NRHA

WELCOME

Rural Health Executive Educational Series

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Housekeeping

- ✓ All attendees are muted during the webinar
- ✓ We like to get through our presentations in about 45 minutes, offering time at the end for questions to the presenter
- ✓ If you have a question for the presenter, please type it into the question section of your GOTO webinar control panel. We will cover it at the end.
- ✓ This event is being recorded. You will receive an email before the end of the day with a link to the recording.

National Rural Health Association

STROUDWATER

FIRST ANNUAL RURAL PROVIDER COMPENSATION SURVEY

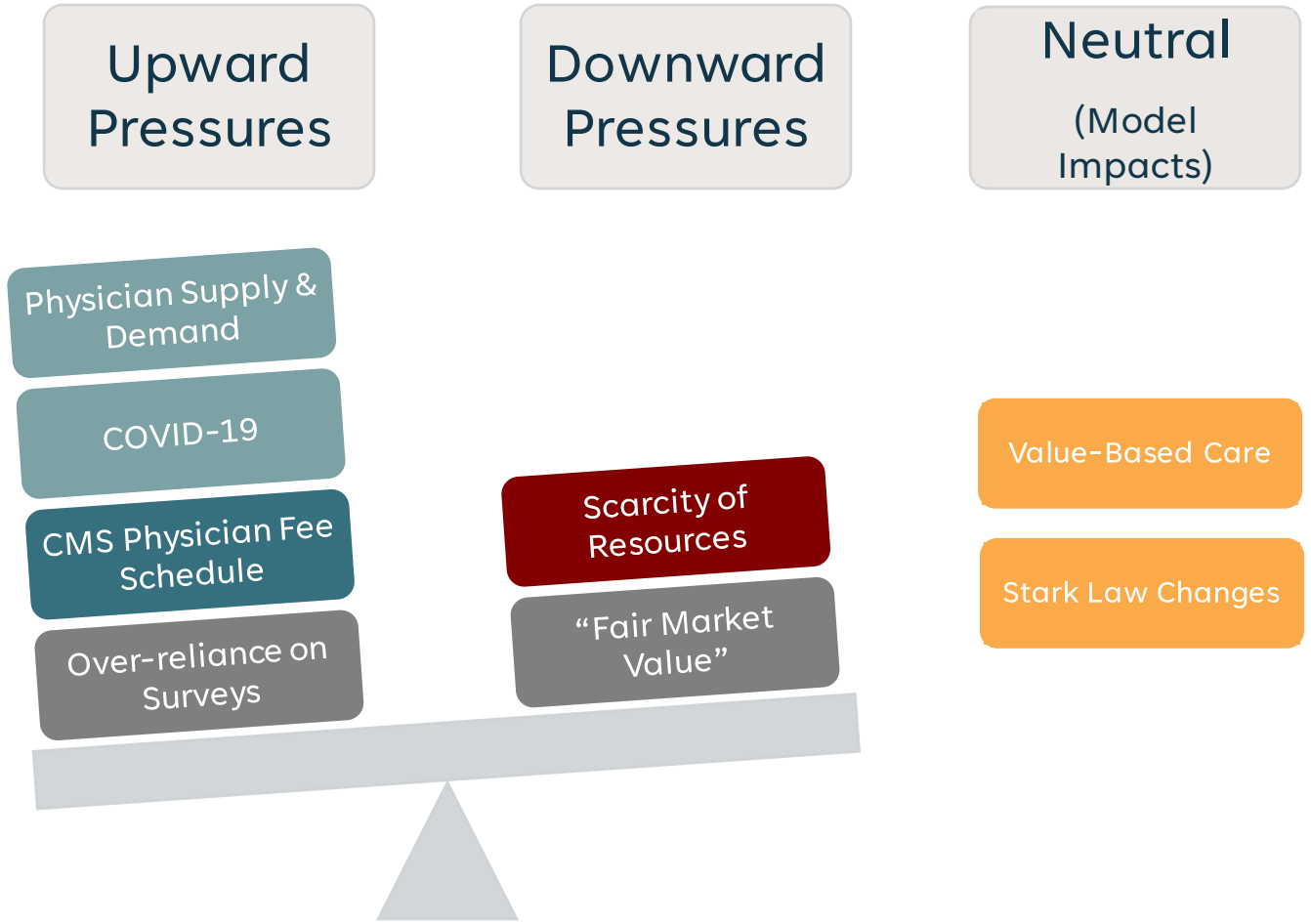
AGENDA

- Current Compensation Market
- Compensation Packages for Recruitment
- Provider Compensation Survey
- Review of Initial Findings: Primary Care
- Review of Initial Findings: Specialty Care
- Q&A

CURRENT COMPENSATION MARKET

FORCES INFLUENCING COMPENSATION

- Regulatory changes, COVID-19 impacts and the transition to value-based care intensify existing challenges with provider supply (shortages) and demand (increasing need), which directly influence compensation
- Factors to the right affect compensation within the industry. Rural hospitals are also affected by:
  - Difficulty recruiting
  - Lack of access to specialists
- Provider compensation must be attuned to present and evolving market forces that impact the healthcare system and organizational goals



Specialty	Group Count	Count
NP: Family Medicine (without OB)	105	293
Family Medicine (without OB)	115	276
Pediatrics: General	43	122
Obstetrics/Gynecology: General	47	114
Emergency Medicine	22	110
Surgery: General	54	104
Hospitalist: Internal Medicine	21	101
Internal Medicine: General	54	96
PA: Family Medicine (without OB)	45	76
Certified Registered Nurse Anesthetist	15	63
Family Medicine (with OB)	27	62
Family Medicine: Ambulatory Only (No Inpatient Work)	12	61
NP (Primary Care)	29	57
Orthopedic Surgery: General	34	55
Licensed Clinical Social Worker	10	50

Group Count: Number of organizations responded
Count: Number of providers represented in by those organizations

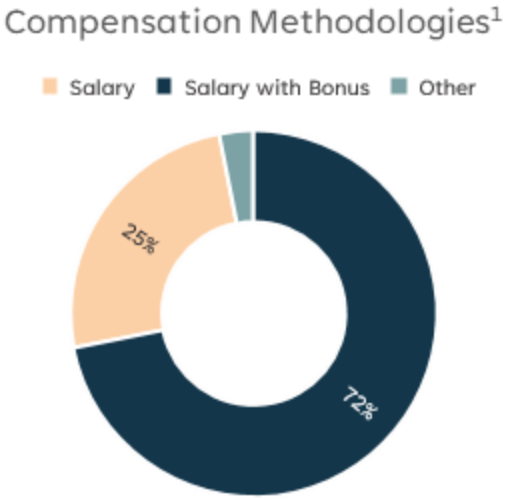
Source: MGMA 2023 Provider Compensation and Productivity Survey (Based on 2022 Data)

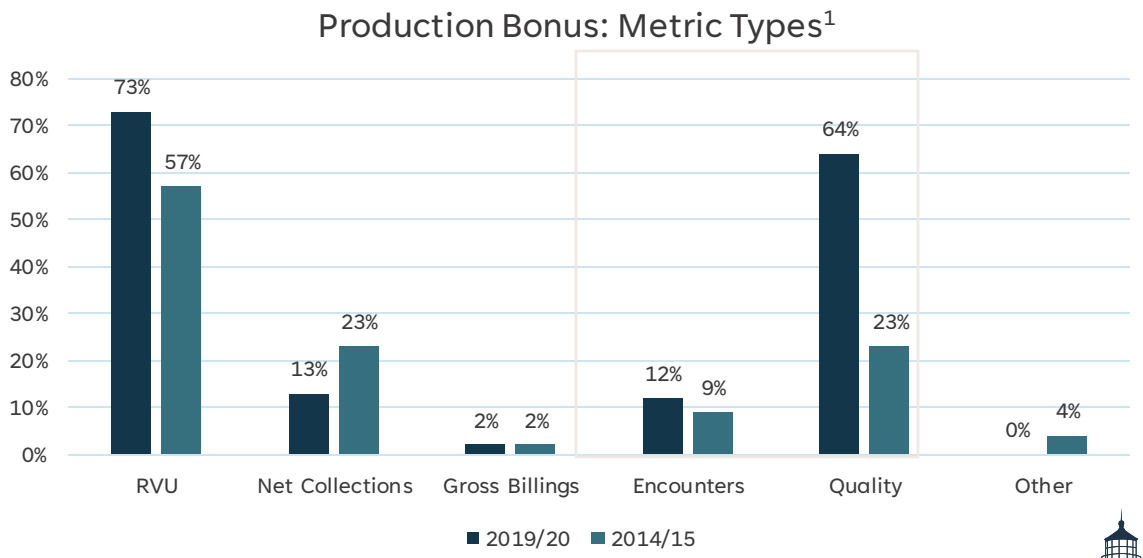
LIMITATIONS TO SURVEY DATA

- Survey data typically publishes total *cash* compensation for professional services
- What is in cash compensation?
  - W-2 wages
  - K-1 compensation
  - Medical director stipends
  - Research income
  - Call compensation
  - APP Supervision stipends
- Not many rural respondents (servicing populations of less than 49,999)
  - General Surgery, OB/GYN, and Orthopedics are the only surgical specialties represented with more than 50 total providers
  - Primary care data represents 1,130 providers

COMPENSATION PACKAGES – WHAT IS INCLUDED

- **Base Salary**
  - Tied to what long-term productivity expectations would be for a provider
  - Share with provider proforma and discuss the assumptions
    - Total patient volumes
    - Plan for the ramp-up period
  - 1–2-year guarantee
- **Productivity Incentives**
  - Productivity metrics need to be consistently measurable
  - Options:
    - % of net professional collections (atypical and significantly gone away)
    - wRVUs
    - Encounters
    - Panel size
- **Quality Compensation** →





1. Merritt_Hawkins_Incentive_Review_2020.pdf (merritthawkins.com)

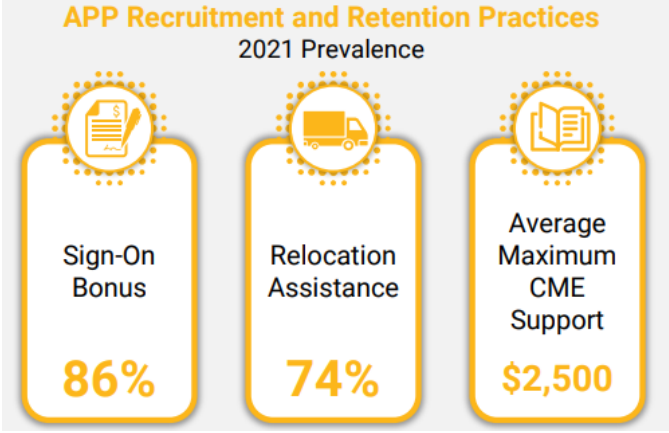
OTHER KEY COMPENSATION FACTORS

- **Call Compensation**
    - Call burden – call rotation, volume & frequency, acuity of care, and restricted vs. unrestricted
    - Specialty
    - Other payments are being made to the provider
    - Who is billing for the services
    - Concurrent call coverage
  - Problematic Compensation
    - Making up for “lost income”
    - Aggregate payments are disproportionately high relative to regular practice income
    - Double-counting compensation
- **Medical Directorship**
  - Entities must *at minimum*:
    - Ensure that medical directorship arrangements are in writing, compensate the physician at fair market value, and outline the services the physician is to perform, as well as the compensation for such services
    - Maintain descriptive documentation of services the medical director performs, such as time logs with activity detail or other accounts
      - Time logs are necessary when administrative FTE is less than 0.5 FTE
  - Median-level medical directorship is 8 hours per week with a median stipend of $25,000

WHAT ABOUT APPS?

