STROUDWATER

INTEGRATING INCENTIVES IN RURAL PROVIDER COMPENSATION

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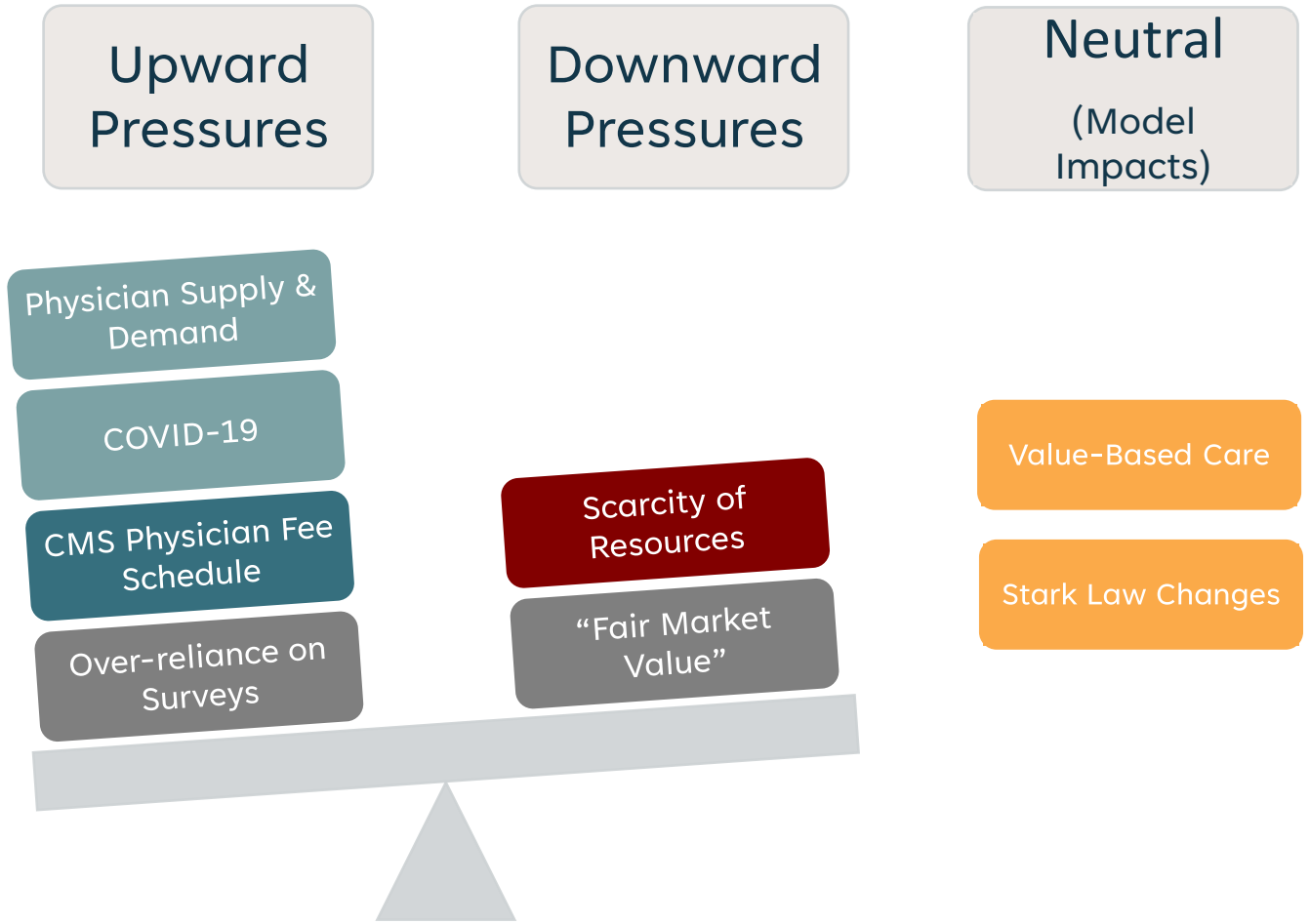
AGENDA

