits that are paid to local residents) is also an important measure of an industry's value to the local economy.⁵ The value of direct wages and benefits in the District of Columbia includes compensation paid to physicians and non-physician staff who are on payroll. This direct amount of wages and benefits totaled to \$3,351.8M in the state in 2015. The total

⁵ For ease of reading, "wages and benefits" is used to mean salaries and wages plus other forms of compensation paid to employees. Values include wages and benefits to all support staff, non-physician practitioners and physicians.

amount of wages and benefits supported by patient care physicians in the District of Columbia was \$4,406.0M (including the indirect wages and benefits supported by the industry), or an average of \$973,050 per physician.

Taxes

The total tax contribution is computed by summing taxation on employee income, proprietor income, indirect business interactions, households, and corporations. Tax revenues are included from the patient care physician industry (direct) and from other affected industries (indirect). These are the “total” tax revenues supported by the industry.

The state and local taxes incorporated in this study include:

- **Social Insurance taxes:** the state portions of social insurance taxes, including both the employee and employer-paid portions (e.g., retirement plans, workers’ compensation, and temporary disability insurance);
- **Personal taxes:** state and local income taxes, gift and estate taxes, motor vehicle taxes/fees, fishing/hunting and other license fees, property taxes, personal property taxes, and other fines/fees or donations;
- **Business taxes:** corporate profits and dividends taxes; and
- **Indirect business taxes:** property taxes, sales taxes, motor vehicle licensing, severance taxes, non-tax payments (e.g., rents and royalties, special assessments, fines, settlements and donations), and other taxes (including business licenses, documentary and stamp taxes).⁶

The aggregate local and state taxes generated by patient care physicians in 2015 totaled \$210.3M, or an average of \$46,440 per physician.

Broad Specialty

Due to likely variation between specialties, we examined economic impacts across three broad specialty groups (primary care, non-surgical and surgical) (**Table 2**).

⁶ Olsen DC. Using Social Accounts to Estimate Tax Impacts. MIG, Inc. Available through IMPLAN.com. (Paper originally given at the Mid-Continent Regional Science Association Meetings in Minneapolis, MN; June 11, 1999).

There were 1,551 physicians classified under the broad specialty of primary care (representing 34.2% of all patient care physicians), 2,362 physicians classified under non-surgical (representing 52.2%), and 616 physicians classified under surgical (representing 13.6%).

In each state, either primary care physicians or non-surgical specialties generated the highest output, jobs, and wages and benefits. This was partly due to physicians most often belonging to one of those two broad specialties and, for the most part, output, jobs, and wages and benefits were highest among the broad specialty with the most physicians in a state. In each state, surgical specialties generated the lowest output, jobs, and wages and benefits related to a smaller number of surgical specialists relative to primary care physicians or non-surgical specialists. In the District of Columbia, total output across broad specialties ranged from \$1,195.9M for surgical to \$4,047.4M for non-surgical. Total jobs ranged from 4,793 for surgical to 17,024 for non-surgical. Total wages and benefits ranged from \$670.2M for surgical to \$2,194.8M for non-surgical.

Table 2: Total Economic Impact of Physicians in the District of Columbia, by Broad Specialty

Broad Specialty	Number of Physicians	Output (\$ in millions)	Jobs	Wages & Benefits (\$ in millions)
Primary care	1,551	\$2,720.7	12,532	\$1,541.0
Non-surgical	2,362	\$4,047.4	17,024	\$2,194.8
Surgical	616	\$1,195.9	4,793	\$670.2
Total	4,528	\$7,964.0	34,349	\$4,406.0

10 Specialties

Lastly, we examined the economic impacts for 10 specialties (**Table 3**). In the District of Columbia, the number of patient care physicians ranged from a low of 56 for urology to a high of 762 for internal medicine.

For the most part, state-level economic impacts were lowest among urologists and, in general, highest among family medicine and internal medicine specialists. One driver of this observation is specialty size. Those specialties often had the fewest and greatest numbers of physicians, respectively. In the District of Columbia, total output across the 10 specialties ranged from \$124.2M for urology to \$988.8M for internal medicine. Total jobs ranged from 479 for urology to 5,037 for internal medicine. Total wages and benefits ranged from \$67.6M for urology to \$556.4M for internal medicine.

Table 3: Total Economic Impact of Physicians in the District of Columbia, for 10 Select Specialties

Specific Specialty	Number of Physicians	Output (\$ in millions)	Jobs	Wages & Benefits (\$ in millions)
Anesthesiology	209	\$266.2	924	\$189.4
Cardiology	172	\$283.0	1,394	\$180.3
Family medicine	220	\$380.2	1,898	\$213.6
General surgery	242	\$267.0	1,274	\$189.7
Internal medicine	762	\$988.8	5,037	\$556.4
Obstetrics/Gynecology	216	\$359.0	1,660	\$211.4
Orthopaedic surgery	87	\$218.8	941	\$115.7
Pediatrics	685	\$905.7	4,812	\$491.5
Psychiatry	362	\$436.3	1,638	\$237.0
Urology	56	\$124.2	479	\$67.6

Comparator Industry Analysis

To help frame the relative economic impact of patient care physicians, we also assessed the economic impacts (output, jobs, and wages and benefits) of other industries both within and outside the health care industry:

1. Higher education (e.g., junior college, college, university, and professional schools),
2. Nursing and community care facilities,
3. Legal services, and
4. Home health.

IMPLAN was instrumental as it provides 2015 output, jobs, and wages and benefits data and multipliers for the following industries: junior colleges, colleges, universities, and professional schools (IMPLAN industry code 473), nursing and community care facilities (483), legal services (447), and home health care services (480).

Table 4: Comparator Industry Total Economic Impacts in the District of Columbia

Industry	Output (\$ in millions)	Jobs	Wages & Benefits (\$ in millions)
Physicians	\$7,964.0	34,349	\$4,406.0
Higher Education	\$4,694.3	34,693	\$2,294.5
Nursing/Community Care Facilities	\$441.3	4,663	\$245.4
Legal Services	\$16,108.0	50,694	\$7,292.7
Home Health	\$464.3	8,926	\$310.8

Output

Physicians generated a greater total output than the higher education, nursing and community care facilities, legal services and home health industries in each state. The only exception was the legal services industry within the District of Columbia, with a total output of \$16.1B compared to \$8.0B for physicians. In the District of Columbia, physicians supported \$7,964.0M in total output. Across comparator industries, total output ranged from \$441.3M for nursing facilities to \$16,108.0M for legal services.