- Provider compensation for APP collaboration
  - What is collaboration? Oversight? Training? Team-based goals?
- Distinguishing pay based on the skills, experience, and license of the APP
- State and payer restrictions on APP utilization are critical considerations

- How do you compensate APPs?
  - Aligning with the work they do with physicians
  - 65% of organizations have APPs in leadership positions
  - 33% have incentives tied to team-based performance
- Expectations for APPs are mimicking physicians
  - 52% of organizations now adjust APPs' compensation based on wRVU data



Source: SullivanCotter 2021 Advanced Practice Provider Compensation Survey

PROVIDER COMPENSATION SURVEY

SCOPE AND PURPOSE

- This presentation is based on the 2023 Provider Compensation Survey issued by Stroudwater Associates in January 2023
- The survey's purpose is to provide insight into rural hospitals and promote more informed decisions when considering physician and advanced practice provider compensation
- Respondents ranged from independent hospitals that reported fewer than 10 staffed beds and system-affiliated hospitals with more than 150 staffed beds
    - No independent respondent reported more than 150 staffed beds

Total Surveys	**156**
Health System Respondents	43
Independent Hospital Respondents	109
No Response – System Status	4

PHYSICIANS REPRESENTED

- Based on respondent feedback, this survey represents, at minimum, approximately 4,234 physicians
  - Responses showed that independent hospitals represented 2,897 (68%) of the total physicians
- **A large majority of physicians from hospitals that identify as independent are consulting/contracted physicians, whereas respondents that identified as systems mostly employ physicians**

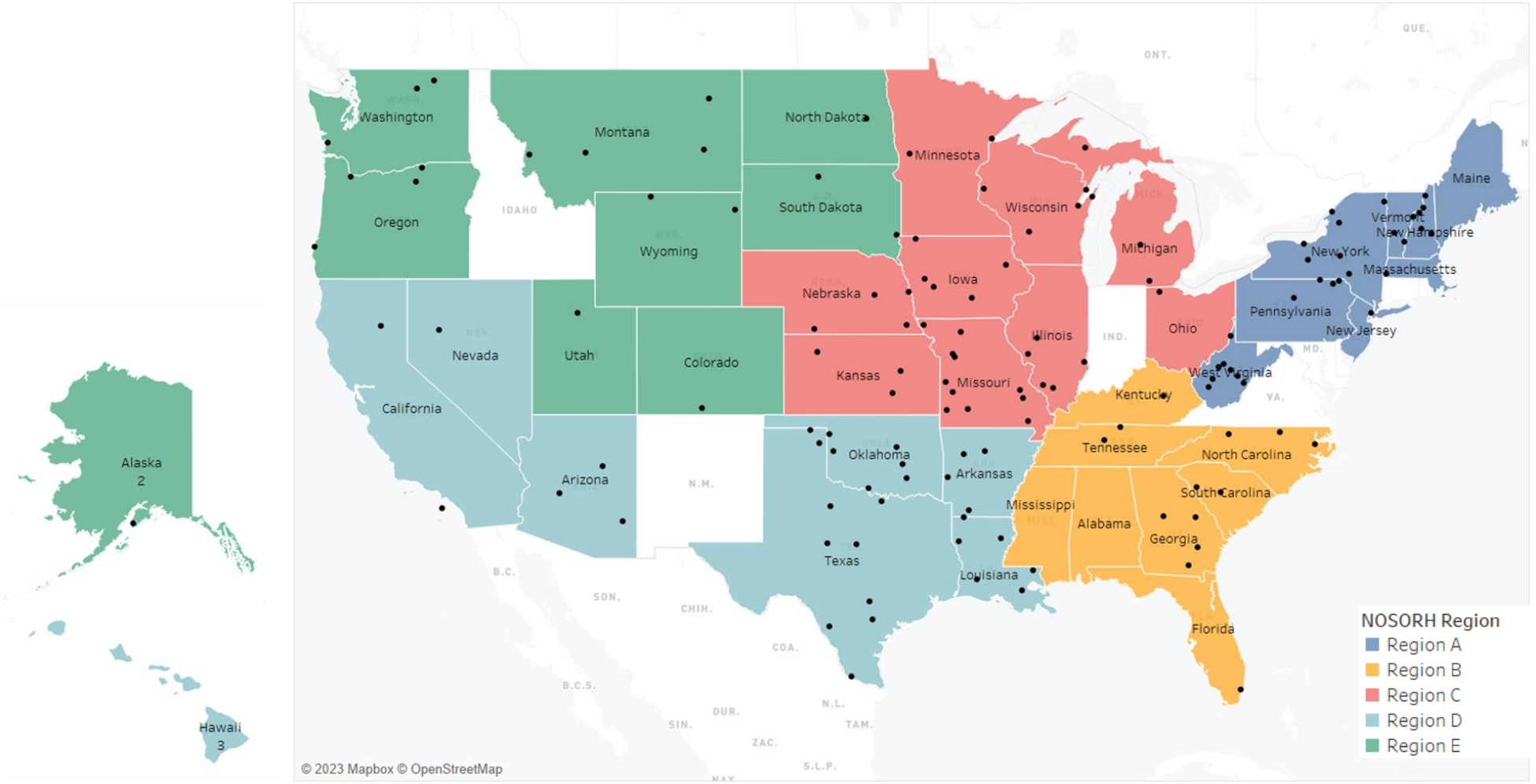
	Reported as System	Reported as Independent	Nationally
Minimum Physicians Represented*	1,337	2,897	4,234
Employed Physicians (W-2)	533	830	1,363
Independent Physicians (1099)	269	607	876
Consulting/Contracted Physicians	417	1,281	1,698
Locums	118	179	297

ADVANCED PRACTICE PROVIDERS REPRESENTED

- Based on respondent feedback this survey represents, at minimum, approximately 1,833 advanced practice providers (APPs)
  - Based on feedback Independent hospitals represented 1,198 (65%) of the total APPs
  - System APPs represent 635 (35%) of the physicians in this survey
- **Most respondents report that their APPs are employed (W-2 rather than 1099)**

	Reported as System	Reported as Independent	Nationally
Minimum APPs Represented*	635	1,198	1,833
Employed APPs (W-2)	428	660	1,088
Independent APPs (1099)	77	250	327
Consulting/Contracted APPs	70	207	277
Locums	60	81	141

NOSORH REGIONAL RESPONDENTS



- Respondents represent 42 out of 50 states
- 5 of 5 (100%) National Organization of State Offices of Rural Health (NOSORH) regions had at least one respondent

NOSORH REGIONAL RESPONDENTS (CONT.)

- NOSORH Regional Response Detail
  - Region C accounted for 36.54% of surveys returned
  - Region A was the only region with a higher percentage of health system respondents than independent respondents
  - Region D had the highest percentage of independent respondents
- Overall, independent hospitals accounted for approximately 70% of total survey responses
  - Health systems were asked to respond based on their total medical staff across their rural hospitals and likely represent multiple rural hospitals; response rates are consistent with the overall composition of the 2,008 rural hospitals in the US

Survey Responses by NOSORH Region	All	System	Independent	No Response	% of System Respondents	% of Independent Respondents	% No Response	Total Response Rate (of surveys returned)
A	24	13	11		54.17%	45.83%	0.00%	15.38%
B	17	7	10		41.18%	58.82%	0.00%	10.90%
C	57	11	43	3	19.30%	75.44%	5.26%	36.54%
D	35	6	29		17.14%	82.86%	0.00%	22.44%
E	20	5	14	1	25.00%	70.00%	5.00%	12.82%
Total	**153**	**42**	**107**	**4**	27.45%	69.93%	2.61%	98.08%

STUDY PROCESS

Measures	Sources	Limitations
• **Compensation Range:** ***Total*** compensation paid within a calendar year (consistent with MGMA's definition of total compensation) • Number of providers by specialty • **Provider employment status:** Providers were identified as W-2, contracted (1099) or locums	• Stroudwater Associates Physician Compensation survey, 156 responses reflective of 42 of 50 states • AANP State Practice Environment map • Rural organizations were contacted through NRHA, NOSORH, and individual State Offices of Rural Health	• First year conducting survey – no historical data or expectations • Data is self-reported by organizations without validation • Data collected was based on compensation ranges and not the inclusion of specific individual compensation

TYPES OF COMPENSATION

- In response to what types of compensation are provided to your employed providers, 56% of respondents pay providers entirely on a straight salary
- 37% of respondents provide some form of incentive compensation
- Additional compensation provided:
  - 125 respondents provide relocation stipends (over half of which exceed $5,000)
  - 121 respondents provide student loan repayment (over half pay less than $45K per provider per year)
  - 91 respondents provide sign-on bonuses (58% pay less than $5K in sign-on per provider)

Types of Incentive Comp	% of Those Providing
wRVU/RVU Based	30.6%
Net Collections	10.0%
Gross Billing	9.4%
Patient Encounter/Visits	18.9%
Patient Panel Size	8.9%
Quality	22.2%

REVIEW OF INITIAL FINDINGS:
PRIMARY CARE

NATIONAL SUMMARY – PRIMARY CARE PHYSICIANS

- 156 respondents specifically representing the rural United States
  - Over 6,000 providers represented compared to 2,632 rural providers in MGMA data
  - This represents at least 4,234 physicians and 1,833 APPs
- 43 health system respondents ranging from 10 or fewer staffed beds to upwards of 150+ staffed beds
- Majority of family medicine physicians make less than $300K

Compensation: Family Medicine Physician (with OB)	% of compensation in this range, per survey
Less than $260,000	59.6%
$260,000-$325,000	24.6%
$325,000-$390,000	15.8%
$390,000-$455,000	0.0%
Greater than $455,000	0.0%
Grand Total	**100.0%**

Compensation: Family Medicine Physician (without OB)	% of compensation in this range, per survey
Less than $234,000	38.8%
$234,000 - $305,500	43.5%
$305,500 - $377,000	16.5%
$377,000 - $442,000	1.2%
Greater than $442,000	0.0%
Grand Total	**100.0%**

NATIONAL SUMMARY – PRIMARY CARE APPS

Compensation: Family Medicine Nurse Practitioner (with OB)	% of compensation in this range, per survey
Less than $110,500	26%
$110,500-$130,000	36%
$130,000-$149,500	19%
$149,500-$169,000	10%
$169,000-$188,500	4%
Greater than $188,500	5%
Grand Total	**100%**