- Current Compensation Market
- Why Do Incentives Matter?
- Compliance Requirements
- Case Study: Midwest Hospital Compensation Engagement
- Q&A

CURRENT COMPENSATION MARKET

FORCES INFLUENCING COMPENSATION

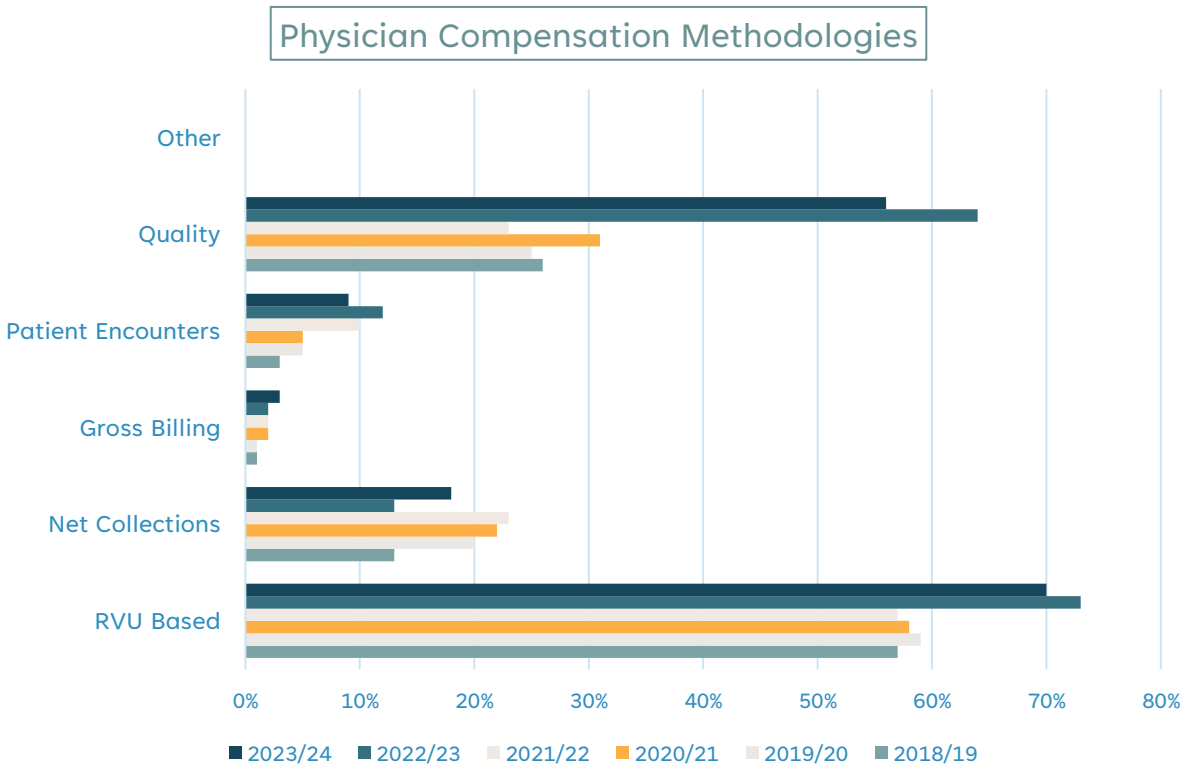
- Regulatory changes, COVID-19 impacts, and the transition to value-based care intensify existing challenges with provider supply (shortages) and demand (increasing need), which directly influence compensation
- Factors to the right affect compensation within the industry. Rural hospitals are also affected 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