Jobs

In most states, physicians supported more jobs than the higher education, nursing and community care facilities, legal services or home health industries. In the District of Columbia, the number of jobs supported by the legal services industry was the highest, while in North Dakota, the number of jobs

supported by the nursing and community care facilities industry was the highest. In the District of Columbia, physicians supported 34,349 total jobs. Across comparator industries, total jobs ranged from 4,663 for nursing facilities to 50,694 for legal services.

Wages and Benefits

Physicians supported higher total wages and benefits than all comparator industries across the states, with one exception—the legal services industry in the District of Columbia. This suggests that physicians compensate their employees well, which allows these employees to purchase services from other industries in the state, thereby stimulating their state’s economy. In the District of Columbia, physicians supported \$4,406.0M in wages and benefits. Across comparator industries, total wages and benefits ranged from \$245.4M for nursing facilities to \$7,292.7M for legal services.

Appendix. Methodological Overview

Three primary data sources were employed in this study: the 2015 AMA Masterfile, 2015 medical practices data from a leading data aggregator, and 2015 IMPLAN. The AMA Masterfile's number of physicians was combined with the per-physician revenue and cost data and IMPLAN's economic impact multipliers to estimate values for the direct, indirect and total economic impact of the physician industry.

AMA Masterfile

The AMA Masterfile contains current and historical data on all physicians, including members and non-members of the AMA and graduates of foreign medical schools who are in the United States (U.S.) and meet educational standards for recognition as physicians. It includes information on geographic location, as well as physician characteristics such as specialty and major professional activity. Masterfile data as of December 2015 was used for this analysis.

Medical Practices Data

The medical practices data aggregator provides national data on the financial characteristics of physician practices including total medical revenue and total payroll costs per full-time physician equivalent. Data are provided for a number of common specialties, as well as by three broad specialty types (primary care, surgical and non-surgical specialties). The data provides information to evaluate different aspects of medical practice performance and to help make policy decisions about medical practice operations. Data are provided for 2015.

IMPLAN

IMPLAN (IMpact analysis for PLANning) is the input-output economic impact modeling system developed by the Minnesota IMPLAN Group. IMPLAN is used to create models of economies allowing for in-depth examinations of economic impacts. The 2015 IMPLAN system estimates output, employment, and labor income multipliers for each industry, at the state and national level, as well as total tax revenues (state and local) generated using a Social Accounting System. Data are taken from a number of sources including the Bureau of Labor Statistics (BLS), the Bureau of Economic Analyses (BEA) and the U.S. Census Bureau.

1.1 2015 AMA Masterfile

The AMA Masterfile was used to estimate the number of post-residency physicians who provide patient care in each state, in aggregate and by specialty. Each record within the AMA Masterfile corresponds to one physician.

Patient care physicians

As of December 2015, 1,022,483 physicians (excluding residents) had a preferred mailing address in one of the 50 states/DC.

The AMA Masterfile categorizes physicians by major professional activity (MPA), a variable based on physician-provided data on present employment and type of practice (see **Table A-1**). In order to arrive at our final sample for analysis, we first limited the AMA Masterfile data to 755,802 (73.9%) physicians whose MPA is the provision of patient care. These physicians are the population of interest, inclusive of both office- and hospital-based physicians as well as locum tenens physicians. Another 57,696 (5.6%) were identified as “not classified” because the AMA had not received any recent information as to their type of practice and present employment.

Table A-1. 2015 AMA Masterfile Physicians by MPA Description

MPA	N	%
Office Based Practice	634,315	62.0%
Hospital Based Full-Time Physician Staff	119,994	11.7%
Locum Tenens	1,493	0.2%
Administration	13,813	1.4%
Inactive	164,553	16.1%
Medical Teaching	12,772	1.3%
Not Classified	57,696	5.6%
Other	4,773	0.5%
Research	13,074	1.3%
Total	1,022,483	100.0%

For the 57,696 (5.6%) physicians who did not provide any responses indicating whether or not they provide patient care on a regular basis, we imputed the physician’s MPA/the provision of patient care. We assume that a portion of these unclassified physicians provide patient care on a regular basis. Therefore, we would underestimate the portion of physicians providing patient care on a regular basis if we were to exclude all unclassified physicians, and we would overestimate the portion of physicians providing patient care on a regular basis if we were to include all of them. We estimated a binary logit

model using GLM parameterization to model the likelihood of providing patient care (as a binary outcome, either providing or not providing patient care).

After examining the variable response distribution between physicians providing patient care, not providing patient care and unclassified, we decided on a final set of independent variables for inclusion and examined co-linearity between potential variables. Our final model included the following categorical variables: 1) age group, 2) gender, 3) physician is or is not board certified, 4) MD or DO, 5) CBSA level of the preferred address (i.e., Metropolitan or Micropolitan), 6) physician does or does not have an NPI number, 7) physician does or does not have a DEA number, 8) primary specialty, 9) physician is or is not an International Medical Graduate and 10) state of the preferred address is or is not the same as the state of the office. In addition, the following interaction terms were included: 11) age (continuous) * broad specialty, and 12) gender * broad specialty. The resulting model had a C-statistic of 0.892. For the output of the model, we specified the creation of a dataset which included an assigned probability to each physician of whether that physician provides patient care based on his/her available data for the independent variables used in the model. Based on the observed ratio of patient care to non-patient care among physicians with non-missing MPA (78.3 to 21.7), we used this event rate as the predicted probability threshold and categorized physicians with a probability of greater or equal to .783 as providing patient care and physicians with a probability of less than .783 as not providing patient care.

Of the 57,696 physicians with unclassified MPA, 36,887 (63.9%) were imputed as providing patient care, yielding a total number of 792,689 physicians providing patient care. Non-missing state of office location was required for this analysis, as the state is the location of the economic activity. Our final sample consisted of 736,873 physicians with a non-missing state for their office location.