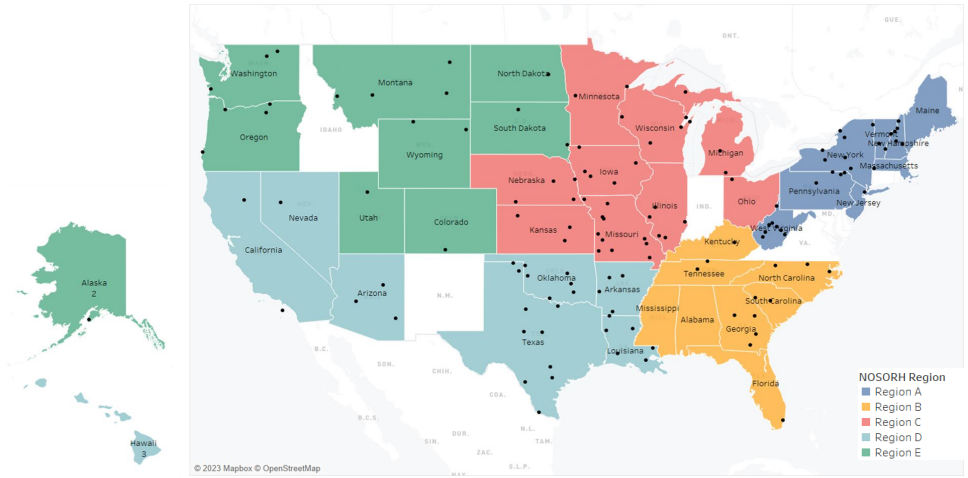
Compensation: Family Medicine Nurse Practitioner (without OB)	% of compensation in this range, per survey
Less than $104,000	15%
$104,000-$130,000	39%
$130,000-$156,000	28%
$156,000-$182,000	7%
$182,000-$208,000	2%
Greater than $208,000	8%
Grand Total	**100%**

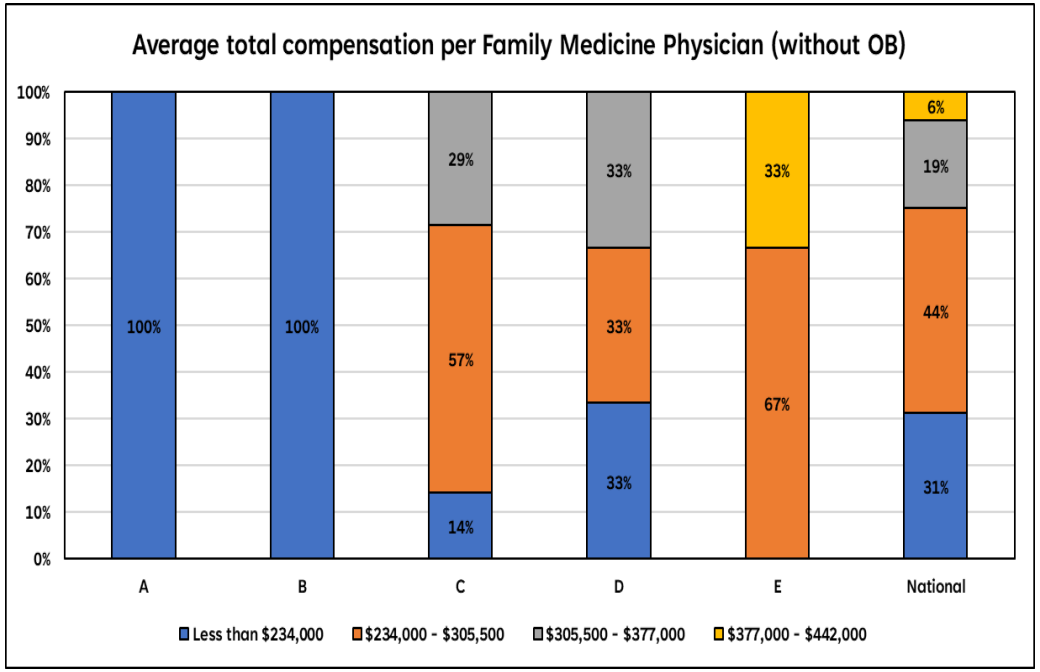
- Majority of Family Medicine NPs make less than $150K per year, regardless of state of licensure or scope of service
- This translates to $72 per hour in a time when, based on a survey by Kaufman Hall, contract nurses are averaging $132 per hour in 2022[1]

Source: The cost of hospital contract labor in 22 numbers (beckershospitalreview.com)

PRIMARY CARE PHYSICIANS (WITHOUT OB)

- Organizations report paying Family Medicine Physicians less in Regions A and B
- Region E is the sole region with organizations reporting paying primary care physicians more than $377K based on survey responses

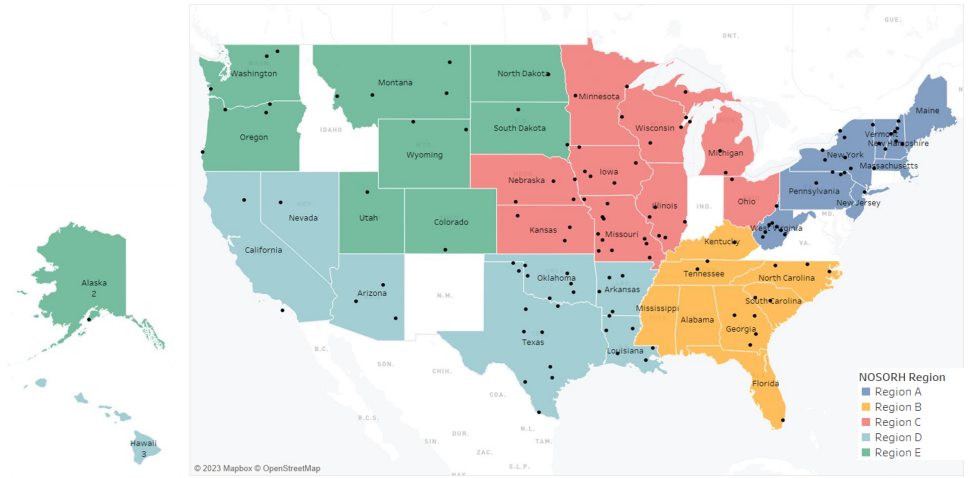


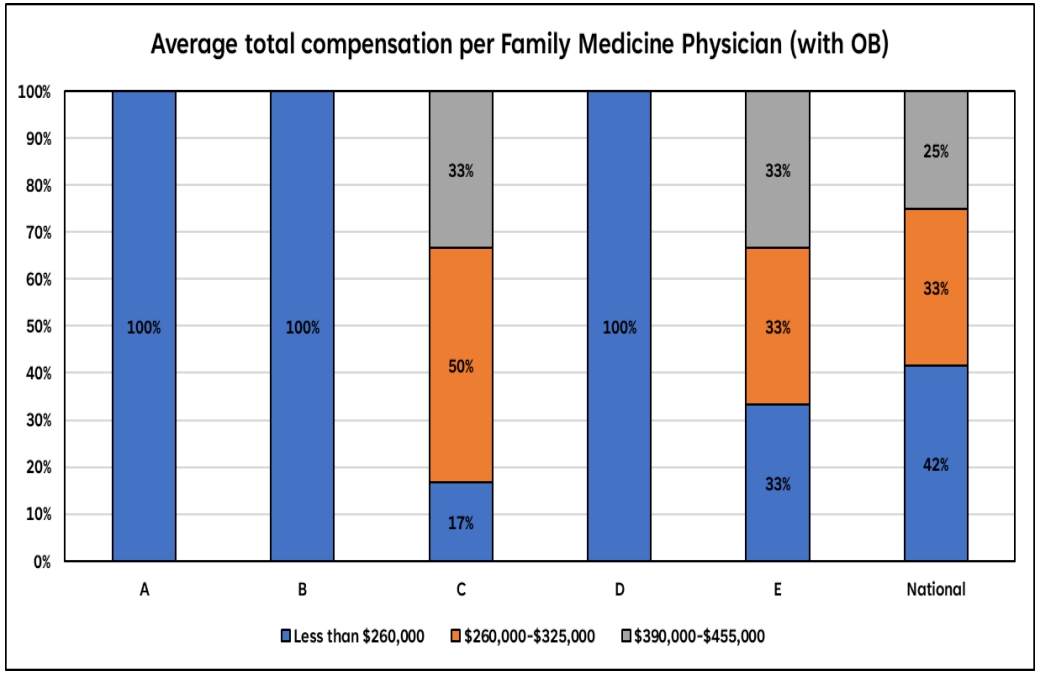


	A	B	C	D	E	National
Less than $234,000	100%	100%	14%	33%		31%
$234,000 - $305,500			57%	33%	67%	44%
$305,500 - $377,000			29%	33%		19%
$377,000 - $442,000					33%	6%

PRIMARY CARE PHYSICIANS (WITH OB)

- Organizations report paying Family Medicine Physicians less in Regions A, B, and D
- Both Regions C and E had respondents who reported paying primary care physicians who provide OB services more than $390K

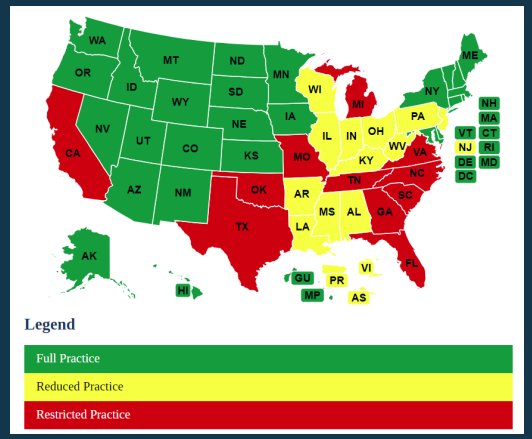




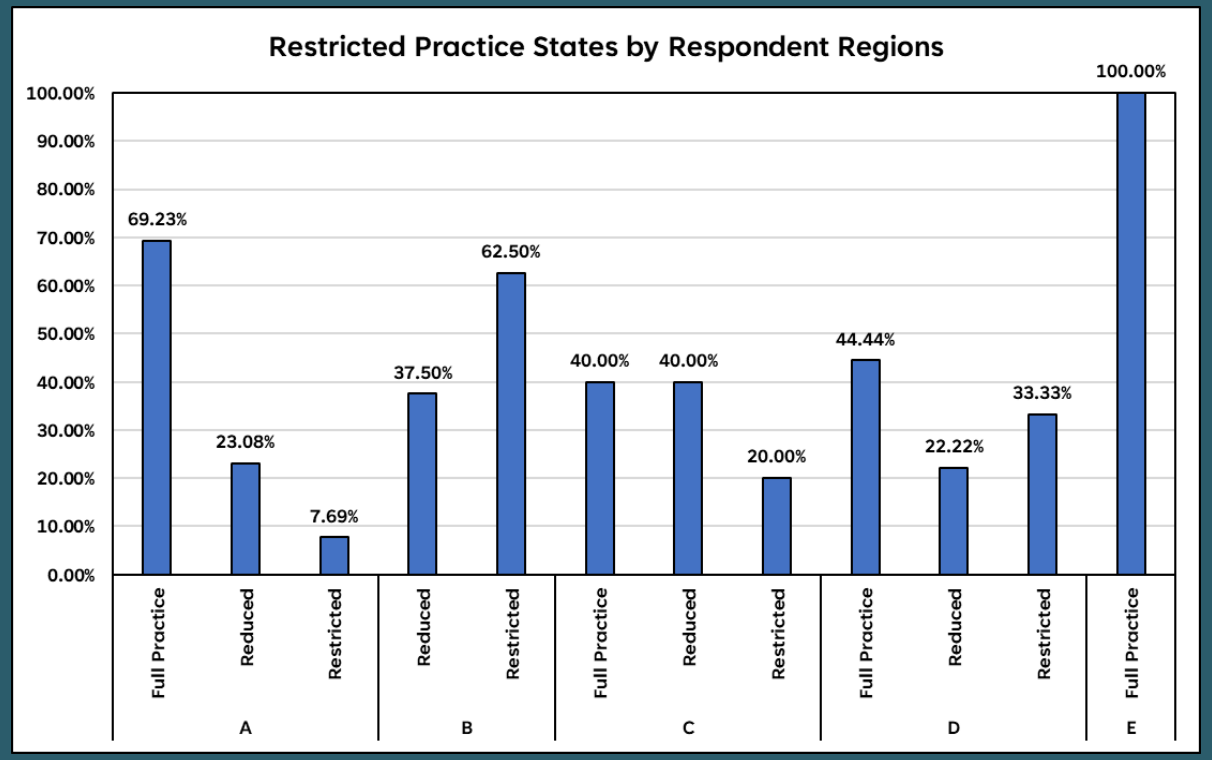
	A	B	C	D	E	Total
Less than $260,000	100%	100%	17%	100%	33%	42%
$260,000-$325,000			50%		33%	33%
$390,000-$455,000			33%		33%	25%