POLL QUESTION 1

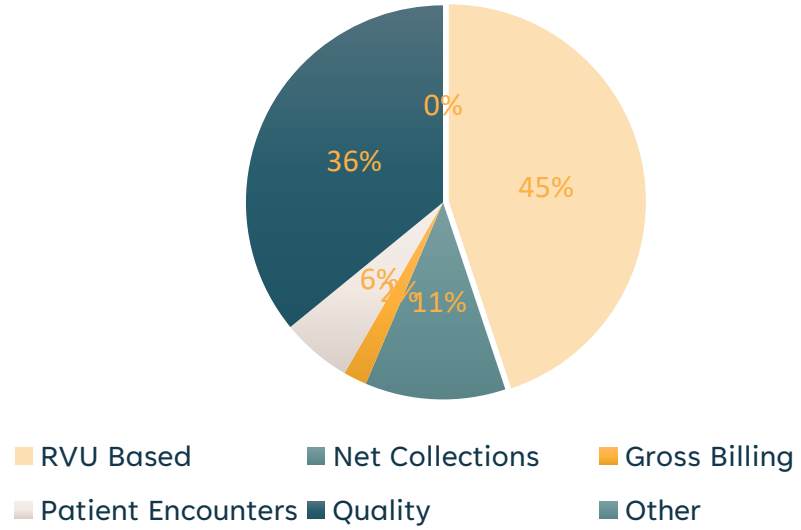
INDUSTRY TRENDS IN COMPENSATION METHODOLOGY

- The majority of physicians are compensated based on a salary plus bonus (such as a productivity incentive)
  - Physicians not compensated based on productivity are more frequently hospital-based



- The most common metrics tied to bonuses include wRVUs, quality and, increasingly, encounters
- Net collections and gross billings are increasingly foregone for wRVUs

Productivity Incentive Methodologies: 2023/24



https://www.amnhealthcare.com/blog/physician/perm/the-latest-trends-in-physician-bonuses/

POLL QUESTION 2

CALL COMPENSATION

- In the past, call compensation was not paid (or at least not separately)
- Excess call comp can be appropriate
- Factors that need to be considered to determine the rate:
  - Call burden
    - Call rotation
    - Restricted versus unrestricted call
    - Volume and frequency of calls
    - Acuity of care provided
  - Specialty
  - What 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 COMPENSATION: INDUSTRY STANDARDS & BEST PRACTICES

- Medical Directors oversee the operations and success of medical services and hospital departments
- Providing compensation for Medical Directorship is industry standard when the Medical Directorship provides a legitimate business purpose and does not exceed those reasonably necessary to accomplish a business purpose (i.e., commercially reasonable), the compensation is within fair market value, and the compensation provided is not in exchange for referrals
- FMV generally considers:
  - Hours spent on medical directorship
  - "Rigor" of responsibilities
  - Survey data for specialty-specific medical directorship compensation
- **Medical Directorship compensation is under significant scrutiny by the Office of Inspector General ("OIG") due to a history in the industry of inappropriate use**
- Entities must *at a 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 the administrative FTE is less than 0.5 FTE
- Median-level medical directorship is 8 hours per week with a median stipend of $25,000

MORE THAN JUST “COMPENSATION”

- Benefits have a cash or in-kind value, and are an increasingly important part of a provider’s total compensation
- The table at right distinguishes between what industry professionals typically categorize as “cash compensation” (or Medicare gross wages) and "benefits”
- The cost of employer-sponsored benefits is typically 10-20% of cash compensation for physicians, depending upon specialty
  - As a result, employee benefits are often the second-highest Operating Expense next to Salaries & Wages

“Cash Compensation” What organizations typically consider compensation	“Benefits” What is actually also compensation
Base Salary	Health Insurance
Signing/Extension Bonus	Retirement Contributions
Productivity Compensation	Paid Time Off Cashouts
Quality Incentive Compensation	Continuing Education & Licensure Fees
Medical Directorship	Dental Insurance
Management of APPs	Disability Insurance
Relocation Stipend	Life Insurance
Housing Stipend	HSA and HRA Contributions
Tuition Repayment	Employer-Paid “Voluntary” Benefits
Other “Cash” Compensation	Other “In Kind” Compensation

FMV opinions often only consider “cash” compensation (or Medicare gross wages) and may overlook issues of stackable compensation and benefits (cash or in-kind)

WHY DO INCENTIVES MATTER?

"Compensation is the remuneration awarded to an employee in exchange for their services or individual contributions to your business. The contributions can be their time, knowledge, skills, abilities, and *commitment* to your company or a project."