Region

Physicians were classified by state. The AMA Masterfile includes information on office location and preferred professional mailing address, which could be either home or office. Should a physician have an office in one state and reside in another, the office location variable was used because, as stated above, the office is the location of the economic activity.

Specialty

The AMA Masterfile contains physician-reported data on a physician's primary specialty. Using this, physicians were mapped to three broad specialty types (primary care, non-surgical and surgical specialties) based on grouping for these broad specialty types by the medical practices data aggregator (see **Table A-2**). Physicians with missing primary specialty within a state were prorated to

the three broad specialty types in proportion to the number of physicians known to be in those broad specialties in that state. Additionally, we examined economic impacts for 10 specialties for which data were available from the medical practices data aggregator (see **Table A-3**):

- 1) Anesthesiology
- 2) Cardiology
- 3) Family medicine
- 4) General surgery
- 5) Internal medicine
- 6) Obstetrics/Gynecology
- 7) Orthopaedic surgery
- 8) Pediatrics
- 9) Psychiatry
- 10) Urology

1.2 2015 Medical Practices Data

The medical practices data aggregator provides physician data at the national level. Reports may be obtained at either the single specialty or the multispecialty level. Data was used to estimate per-physician output (revenue), jobs, and wages and benefits for 2015, by specialty. Only data for single specialty physicians were included in this analysis.

Data are provided for overall practices as well as by legal ownership of a practice (physician owned, hospital/integrated delivery system [IDS] owned or other). There were observed differences in medical revenue between physician-owned and hospital-owned practices, related to accounting differences. For hospital-owned practices, medical revenue is underreported, as some practice revenue is accounted for as hospital revenue, particularly that for ancillary services. Therefore, we calculated a weighted average of medical revenue considering both physician-owned and imputed hospital-owned revenue (see the Variables subsection under this same section for more details). Because data are provided at the national level, output and wages and benefits were geographically adjusted to specific states.

Specialties

Practices that provide information to the medical practices data aggregator record the specialties of their member physicians. Those specialties are then mapped to three broad provider classification groupings: primary care, non-surgical specialist, and surgical specialist (see **Table A-2** for available single specialties and the single specialties that fall under the three broader groups).

Because physician specialty was used to link the medical practices data from a leading data aggregator with AMA data, specialty categories were cross-walked between the two datasets. While the Masterfile data offer flexibility in the creation of aggregate specialties from its 250+ specialty categories, the medical practices data aggregator software offers limited options with set definitions. The medical practices data aggregator specialties, therefore, were the limiting factor in our specialty-to-specialty match-up across files.

In this analysis, we used the high-level categorization of the three broad specialty categories: primary care, non-surgical and surgical specialties. This is a classification scheme defined by the medical practices data aggregator. We mapped AMA specialties to these three broad specialties. **Table A-2** shows which specialties the medical practices data aggregator included in the three broad categories, as well as the AMA primary specialties we allocated to each of the three in order to best match the medical practices data aggregator definitions.

Table A-2. 2015 AMA Masterfile and Medical Practices Data Aggregator Specialties, by Broad Specialty

Medical Practices Data Aggregator	AMA Masterfile
<i>Primary Care</i>	
Family Medicine (with OB)	Adolescent Medicine (Family Medicine)
Family Medicine (without OB)	Adolescent Medicine (Internal Medicine)
Family Medicine: Ambulatory only (no inpatient work)	Adolescent Medicine (Pediatrics)
Family Medicine: Sports Medicine	Family Medicine
Family Medicine: Urgent Care	General Practice
Geriatrics	Geriatric Medicine (Family Medicine)
Hospice/Palliative Care	Geriatric Medicine (Internal Medicine)
Hospitalist: Family Medicine	Gynecology
Hospitalist: Internal Medicine	Hospice & Palliative Medicine
Hospitalist: Ob/Gyn	Hospice & Palliative Medicine (Family Medicine)
Internal Medicine: General	Hospice & Palliative Medicine (Internal Medicine)
Internal Medicine: Ambulatory only (no inpatient work)	Hospice & Palliative Medicine (Obstetrics & Gynecology)
OB/GYN: General	Hospice & Palliative Medicine (Pediatrics)
OB/GYN: Gynecology (only)	Hospitalist

Pediatrics: General
 Pediatrics: Adolescent Medicine
 Pediatrics: Hospitalist
 Pediatrics: Hospitalist-Internal Medicine
 Pediatrics: Internal Medicine
 Pediatrics: Sports Medicine
 Pediatrics: Urgent Care
 Urgent Care

Internal Medicine
 Internal Medicine/Family Practice
 Internal Medicine/Pediatrics
 Obstetrics & Gynecology
 Palliative Medicine
 Pediatrics
 Sports Medicine (Family Medicine)
 Sports Medicine (Internal Medicine)
 Sports Medicine (Pediatrics)
 Urgent Care Medicine

Non-surgical

Allergy/Immunology
 Anesthesiology
 Bariatrics (Nonsurgical)
 Clinical Pharmacology
 Critical Care: Intensivist
 Dentistry
 Dermatology
 Emergency Medicine
 Endocrinology/Metabolism
 Gastroenterology
 Genetics
 Hematology/Oncology
 Hematology/Oncology: Oncology (only)
 Hyperbaric Medicine/Wound Care
 Infectious Disease
 Nephrology
 Neurology
 Occupational Medicine
 Orthopaedic (Nonsurgical)
 Pathology: Anatomic and Clinical
 Pathology: Anatomic
 Pathology: Clinical
 Physiatry (Physical Medicine and Rehabilitation)
 Podiatry: General
 Psychiatry: General
 Pulmonary Medicine: General
 Pulmonary Medicine: Critical Care
 Pulmonary Medicine: General and Critical Care
 Radiation Oncology
 Rheumatology
 Sleep Medicine
Nonsurgical Subspecialist
 Anesthesiology: Pain Management