RESTRICTED PRACTICE STATES

- Region B has the highest rate of restricted practice states
- Region B is also one of the lowest-paying regions for APP compensation
  - This has far-reaching implications regarding APP recruitment, retention, and alignment in reduced and restricted practice states

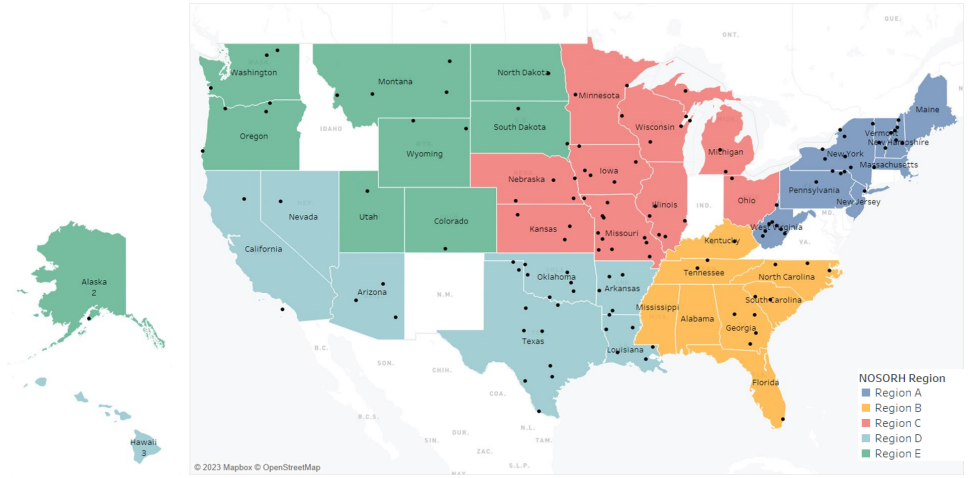


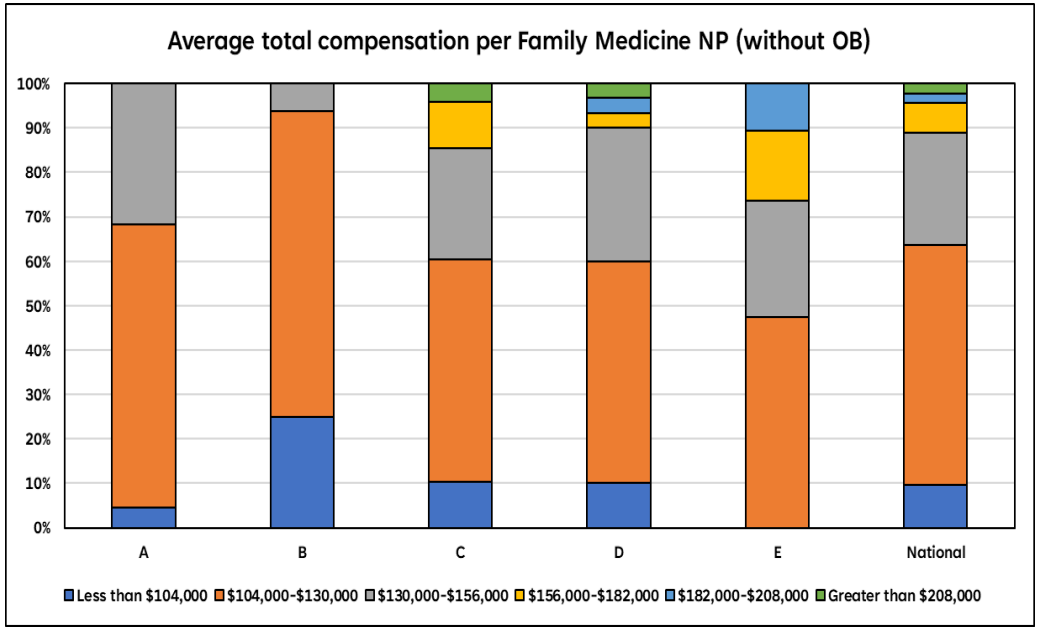
- Please see the Appendix for the full state practice environment map



PRIMARY CARE NURSE PRACTITIONER (WITHOUT OB)

- Regions A and B have no respondents, regardless of system status, who report compensating NPs (without OB) more than $156K
  - Only 6% of respondents from Region B reported paying between $130K-156K for primary care NPs (without OB)
- Regions D and C are the only regions with respondents that report compensating NPs (without OB) at a rate higher than $208K annually
- Region E reported no primary care NPs (without OB) being compensated at a rate less than $104K

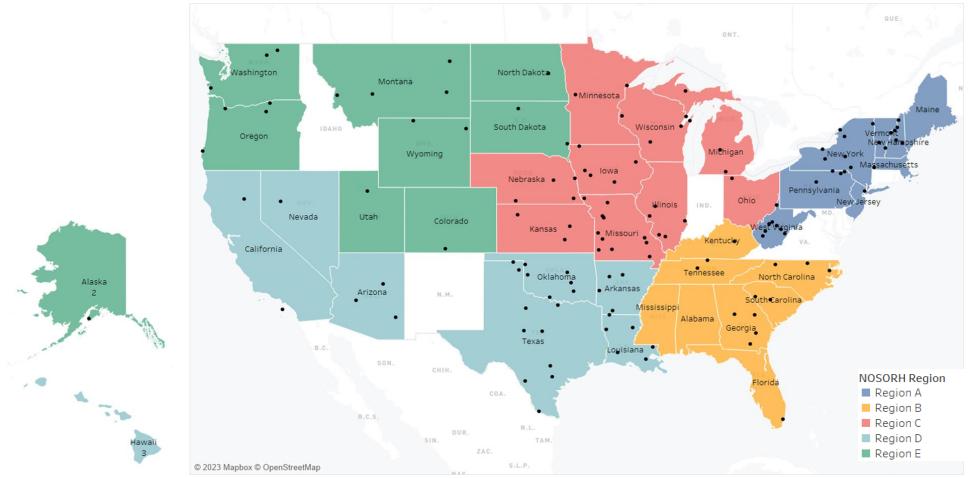


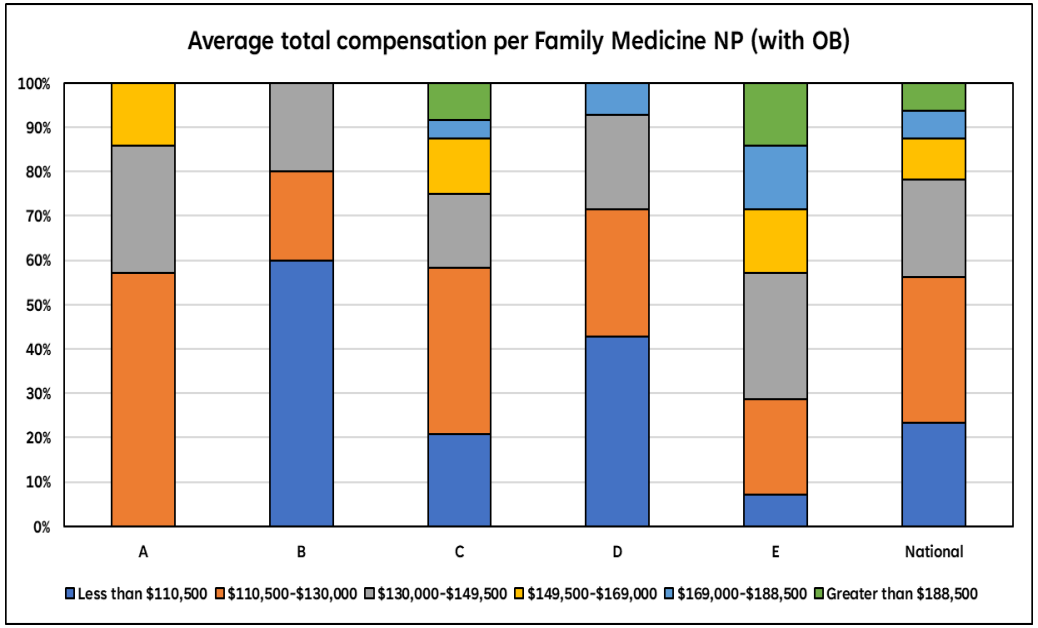


	A	B	C	D	E	Total
Less than $104,000	5%	25%	10%	10%	0%	10%
$104,000-$130,000	64%	69%	50%	50%	47%	54%
$130,000-$156,000	32%	6%	25%	30%	26%	25%
$156,000-$182,000	0%	0%	10%	3%	16%	7%
$182,000-$208,000	0%	0%	0%	3%	11%	2%
Greater than $208,000	0%	0%	4%	3%	0%	2%

PRIMARY CARE NURSE PRACTITIONER (WITH OB)

- Region B has no respondents, regardless of system status, who report compensating NPs who provide OB services more than $149.5KK
  - 20% of respondents from Region B report paying between $130K-149.5K for primary care NPs (with OB)
- Regions C and E are the only regions where respondents reported compensating NPs (with OB) at a rate higher than $188.5K annually
- Region A indicated no primary care NPs (with OB) being compensated at a rate less than $110.5K