Abdominal Radiology
 Addiction Medicine
 Addiction Psychiatry
 Adult Cardiothoracic Anesthesiology (Anesthesiology)
 Adult Congenital Heart Disease (Internal Medicine)
 Advanced Heart Failure and Transplant Cardiology (Internal Medicine)
 Aerospace Medicine
 Allergy
 Allergy and Immunology
 Anatomic Pathology
 Anatomic/Clinical Pathology
 Anesthesiology
 Anesthesiology Critical Care Medicine (Emergency Medicine)
 Blood Banking/Transfusion Medicine
 Brain Injury Medicine (Neurology)
 Brain Injury Medicine (Physical Medicine & Rehabilitation)
 Cardiothoracic Radiology
 Cardiovascular Disease
 Chemical Pathology
 Child & Adolescent Psychiatry
 Child Abuse Pediatrics
 Child Neurology
 Clinical & Laboratory Dermatological Immunology
 Clinical & Laboratory Immunology (Pediatrics)
 Clinical and Laboratory Immunology (Internal Medicine)
 Clinical Biochemical Genetics
 Clinical Cardiac Electrophysiology
 Clinical Cytogenetics
 Clinical Genetics
 Clinical Informatics (Pathology)
 Clinical Informatics (Preventive Medicine)
 Clinical Laboratory Immunology (Allergy & Immunology)
 Clinical Molecular Genetics

Cardiology: Electrophysiology
 Cardiology: Invasive
 Cardiology: Invasive-Interventional
 Cardiology: Noninvasive
 Dermatology: Dermatopathology
 Gastroenterology: Hepatology
 Neurology: Epilepsy/EEG
 Neurology: Neuromuscular
 Neurology: Stroke Medicine
 Ob/Gyn: Gynecological Oncology
 Ob/Gyn: Maternal and Fetal Medicine
 Ob/Gyn: Reproductive Endocrinology
 Ob/Gyn: Urogynecology
 Pain Management: Nonanesthesia
 Pathology: Anatomic-Autopsy
 Pathology: Anatomic-Cytopathology
 Pathology: Anatomic-Neuropathology
 Pathology: Anatomic-Renal
 Pathology: Clinical-Hematopathology
 Pathology: Clinical-Transfusion Medicine
 Pediatrics: Allergy/Immunology
 Pediatrics: Anesthesiology
 Pediatrics: Bone Marrow Transplant
 Pediatrics: Cardiology
 Pediatrics: Child Development
 Pediatrics: Clinical and Lab Immunology
 Pediatrics: Critical Care/Intensivist
 Pediatrics: Dermatology
 Pediatrics: Emergency Medicine
 Pediatrics: Endocrinology
 Pediatrics: Gastroenterology
 Pediatrics: Genetics
 Pediatrics: Hematology/Oncology
 Pediatrics: Infectious Disease
 Pediatrics: Neonatal Medicine
 Pediatrics: Nephrology
 Pediatrics: Neurology
 Pediatrics: Pulmonology
 Pediatrics: Radiology
 Pediatrics: Rheumatology
 Psychiatry: Child and Adolescent
 Psychiatry: Forensic
 Psychiatry: Geriatric
 Radiology: Interventional
 Radiology: Diagnostic

Clinical Neurophysiology
 Clinical Pathology
 Clinical Pharmacology
 Critical Care Medicine (Anesthesiology)
 Critical Care Medicine (Emergency Medicine)
 Critical Care Medicine (Internal Medicine)
 Critical Care Medicine (Obstetrics & Gynecology)
 Cytopathology
 Dermatology
 Dermatopathology (Pathology)
 Developmental-Behavioral Pediatrics
 Diabetes
 Diagnostic Radiology
 Emergency Medical Services
 Emergency Medicine
 Emergency Medicine/Family Medicine
 Endocrinology, Diabetes & Metabolism
 Epidemiology
 Epilepsy (Neurology)
 Family Medicine/Preventive Medicine
 Forensic Pathology
 Forensic Psychiatry
 Gastroenterology
 General Preventive Medicine
 Geriatric Psychiatry
 Gynecologic Oncology
 Hematology (Internal Medicine)
 Hematology (Pathology)
 Hematology/Medical Oncology
 Hepatology
 Hospice & Palliative Medicine (Anesthesiology)
 Hospice & Palliative Medicine (Emergency Medicine)
 Hospice & Palliative Medicine (Physical Medicine & Rehabilitation)
 Hospice & Palliative Medicine (Psychiatry & Neurology)
 Hospice & Palliative Medicine (Radiology)
 Immunology
 Infectious Disease
 Internal Med/Emergency Med/Critical Care Med
 Internal Med/Phys Med and Rehabilitation
 Internal Med/Psychiatry
 Internal Medicine/Anesthesiology
 Internal Medicine/Dermatology
 Internal Medicine/Emergency Medicine
 Internal Medicine/Medical Genetics
 Internal Medicine/Neurology

Radiology: Neurological
Radiology: Nuclear Medicine

Internal Medicine/Preventive Medicine
Interventional Cardiology
Legal Medicine
Maternal and Fetal Medicine
Medical Biochemical Genetics
Medical Genetics
Medical Management
Medical Microbiology
Medical Oncology
Medical Toxicology (Emergency Medicine)
Medical Toxicology (Pediatrics)
Medical Toxicology (Preventive Medicine)
Molecular Genetic Pathology (Medical Genetics)
Molecular Genetic Pathology (Pathology and Medical Genetics)
Musculoskeletal Oncology
Musculoskeletal Radiology
Neonatal-Perinatal Medicine
Nephrology
Neurodevelopmental Disabilities (Pediatrics)
Neurodevelopmental Disabilities (Psychiatry & Neurology)
Neurology
Neurology/Diagnostic Radiology/Neuroradiology
Neurology/Physical Medicine and Rehabilitation
Neuromuscular Medicine (Neurology)
Neuromuscular Medicine (Physical Medicine & Rehabilitation)
Neuropathology
Neuropsychiatry
Neuroradiology
Nuclear Cardiology
Nuclear Medicine
Nuclear Radiology
Nutrition
Obstetrics
Obstetric Anesthesiology (Anesthesiology)
Occupational Medicine
Osteopathic Manipulative Medicine
Pain Management
Pain Medicine
Pain Medicine (Anesthesiology)
Pain Medicine (Neurology)
Pain Medicine (Physical Medicine & Rehabilitation)
Pain Medicine (Psychiatry)
Pediatric Allergy
Pediatric Anesthesiology (Anesthesiology)
Pediatric Cardiology

Pediatric Critical Care Medicine
Pediatric Dermatology
Pediatric Emergency Med (Emergency Med)
Pediatric Emergency Medicine (Pediatrics)
Pediatric Endocrinology
Pediatric Gastroenterology
Pediatric Hematology-Oncology
Pediatric Infectious Disease
Pediatric Nephrology
Pediatric Pathology
Pediatric Pulmonology
Pediatric Radiology
Pediatric Rehabilitation Medicine
Pediatric Rheumatology
Pediatric Transplant Hepatology
Pediatrics/Anesthesiology
Pediatrics/Dermatology
Pediatrics/Emergency Medicine
Pediatrics/Medical Genetics
Pediatrics/Physical Medicine and Rehabilitation
Pediatrics/Psychiatry/Child & Adolescent Psychiatry
Pharmaceutical Medicine
Phlebology
Physical Medicine and Rehabilitation
Procedural Dermatology
Proctology
Psychiatry
Psychiatry/Family Medicine
Psychiatry/Neurology
Psychoanalysis
Psychosomatic Medicine
Public Health and General Preventive Medicine
Pulmonary & Critical Care Medicine
Pulmonary Disease
Radiation Oncology
Radiological Physics
Radiology
Reproductive Endocrinology and Infertility
Rheumatology
Selective Pathology
Sleep Medicine
Sleep Medicine (Internal Medicine)
Sleep Medicine (Otolaryngology)
Sleep Medicine (Pediatrics)
Sleep Medicine (Psychiatry & Neurology)

Spinal Cord Injury Medicine
 Sports Medicine (Emergency Medicine)
 Sports Medicine (Physical Medicine & Rehabilitation)
 Transplant Hepatology (Internal Medicine)
 Undersea & Hyperbaric Medicine (Emergency Medicine)
 Undersea & Hyperbaric Medicine (Preventive Medicine)
 Vascular and Interventional Radiology
 Vascular Medicine
 Vascular Neurology

Surgical

Ophthalmology
 Orthopaedic Surgery: General
 Otorhinolaryngology
 Surgery: General
 Urology
Surgical Subspecialist
 Dermatology: Mohs Surgery
 Ophthalmology: Corneal and Refractive Surgery
 Ophthalmology: Glaucoma
 Ophthalmology: Neurology
 Ophthalmology: Oculoplastic and Reconstructive Surgery
 Ophthalmology: Retina
 Orthopaedic Surgery: Foot and Ankle
 Orthopaedic Surgery: Hand
 Orthopaedic Surgery: Hip and Joint
 Orthopaedic Surgery: Oncology
 Orthopaedic Surgery: Shoulder/Elbow
 Orthopaedic Surgery: Spine
 Orthopaedic Surgery: Trauma
 Orthopaedic Surgery
 Pediatrics: Otorhinolaryngology
 Pediatrics: Surgery
 Pediatrics: Cardiovascular Surgery
 Pediatrics: Neurological Surgery
 Pediatrics: Plastic and Reconstruction Surgery
 Pediatrics: Urology
 Podiatry: Surgery-Foot and Ankle
 Podiatry: Surgery-Forefoot only
 Surgery: Bariatric
 Surgery: Breast
 Surgery: Cardiovascular
 Surgery: Colon and Rectal
 Surgery: Endovascular (Primary)
 Surgery: Neurological

Abdominal Surgery
 Adult Reconstructive Orthopaedics
 Colon and Rectal Surgery
 Complex General Surgical Oncology (Surgery)
 Congenital Cardiac Surgery (Thoracic Surgery)
 Cosmetic Surgery
 Craniofacial Surgery
 Dermatologic Surgery
 Endovascular Surgical Neuroradiology (Neurological Surgery)
 Endovascular Surgical Neuroradiology (Neurology)
 Endovascular Surgical Neuroradiology (Radiology)
 Facial Plastic Surgery
 Female Pelvic Medicine (Urology)
 Female Pelvic Medicine and Reconstructive Surgery (Obstetrics & Gynecology)
 Foot and Ankle Orthopaedics
 General Surgery
 Hand Surgery
 Hand Surgery (Orthopaedics)
 Hand Surgery (Plastic Surgery)
 Hand Surgery (Surgery)
 Head and Neck Surgery
 Hospice & Palliative Medicine (Surgery)
 Neurological Surgery
 Neurotology (Otolaryngology)
 Ophthalmic Plastic and Reconstructive Surgery (Ophthalmology)
 Ophthalmology
 Oral & Maxillofacial Surgery
 Orthopaedic Surgery
 Orthopaedic Surgery of the Spine
 Orthopaedic Trauma
 Otolaryngology
 Pediatric Cardiothoracic Surgery
 Pediatric Ophthalmology
 Pediatric Orthopaedics

Surgery: Oncology	Pediatric Otolaryngology
Surgery: Oral	Pediatric Surgery (Neurology)
Surgery: Plastic and Reconstruction	Pediatric Surgery (Surgery)
Surgery: Plastic and Reconstruction-Hand	Pediatric Urology
Surgery: Thoracic (Primary)	Plastic Surgery
Surgery: Transplant	Plastic Surgery within the Head & Neck
Surgery: Transplant-Heart	Plastic Surgery within the Head & Neck (Otolaryngology)
Surgery: Transplant-Heart/Lung	Plastic Surgery within the Head & Neck (Plastic Surgery)
Surgery: Transplant-Kidney	Sports Medicine (Orthopaedic Surgery)
Surgery: Transplant-Liver	Surgical Critical Care (Surgery)
Surgery: Trauma	Surgical Oncology
Surgery: Trauma-Burn	Thoracic Surgery
Surgery: Vascular (Primary)	Transplant Surgery
	Traumatic Surgery
	Urology
	Vascular Surgery

The second categorization of specialties was at a more granular level of detail than that of the three broad groups. The availability of data from the medical practices data aggregator is limited based on respondent count. We selected 10 specialties for which necessary data were available. **Table A-3** presents the full allocation of AMA primary specialties mapped to the single specialties of interest provided by the medical practices data aggregator. It is a limitation that there may be potentially differing subspecialties grouped under the selected specialties for AMA versus the medical practices data aggregator.