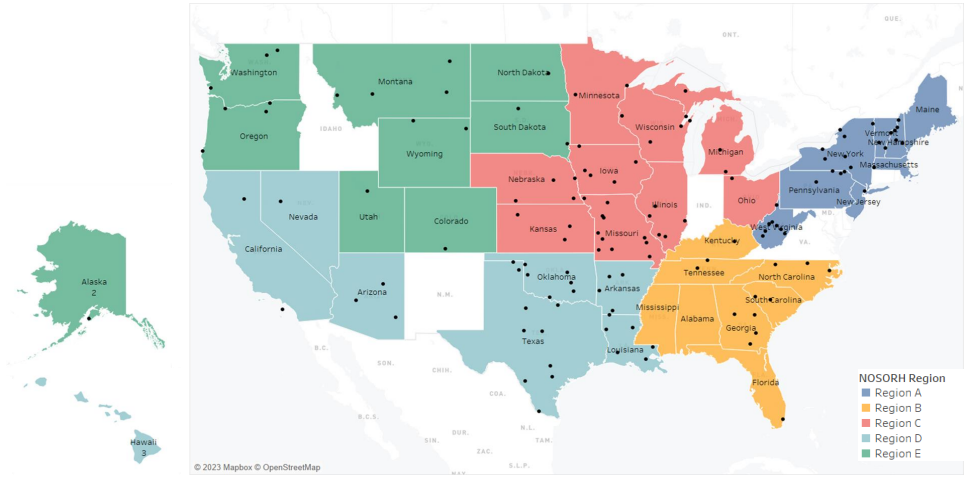


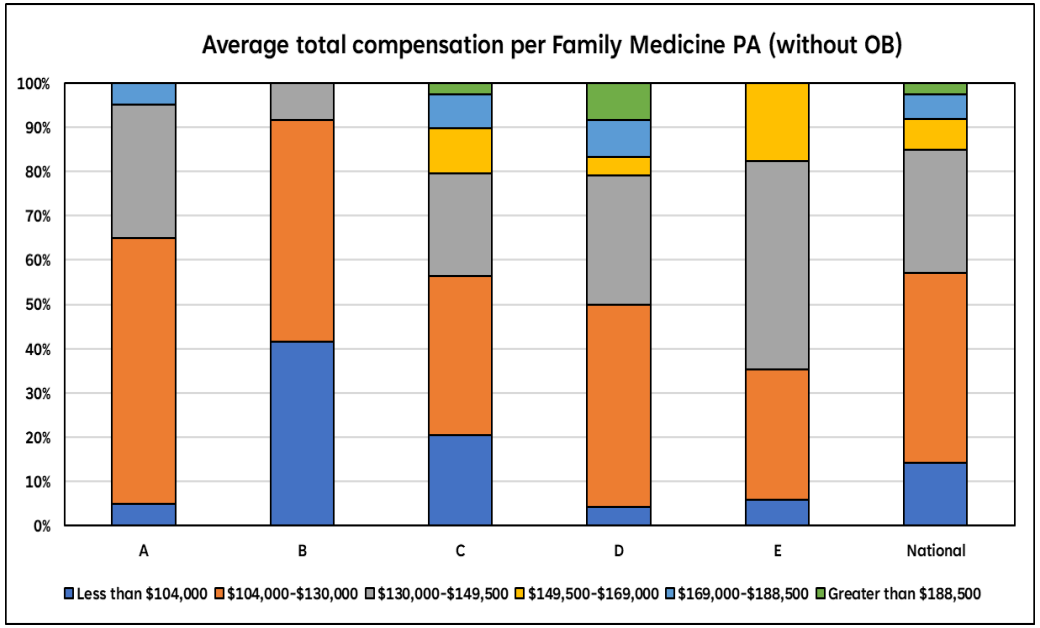


	A	B	C	D	E	National
Less than $110,500	0%	60%	21%	43%	7%	23%
$110,500-$130,000	57%	20%	38%	29%	21%	33%
$130,000-$149,500	29%	20%	17%	21%	29%	22%
$149,500-$169,000	14%	0%	13%	0%	14%	9%
$169,000-$188,500	0%	0%	4%	7%	14%	6%
Greater than $188,500	0%	0%	8%	0%	14%	6%

PRIMARY CARE PHYSICIAN ASSISTANT (WITHOUT OB)

- Region B has no respondents, regardless of system status, who report compensating PAs (without OB) more than $149.5K
  - 8% of respondents from Region B reports paying between $130K-149.5K for primary care PAs (without OB)
- Regions C and D are the only regions with reports of compensating PAs (without OB) at a rate higher than $188.5K annually
- Most primary care PAs (without OB) are reported to be compensated between $104K and $149.5K annually

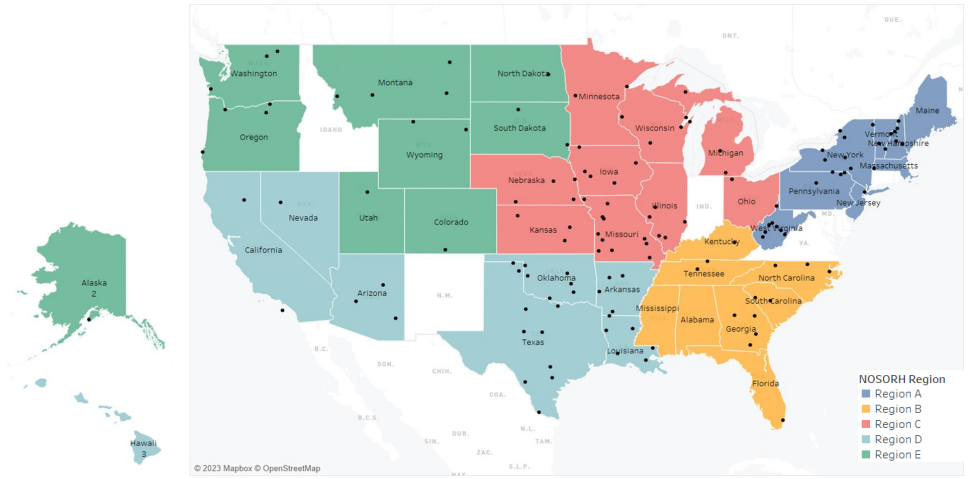


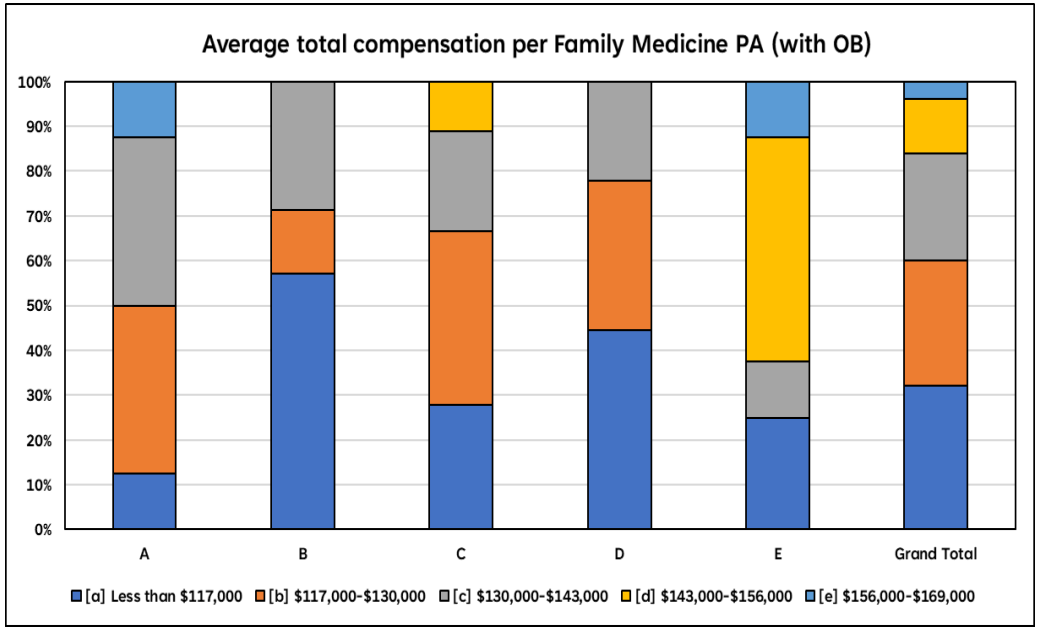


	A	B	C	D	E	National
Less than $104,000	5%	42%	21%	4%	6%	14%
$104,000-$130,000	60%	50%	36%	46%	29%	43%
$130,000-$149,500	30%	8%	23%	29%	47%	28%
$149,500-$169,000	0%	0%	10%	4%	18%	7%
$169,000-$188,500	5%	0%	8%	8%	0%	5%
Greater than $188,500	0%	0%	3%	8%	0%	3%

PRIMARY CARE PHYSICIAN ASSISTANT (WITH OB)

- Regions B and D have no reported respondents, regardless of system status, compensating PAs who provide OB care more than $143K
- Regions A and E are the only regions reporting that PAs (with OB) are compensated between $156-169K
- Most primary care PAs (with OB) are reportedly being compensated less than $130K annually



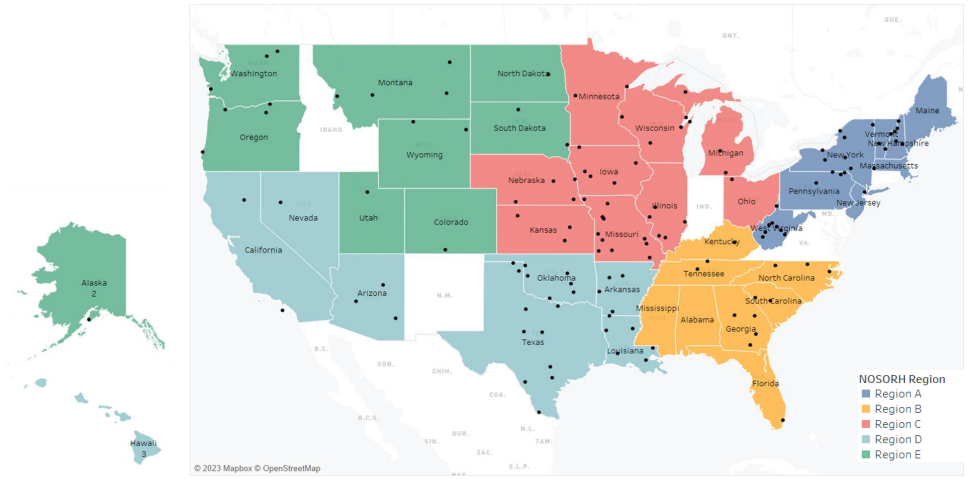


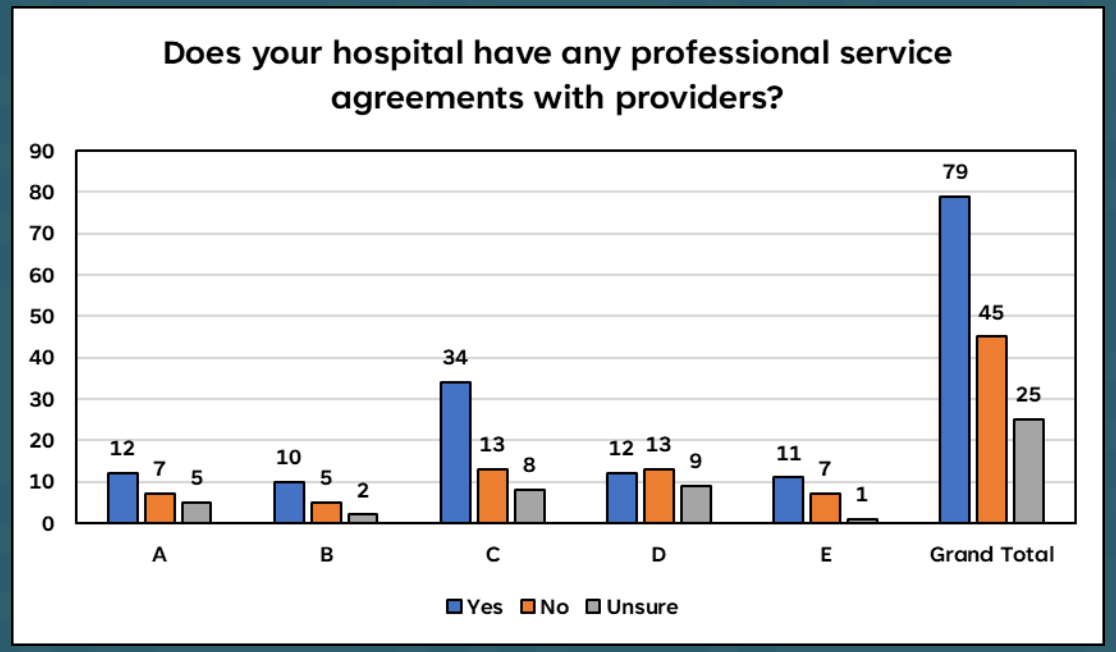
	A	B	C	D	E	National
Less than $117,000	13%	57%	28%	44%	25%	32%
$117,000-$130,000	38%	14%	39%	33%	0%	28%
$130,000-$143,000	38%	29%	22%	22%	13%	24%
$143,000-$156,000	0%	0%	11%	0%	50%	12%
$156,000-$169,000	13%	0%	0%	0%	13%	4%