Table A-3. 2015 AMA Masterfile Specialties, by Specialties of Interest

Specialties of Interest
Anesthesiology
Adult Cardiothoracic Anesthesiology (Anesthesiology)
Anesthesiology
Anesthesiology Critical Care Medicine (Emergency Medicine)
Critical Care Medicine (Anesthesiology)
Hospice & Palliative Medicine (Anesthesiology)
Internal Medicine/Anesthesiology
Pain Management
Pain Medicine (Anesthesiology)
Cardiology
Advanced Heart Failure and Transplant Cardiology (Internal Medicine)
Cardiothoracic Radiology
Cardiovascular Disease
Clinical Cardiac Electrophysiology
Interventional Cardiology
Nuclear Cardiology
Pediatric Cardiology
Family Medicine
Adolescent Medicine (Family Medicine)
Emergency Medicine/Family Medicine
Family Medicine

Family Medicine/Preventive Medicine
 Geriatric Medicine (Family Medicine)
 Hospice & Palliative Medicine (Family Medicine)
 Internal Medicine/Family Practice
 Sports Medicine (Family Medicine)

General Surgery

Abdominal Surgery
 Colon and Rectal Surgery
 Complex General Surgical Oncology (Surgery)
 Craniofacial Surgery
 Dermatologic Surgery
 General Surgery
 Hand Surgery
 Hand Surgery (Surgery)
 Head and Neck Surgery
 Hospice & Palliative Medicine (Surgery)
 Oral & Maxillofacial Surgery
 Pediatric Surgery (Surgery)
 Surgical Critical Care (Surgery)
 Surgical Oncology
 Thoracic Surgery
 Transplant Surgery
 Traumatic Surgery
 Vascular Surgery

Internal Medicine

Adolescent Medicine (Internal Medicine)
 Adult Congenital Heart Disease (Internal Medicine)
 Clinical and Laboratory Immunology (Internal Medicine)
 Critical Care Medicine (Internal Medicine)
 Diabetes
 Geriatric Medicine (Internal Medicine)
 Hematology (Internal Medicine)
 Hepatology
 Hospice & Palliative Medicine (Internal Medicine)
 Internal Med/Emergency Med/Critical Care Med
 Internal Med/Phys Med and Rehabilitation
 Internal Medicine
 Internal Medicine/Dermatology
 Internal Medicine/Emergency Medicine
 Internal Medicine/Medical Genetics
 Internal Medicine/Neurology
 Internal Medicine/Preventive Medicine
 Medical Oncology
 Nutrition
 Sleep Medicine (Internal Medicine)
 Sports Medicine (Internal Medicine)
 Transplant Hepatology (Internal Medicine)

Obstetrics/Gynecology

Critical Care Medicine (Obstetrics & Gynecology)
 Female Pelvic Medicine and Reconstructive Surgery (Obstetrics & Gynecology)
 Gynecologic Oncology
 Gynecology
 Hospice & Palliative Medicine (Obstetrics & Gynecology)
 Maternal and Fetal Medicine
 Obstetric Anesthesiology (Anesthesiology)
 Obstetrics
 Obstetrics & Gynecology
 Reproductive Endocrinology and Infertility

Orthopaedic Surgery

Adult Reconstructive Orthopaedics
 Foot and Ankle Orthopaedics
 Hand Surgery (Orthopaedics)
 Musculoskeletal Oncology
 Orthopaedic Surgery
 Orthopaedic Surgery of the Spine
 Orthopaedic Trauma
 Osteopathic Manipulative Medicine
 Pediatric Orthopaedics
 Sports Medicine (Orthopaedic Surgery)

Pediatrics

Adolescent Medicine (Pediatrics)
 Child Abuse Pediatrics
 Child Neurology
 Clinical & Laboratory Immunology (Pediatrics)
 Developmental-Behavioral Pediatrics
 Hospice & Palliative Medicine (Pediatrics)
 Internal Medicine/Pediatrics
 Medical Toxicology (Pediatrics)
 Neonatal-Perinatal Medicine
 Neurodevelopmental Disabilities (Pediatrics)
 Pediatric Allergy
 Pediatric Anesthesiology (Anesthesiology)
 Pediatric Cardiothoracic Surgery
 Pediatric Critical Care Medicine
 Pediatric Dermatology
 Pediatric Emergency Medicine (Pediatrics)
 Pediatric Endocrinology
 Pediatric Gastroenterology
 Pediatric Hematology-Oncology
 Pediatric Infectious Disease
 Pediatric Nephrology
 Pediatric Ophthalmology
 Pediatric Otolaryngology
 Pediatric Pathology
 Pediatric Pulmonology
 Pediatric Radiology
 Pediatric Rehabilitation Medicine
 Pediatric Rheumatology
 Pediatric Transplant Hepatology
 Pediatrics
 Pediatrics/Anesthesiology
 Pediatrics/Dermatology
 Pediatrics/Emergency Medicine
 Pediatrics/Medical Genetics
 Pediatrics/Physical Medicine and Rehabilitation
 Sleep Medicine (Pediatrics)

Psychiatry

Addiction Psychiatry
 Child & Adolescent Psychiatry
 Forensic Psychiatry
 Geriatric Psychiatry
 Hospice & Palliative Medicine (Psychiatry & Neurology)
 Internal Med/Psychiatry
 Neurodevelopmental Disabilities (Psychiatry & Neurology)
 Neuropsychiatry
 Pain Medicine (Psychiatry)
 Pediatrics/Psychiatry/Child & Adolescent Psychiatry
 Psychiatry
 Psychiatry/Family Medicine
 Psychiatry/Neurology
 Psychoanalysis
 Psychosomatic Medicine
 Sleep Medicine (Psychiatry & Neurology)

Urology

Urology
 Pediatric Urology

Variables

Variables used for each of the broad and 10 specialties included data per physician on output, jobs and wages and benefits. We calculated the following for each of the three broad specialties and the 10 specialties:

- 1) **Medical revenue per physician.** The reported medical revenue from the medical practices data aggregator varies between physician-owned practices vs. hospital-owned practices. Medical revenue is underreported among hospital-owned practices due to accounting differences whereby some practice revenue is accounted for as hospital revenue. To address this, we separately assessed physician-owned practice medical revenue and hospital-owned practice medical revenue. We calculated the ratio of mean wages and benefits to mean revenue among physician-owned practices, assuming this ratio is the same as for hospital-owned practices. We made the assumption that compensation is the same for physician-owned vs. hospital-owned practices, assuming resources are mobile and substitutable between the two types of practices. This assumes that the average productivity of resources (proxied by compensation costs per revenue) is the same across similarly-scaled practices, independent of ownership. We then applied the inverse of this physician-owned practice ratio to hospital-owned practice mean wages and benefits in order to impute hospital-owned practice revenue. We used this imputed value of hospital-owned revenue in place of that reported by the medical practices data aggregator. Finally, we calculated a weighted average of mean physician-owned revenue and mean imputed hospital-owned revenue based on respondent Ns. Because practice revenues vary according to geographic variation in price levels and costs of services, we calculated estimates at the national level and adjusted medical revenue using weighted state values for Medicare's 2015 Geographic Adjustment Factor (GAF). The mean medical revenue in a state was calculated as the national weighted mean for medical revenue \times the weighted state Medicare GAF.

- 2) **Total jobs per physician** (sum of mean physician, non-physician provider and support staff FTEs). For the non-physician and support staff categories, the medical practices data aggregator reports means that are calculated based only on respondents that have staff in that category. The N shown for each mean reflects that. In particular, there was a much lower N for non-physician provider FTEs relative to support staff FTEs, as most reporting practices did not employ non-physician provider staff. For these two categories, we calculated adjusted mean jobs (inclusive of practices with no staff in that category) using the reported N for physician costs as the total N. In most cases, the reported N for physician costs was slightly

higher than the reported N for support staff FTEs. For the most part, this adjustment lowered the mean non-physician provider FTEs and slightly lowered the mean support staff FTEs.

- 3) **Total wages and benefits per physician** (sum of mean physician, non-physician provider and support staff cost). As with jobs, the mean non-physician provider costs and mean support staff costs per physician that are provided by the medical practices data aggregator are based only on respondents that have staff in that category. We calculated adjusted mean costs for these two categories in a similar fashion as for adjusted mean FTEs. For the most part, this adjustment lowered the mean non-physician provider cost and slightly lowered the mean support staff cost. Because wages and benefits spending varies by local wage levels, we calculated estimates at the national level and adjusted wages and benefits using weighted state values for Medicare's 2015 Wage Index. The mean per-physician wages and benefits in a state was calculated as the national mean for wages and benefits \times the weighted state wage index.

The mean was used for all variables reported by the medical practices data aggregator. However, means are sensitive to outliers and in cases where the mean was greater than the 90th percentile for a variable, the median was used. The median was used in place of the mean for nonsurgical support staff cost for all practices and hospital-owned practices, and for surgical nonphysician provider cost and support staff cost for all practices and hospital-owned practices.

All needed data points were available with the exception of: mean medical revenue, physician cost, non-physician cost and support staff cost for internal medicine and psychiatry physician-owned practices, mean non-physician cost for general surgery physician-owned practices, mean non-physician cost for anesthesiology and urology hospital-owned practices and mean support staff cost for hospital-owned anesthesiology practices. These data points were not reported (due to fewer than 10 practices of an individual specialty providing a response), but were necessary to calculate physician-owned revenue and imputed hospital-owned revenue. In these instances, we used the medical revenue or adjusted cost for the relevant broad specialty as a proxy.

Medical Practices Data Aggregator Geographic Limitation

Physician practice revenues and wages and benefits vary according to geographic variation in price levels and costs of services. However, the medical practices data aggregator does not provide data at the state level; therefore, we calculated specialty-specific estimates at the national level and geographically adjusted revenue and wages and benefits.

Medicare uses three Geographic Practice Cost Indices (GPCIs), physician work (PW), practice expense (PE) and malpractice (MP), weighted at approximately 51%, 45% and 4%, respectively, in 2015, to arrive at the GAF to adjust payments to physicians.⁷ Medicare calculates the three GPCIs for payment areas known as Medicare localities. Localities are states and sub-state regions. There are 89 Medicare payment localities which are defined by state boundaries (e.g., Wisconsin), metropolitan statistical areas (MSAs) (e.g., metropolitan St. Louis, MO), portions of an MSA (e.g., Manhattan), or rest-of-state areas that exclude metropolitan areas (e.g., rest of Missouri). Practice revenues were adjusted using Medicare's 2015 GAF. The 2015 GAF is available for January – March 2015 and April – December 2015. A weighted annual 2015 GAF was calculated. The weighted 2015 GAF was used when the locality is at the state level. For localities which are at the sub-state region level, a weighted GAF was calculated for the state based on the underlying county population. A county-level file with 2015 population from the U.S. Census Bureau was used, mapped to a file with the counties included in the 2015 localities from the Centers for Medicare and Medicaid Services (CMS).⁸

Because wages and benefits vary by geographic region, we adjusted national level wages and benefits spending by a state-level wage index incorporating both physician wages and clinical and administrative office staff wages. Medicare provides the 2015 Wage Index for core based statistical areas (CBSAs) for urban (MSAs) and rural areas.⁹ A weighted state-level wage index was calculated based on the underlying county population. The 2015 county-level population file was again utilized.

Medical Practices Data Aggregator Limitations

Limitations of the data reported by the medical practices data aggregator include: 1) bias towards larger practices, 2) differences by practice ownership (physician vs. hospital owned), 3) sensitivity to outliers and 4) availability only at the national level. We cannot adjust for the possible data bias towards larger practices. However, we attempted to minimize this bias by including data for all practices with fewer than three physicians instead of relying on the default setting which only provides data for practices with three or more physicians. We corrected for underreporting of revenue by hospital-owned practices by imputing the mean per-physician revenue in hospital-owned practices and using these imputed values rather than the reported means. Because means may be sensitive to outliers, in cases where the mean was greater than the 90th percentile for a variable, the median was used. We also

⁷ Addendum D Geographic Adjustment Factors (GAFs). CY 2015 PFS Final Rule Addenda. CMS-1612-FC. Available at: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1612-FC.html>.