REVIEW OF INITIAL FINDINGS:
SPECIALTY CARE

PROFESSIONAL SERVICE AGREEMENTS

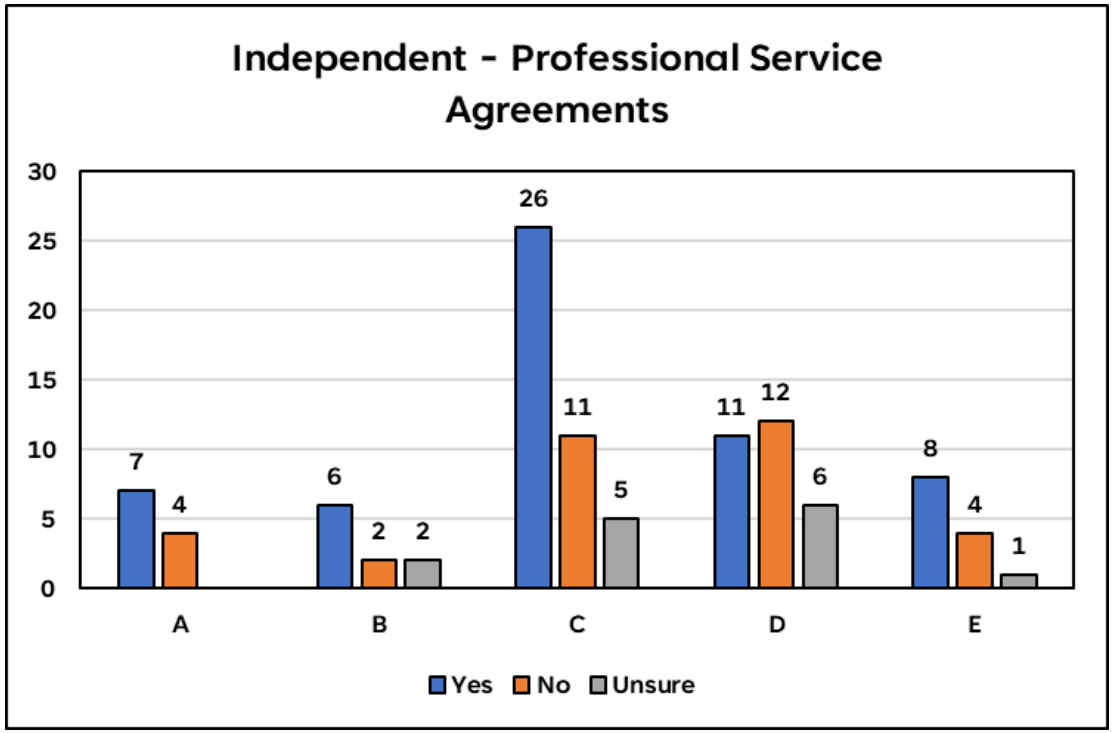
- Regardless of system affiliation status, 53% of respondents indicated they have professional service agreements in place with providers
  - Region C reported the most professional service agreements while Region B reported the least

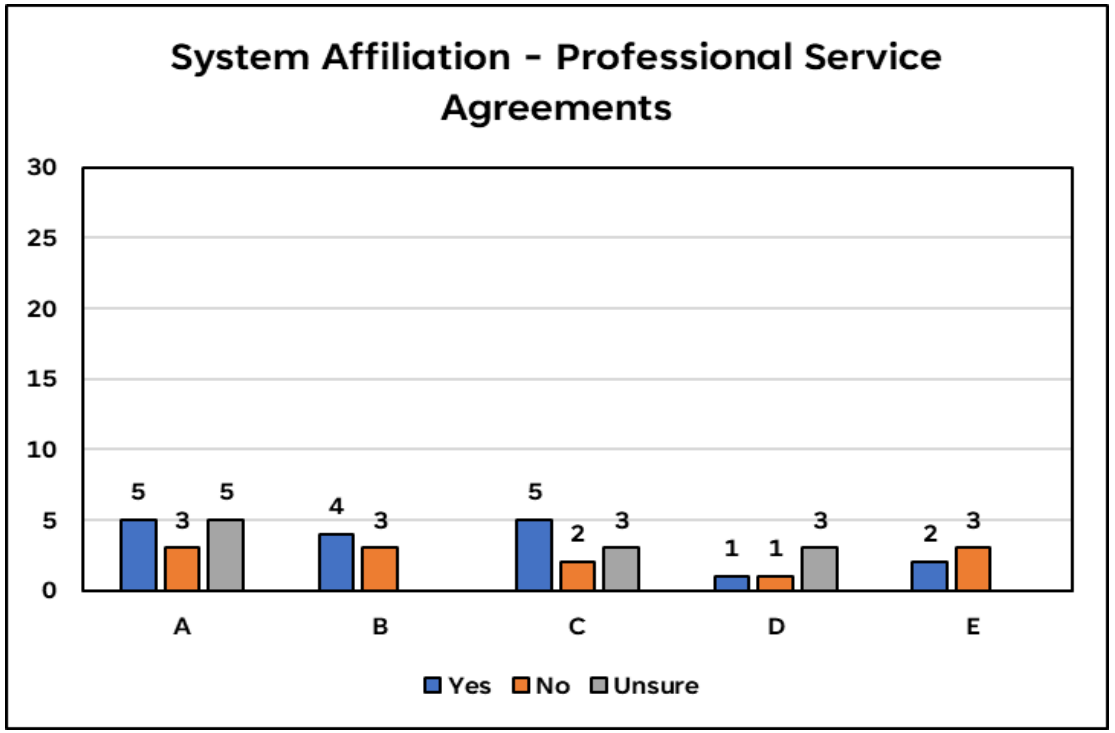




SYSTEM VERSUS INDEPENDENT PROVIDER AGREEMENTS

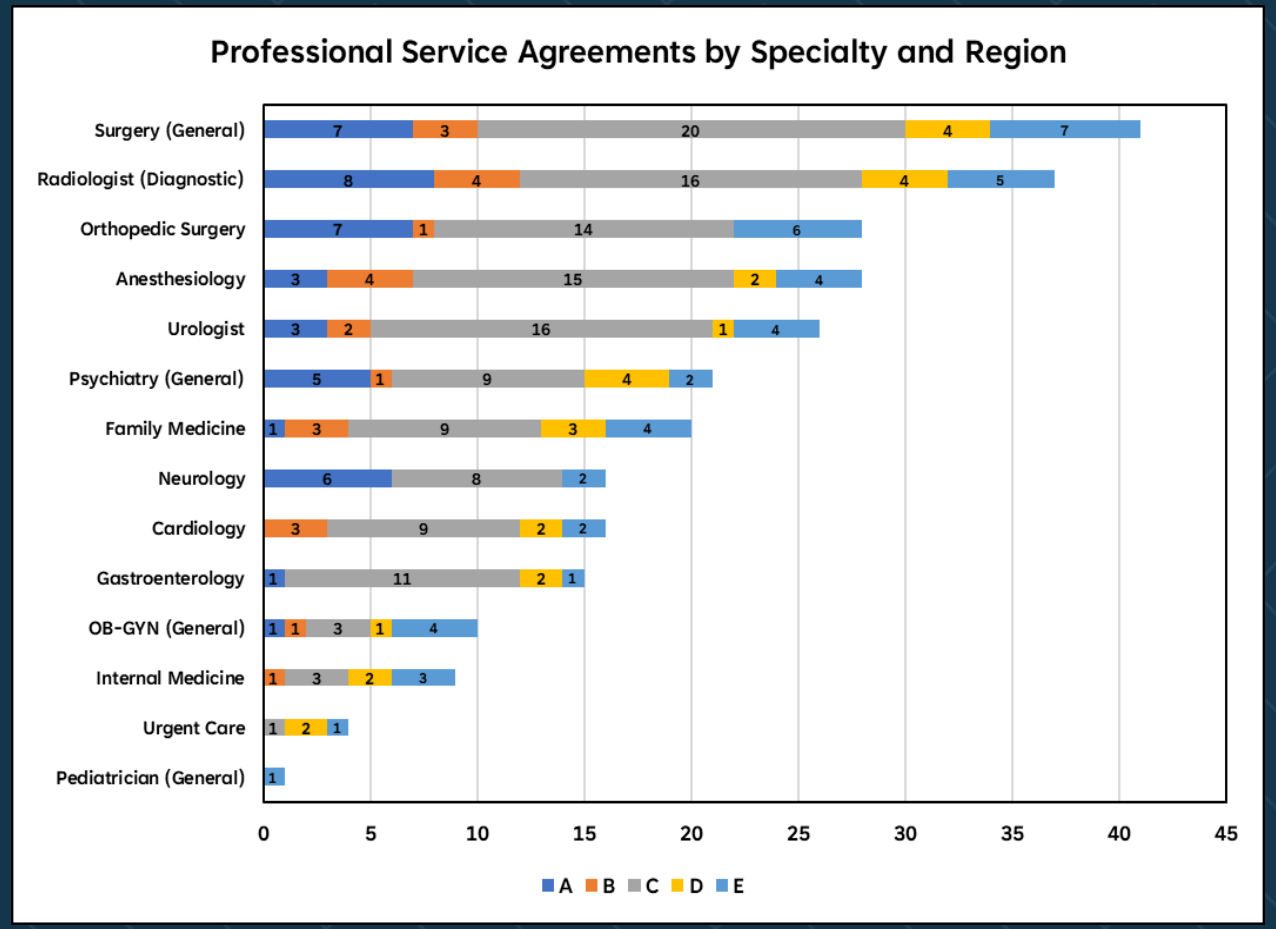
- When broken down by system versus independent status, the results remain consistent regardless of status
  - Of the system respondents there is a higher rate of “unsure” responses, potentially indicating provider contracting is being handled at the system level rather than at the rural affiliate