⁸ United States Census Bureau. American Fact Finder. Available at: <https://factfinder.census.gov/bkmk/table/1.0/en/PEP/2015/PEPANNRES>.

⁹ FY 2015 Final Rule Wage Index Tables. FY 2015 Wage Index Home Page. Available at: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Wage-Index-Files-Items/FY-2015-Wage-Index-Home-Page.html?DLPage=1&DLEntries=10&DLSort=1&DLSortDir=descending>.

note that 2012 differed from other years in terms of reported physician-owned revenue, likely due to errors in reporting. For example, it appears that one large physician-owned practice underreported their revenue in 2012, resulting in a lower average value in 2012 compared to previous and following years. Geographic adjustment was used to address the limitation that data are only available at the national level.

1.3 2015 IMPLAN

IMPLAN data contain industry-based output, employment, and labor income multipliers, as well as tax data by state and at the national level.

Multipliers

Multipliers are specific to a state and to a particular industry. State-level and national 2015 multipliers for “Offices of physicians” (IMPLAN industry code 475) were used. Of note, for the 2012 analysis, 2011 IMPLAN multipliers were used for “Offices of physicians, dentists, and other health practitioners” (IMPLAN industry code 394), a composite industry which was later changed to distinct industries. Related to this, IMPLAN had 440 industries in 2011 which increased to 536 industries by 2015. Upon creation of each model’s geographies, the software calculates multipliers for output, employment (based on millions of dollars of output) and labor income (based on dollars of output). Type SAM (Social Accounting Matrix) output multipliers were used to apply to direct revenue. Type SAM multipliers consider the direct, indirect and induced effects where the induced effect is based on information in the Social Account Matrix. Type SAM multipliers tell us how a specific industry responds to an impact on itself (i.e., rounds of indirect and induced purchasing that occur in that industry). Indirect and induced effect multipliers were used to calculate total jobs and total wages and benefits. A jobs multiplier (the sum of indirect and induced effect employment multipliers) was applied to direct revenue in millions of dollars, in order to calculate indirect and induced jobs per million dollars of output. A wages and benefits multiplier (the sum of indirect and induced effect labor income multipliers) was applied to direct revenue, in order to calculate indirect and induced wages and benefits per dollar of output.

We noted an 8.6% increase in the national output multiplier from 2011 to 2015. The average change was 8.2% with a minimum of 1.6% and a maximum of 14.1%. Other health-related industries saw increases, including a 15.9% increase in the national output multiplier for home health services. All state values in the model are forced to sum to U.S. control totals, so a change at the national level will be reflected in all states. The observed increases in health-related national multipliers are consistent with the increase in the growth of health care spending. National health expenditure grew 5.8% in

2015 and accounted for 17.8% of GDP.¹⁰ Physician and clinical services expenditures grew 6.3% in 2015, an acceleration from growth of 4.8% in 2014, and the first time since 2005 that the growth rate exceeded 6.0%. Health care spending accounted for 17.2% of GDP in 2012.¹¹

Tax Analyses

Patient care physicians also generate tax revenues at the local and state levels. IMPLAN software estimates the impact of economic activity on state and local tax revenues, including income, sales, and property taxes. Tax impacts were estimated at the state and national levels using a contribution analysis, where existing total direct output provides the initial effects of the analysis.¹² Tax calculations were based on 2015 IMPLAN modeling presented in 2015 dollars, using calculated 2015 direct output.

The total tax contribution is computed by summing taxation on employee income, proprietor income, indirect business interactions, households, and corporations. Tax revenues are included from physician practices and from other affected industries (indirect); i.e., these are the “total” tax revenues supported by the industry.

The state and local taxes incorporated in this study include:

- Social Insurance taxes: the state portions of social insurance taxes, including both the employee and employer-paid portions (e.g., retirement plans, workers’ compensation, and temporary disability insurance);
- Personal taxes: state and local income taxes, gift and estate taxes, motor vehicle taxes/fees, fishing/hunting and other license fees, property taxes, personal property taxes, and other fines/fees or donations;
- Business taxes: corporate profits and dividends taxes; and
- Indirect business taxes: property taxes, sales taxes, motor vehicle licensing, severance taxes, non-tax payments (e.g., rents and royalties, special assessments, fines, settlements and donations), and other taxes (including business licensing, documentary and stamp taxes).

While patient care physicians also generate federal tax revenue, the federal tax revenue is beyond the scope of this analysis.

¹⁰ National Health Expenditures 2015 Highlights. Available at: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/downloads/highlights.pdf>.

¹¹ Martin et al. National Health Spending in 2012: Rate of Health Spending Growth Remained Low for the Fourth Consecutive Year. *Health Affairs*. 2014;33:67-77.

¹² Estimating the Contribution of a Current Industry Using IMPLAN. MIG, Inc. Available at: http://support.implan.com/index.php?option=com_content&view=article&id=351:351&catid=212:contribution-analysis.

1.4 Data Analysis

The data from the three source datasets were combined and the following measures were calculated by state:

- 1) Direct impacts of physicians (state-level total medical output, total jobs and total wages and benefits per physician from the medical practices data aggregator \times counts from the AMA Masterfile)
- 2) Indirect impacts of physicians
 - a. Calculated direct output \times (IMPLAN output multiplier – 1)
 - b. (Calculated direct output/\$1,000,000) \times IMPLAN jobs multiplier
 - c. Calculated direct output \times IMPLAN wages and benefits multiplier
- 3) Total impacts of physicians (direct and indirect impacts summed for output, jobs and wages and benefits);
- 4) Tax revenues obtained from physicians.

At the state level, direct, indirect and total impacts were calculated in aggregate (as the sum of primary care, non-surgical and surgical broad specialties) as well as for the 10 specialties. Direct impacts by state (sum of primary care, non-surgical and surgical broad specialties) were aggregated to the national level, and then national IMPLAN multipliers were applied to calculate national total impacts. Tax revenues were also calculated at the national and state levels.