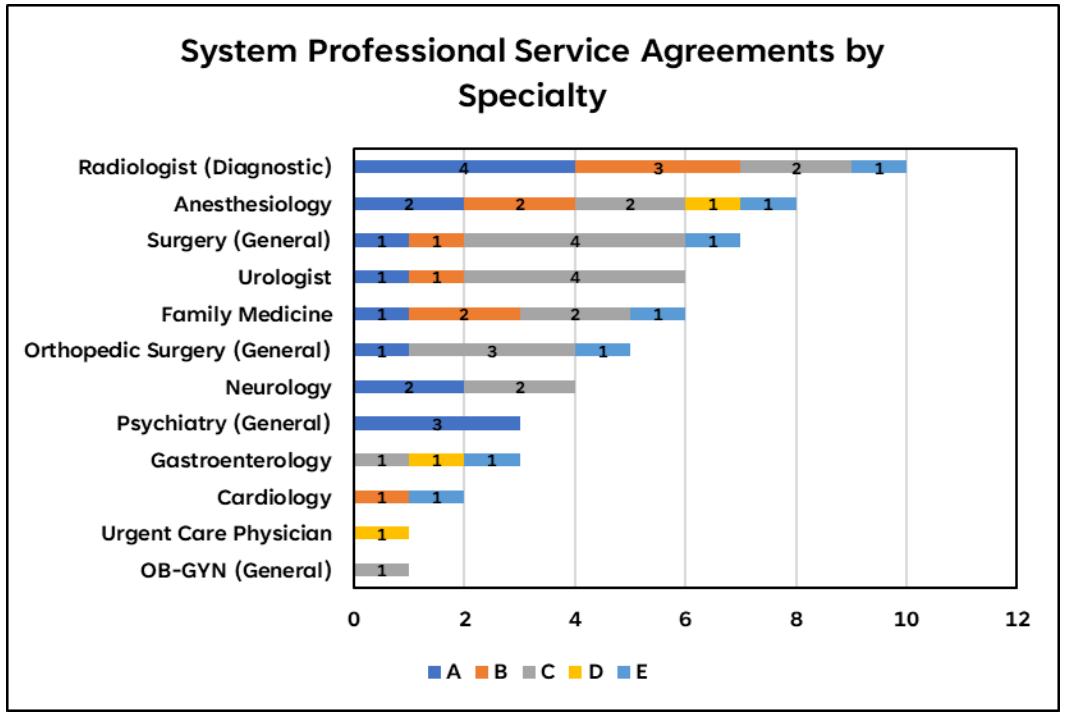
PROFESSIONAL SERVICE AGREEMENTS BY SPECIALTY

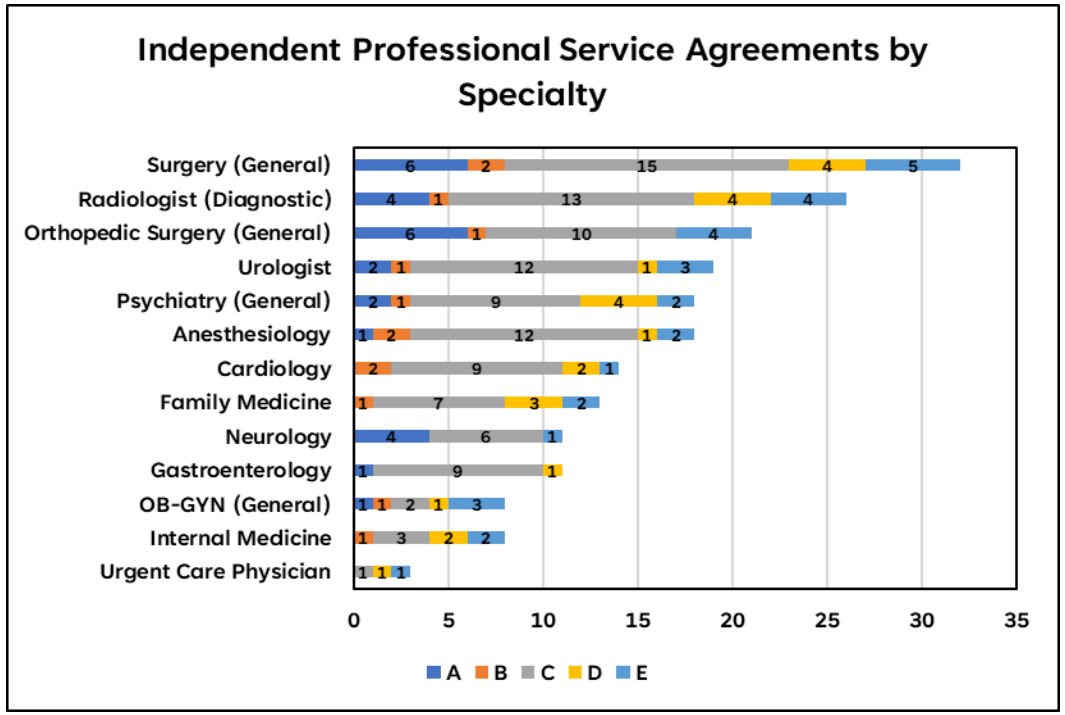
- Regardless of system affiliation status, general surgery and diagnostic radiology are reported to be the most established specialties for professional service agreements
  - As indicated in the prior slides, Region C has the most professional service agreements
  - 81 respondents report utilizing PSAs
    - Majority of respondents indicate having multiple PSAs
- Only 21 respondents indicated having access to psychiatrists



PROFESSIONAL SERVICE AGREEMENTS BY SYSTEM STATUS

- When analyzed by system versus independent status, no system status respondents reported a professional service agreement with internal medicine
- Additionally, where independent respondents report more professional service agreements in the general surgery and orthopedic specialties, system respondents report those as less common than radiology and anesthesiology





SPECIALTY CARE PHYSICIANS – FURTHER ANALYSIS

Anesthesiologist Total Compensation: All regions, regardless of system affiliation status, pay less than $520,000 for anesthesiology physicians; MGMA median is $498,954

Cardiology Total Compensation: Low response rates from health system respondents; independent status respondents report 55% of cardiology physicians being compensated between $325,000-$520,000; MGMA median for noninvasive Cardiology is $559,107

Gastroenterology: All regions, regardless of system affiliation status, pay less than $585,000 for gastroenterology physicians; MGMA median is $556,675

Neurology: All respondents paying less than $422,500; MGMA median is $347,348

OB/GYN: Low rate of response amongst system status respondents. Independent respondents indicated OB/GYNs in Region D generally are compensated at a higher rate than their Region A and Region B colleagues. MGMA median is $369,179.

Orthopedic Surgery: Low response rate amongst system status respondents; independent respondents indicate Region B is compensating orthopedic physicians at a lower rate than most of the other regions. MGMA median is $639,741.

SPECIALTY CARE APPS – ANESTHESIOLOGY

- **Anesthesiology Total Compensation:** 48% of respondents, regardless of affiliation status, report paying employed CRNAs more than $188.5K annually and reported 35% of non-employed CRNAs earning less than $234K regardless of organization affiliation status

Employed CRNA Compensation	National % of respondents
Less than $110,500	24%
$110,500-$130,000	11%
$130,000-$149,500	4%
$149,500-$169,000	4%
$169,000-$188,500	9%
Greater than $188,500	48%
Grand Total	**100%**

PSA per CRNA FTE Coverage	National % of respondents
Less than $234,000	35%
$234,000-$260,000	23%
$260,000-$286,000	11%
$286,000-$312,000	11%
$312,000-$338,000	15%
Greater than $338,000	5%
Grand Total	**100%**

WHAT'S NEXT?

- Stroudwater and NRHA will be hosting a webinar on October 10th reviewing the survey for those that missed the conference
- Stroudwater plans to update and distribute this survey annually. 2024's survey will continue to build upon the information already obtained.
  - Questions already requested:
- **Action Requested**
  - **If you receive this survey, please respond and complete all questions to help us continually improve and provide value to rural healthcare providers**
  - **If you have feedback on ways to improve the survey or items you would like to see included in future presentations, please contact Opal Greenway at ogreenway@stroudwater.com**

Q&A

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THANK YOU

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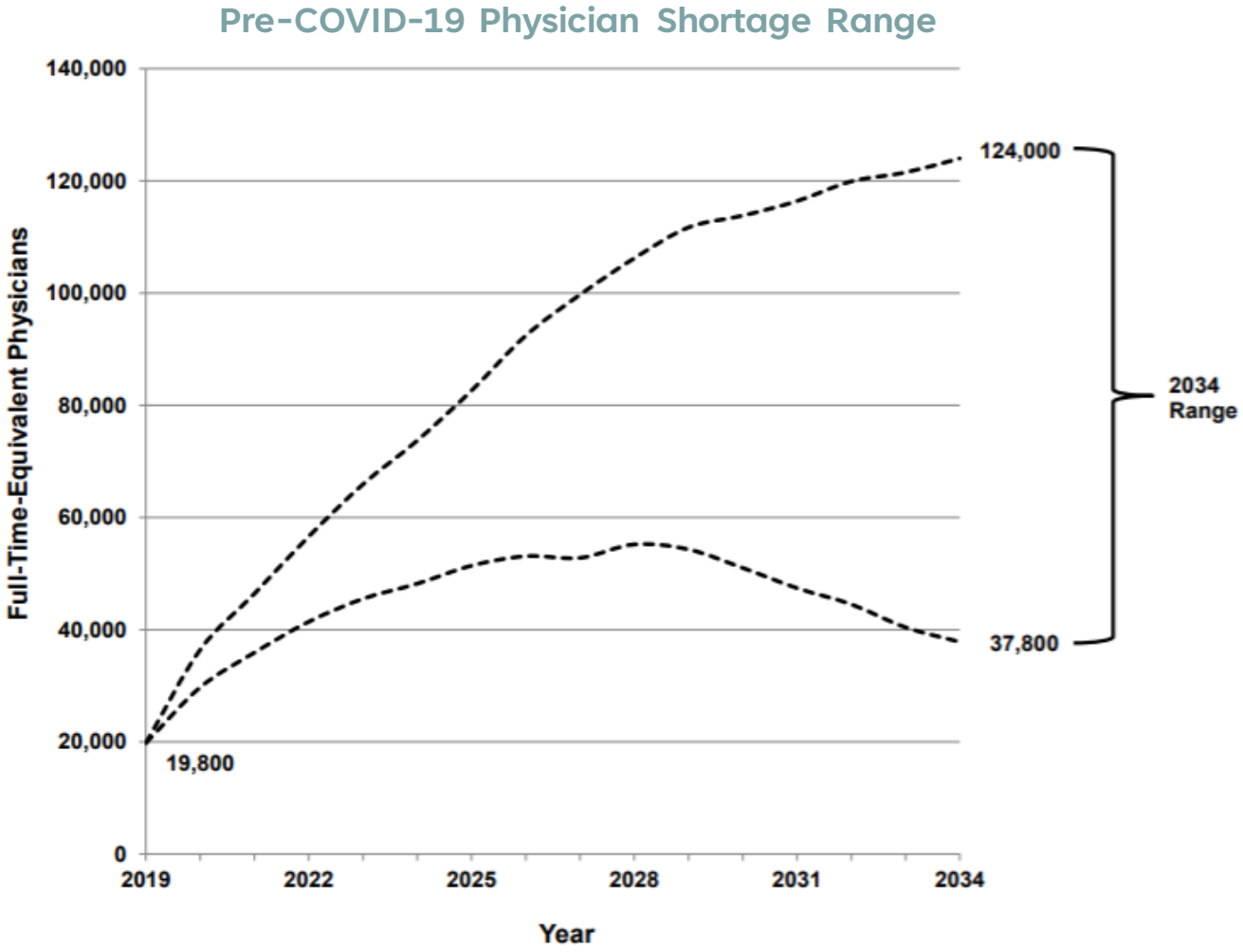
APPENDIX

PRE-COVID STATE OF PHYSICIAN SUPPLY & DEMAND

- Increasing demand for physicians continues to outpace growth in supply
- The Association for American Medical Colleges projected the following shortages by 2034, based on 2019 data assuming physician supply and demand were in equilibrium:
  - 37,800 to 124,000 total physicians
  - 17,800 to 48,000 in primary care
  - 21,000 to 77,000 in specialty care
- COVID-19 has raised awareness of disparities in health and access to care by minorities, people living in rural communities, and people without health insurance
  - If these populations had healthcare patterns of like populations with fewer barriers, the national shortage ranges from **102,400 to 180,400**



Source: The Complexities of Physician Supply and Demand: Projections From 2019 to 2034. AAMC. https://www.aamc.org/media/54681/download

2021 & 2022 PHYSICIAN FEE SCHEDULE

- Changes are made annually to the Medicare Physician Fee Schedule ("PFS") to address revised CPT codes and corresponding work RVUs ("wRVUs"); quarterly changes also apply, but are generally less significant
- On December 2nd, 2020, CMS published the final rule for 2021
  - Most significantly, CMS overhauled the office and outpatient evaluation and management ("E&M") codes 99201-99205 (new patients) and 99211 – 99215 (established patients)[1]
  - Changes were intended to address the ongoing documentation burden on physicians and the undervaluation of time and effort involved in these services
  - Most compensation models are based on wRVUs and, therefore, without intervention, compensation would increase significantly for certain specialties
- On November 2nd, 2021, CMS published the final rule for the 2022 PFS which includes a conversion factor of $33.59, a 7% decrease from 2021's conversion factor of $34.89
  - No material change in wRVUs based on 2021 PFS applied
- **The impact of the 2021 and 2022 PFS changes: Potentially higher provider compensation with lower reimbursement**

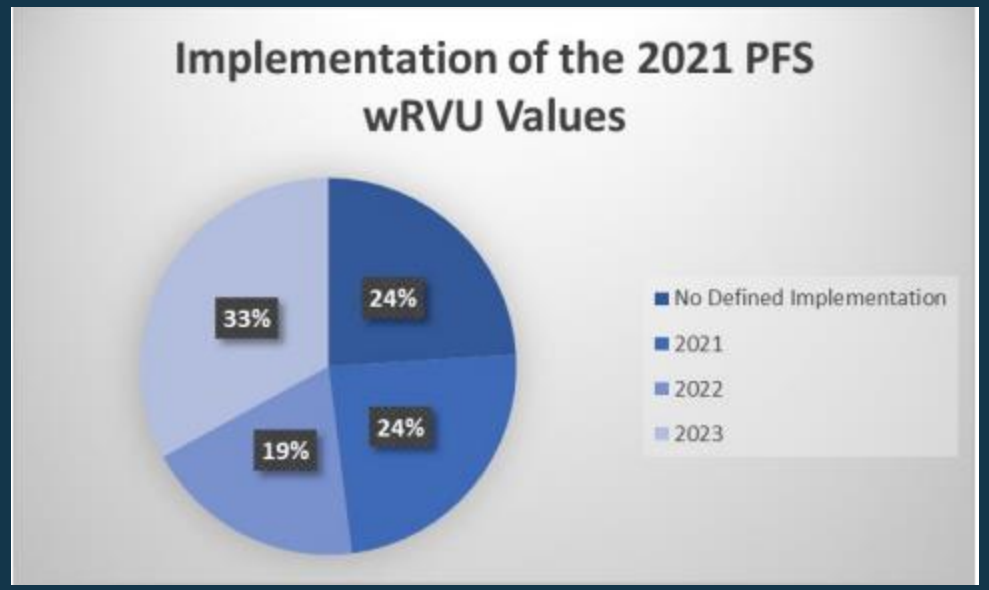
Specialty	% Change in Total wRVUs[2]
Urgent Care	24.4%
Family Medicine (w/o OB)	19.3%
Hematology/Oncology	17.4%
Internal Medicine: General	17.4%
Pediatrics: General	13.5%
Cardiology: Noninvasive	8.4%
Orthopedic Surgery: General	6.3%
OB/GYN: General	3.9%
Gastroenterology	3.8%
Surgery: General	3.0%

1. Note: 99201 was eliminated (historically used for nurse visits)

Source: Gallagher/Integrated Healthcare Strategies. Based on MGMA procedural profile

PFS CHANGE – NO ONE IMPLEMENTED UNIFORMLY

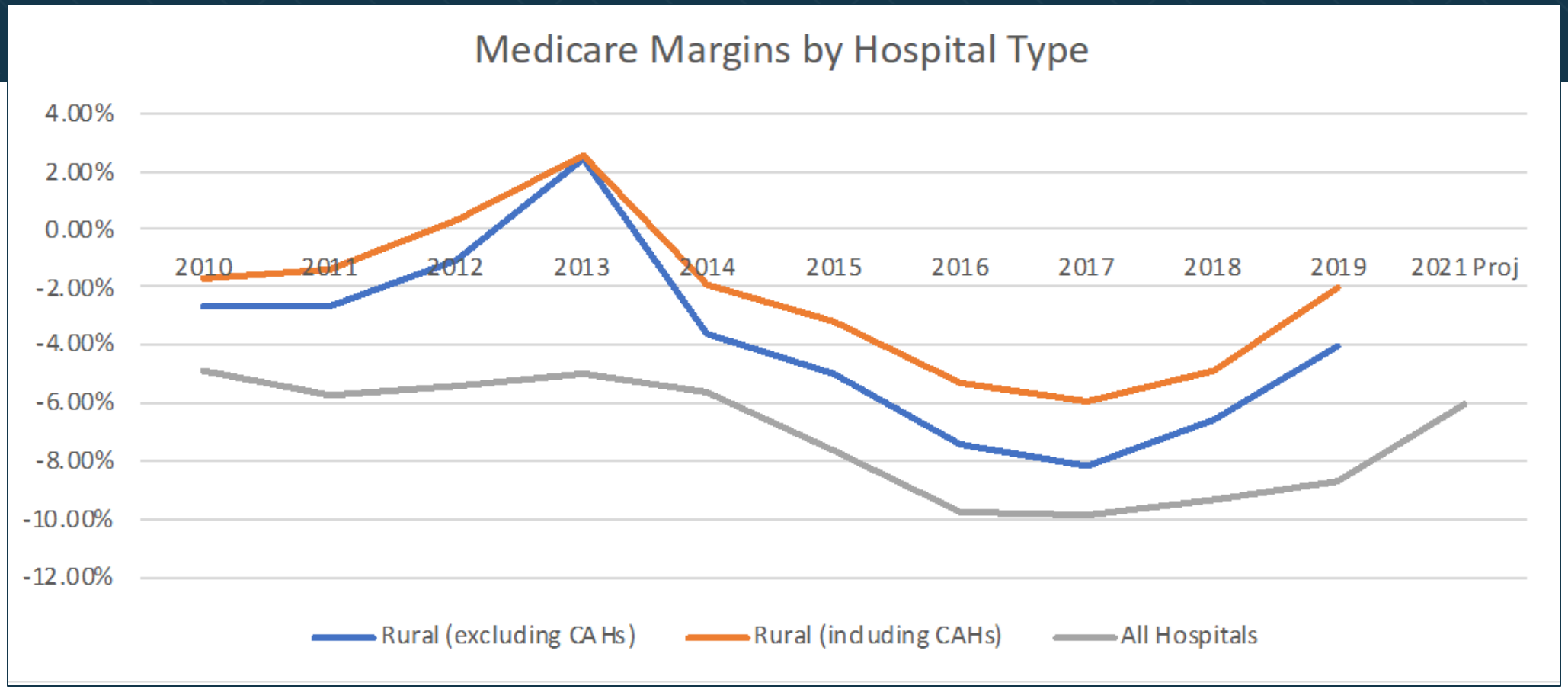
- Over a third of MGMA respondents have not gone live on the 2021 PFS!
- Only 12% allowed for providers to access a full increase in compensation resulting from changes in wRVU values



Source: American Association of Provider Compensation Professionals – "Physician Fee Schedule wRVUs and Billing Rules – This Changes Everything You Know About Provider Data"

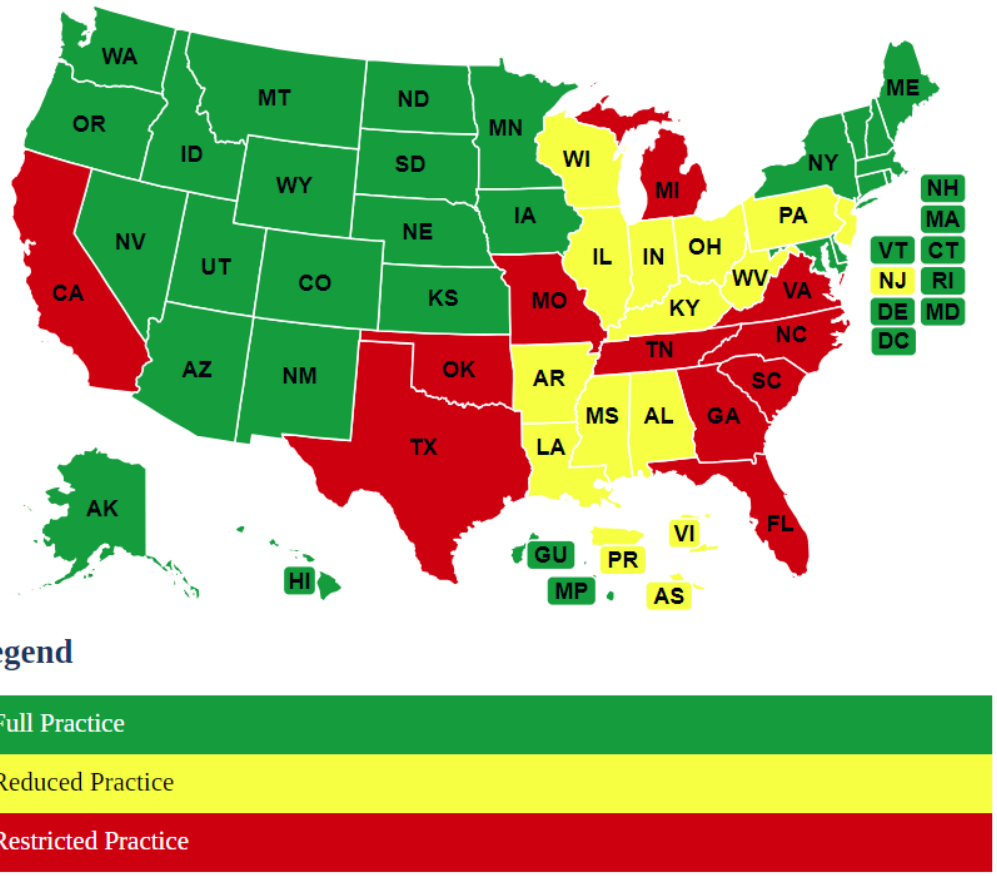
SCARCITY HITTING RURAL

According to the Bipartisan Policy Center, 441 rural hospitals are at risk of closure



PRACTICE ENVIRONMENT DEFINITIONS

- **Full Practice**
  - State practice and licensure laws permit all NPs to evaluate patients; diagnose, order, and interpret diagnostic tests; and initiate and manage treatments, including prescribing medications and controlled substances, under the exclusive licensure authority of the state board of nursing. This is the model recommended by the National Academy of Medicine, formerly called the Institute of Medicine, and the National Council of State Boards of Nursing.
- **Reduced Practice**
  - State practice and licensure laws reduce the ability of NPs to engage in at least one element of NP practice. State law requires a career-long regulated collaborative agreement with another health provider for the NP to provide patient care, or it limits the setting of one or more elements of NP practice.
- **Restricted Practice**
  - State practice and licensure laws restrict the ability of NPs to engage in at least one element of NP practice. State law requires career-long supervision, delegation, or team management by another health provider for the NP to provide patient care.



Source - https://www.aanp.org/advocacy/state/state-practice-environment