CURRENT ENVIRONMENT

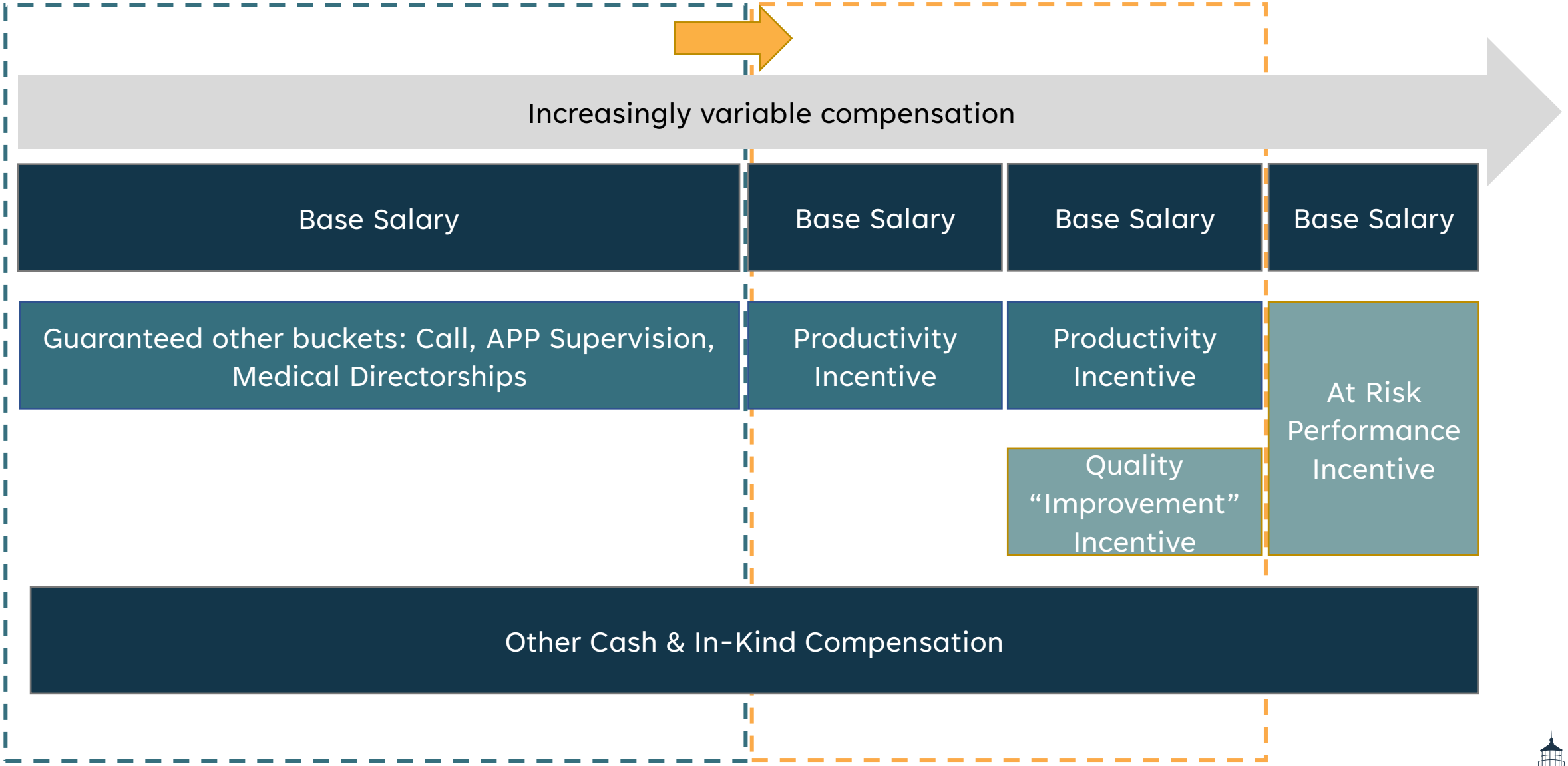
Stroudwater's 2nd Annual Rural Provider Compensation Survey, co-sponsored by NRHA and NOSORH, indicates that 54.7% of rural hospitals DO NOT pay providers incentive compensation

Rural organizations worry about being competitive if ANY compensation is at risk

Total compensation is increasing across the board, except for emergency medicine

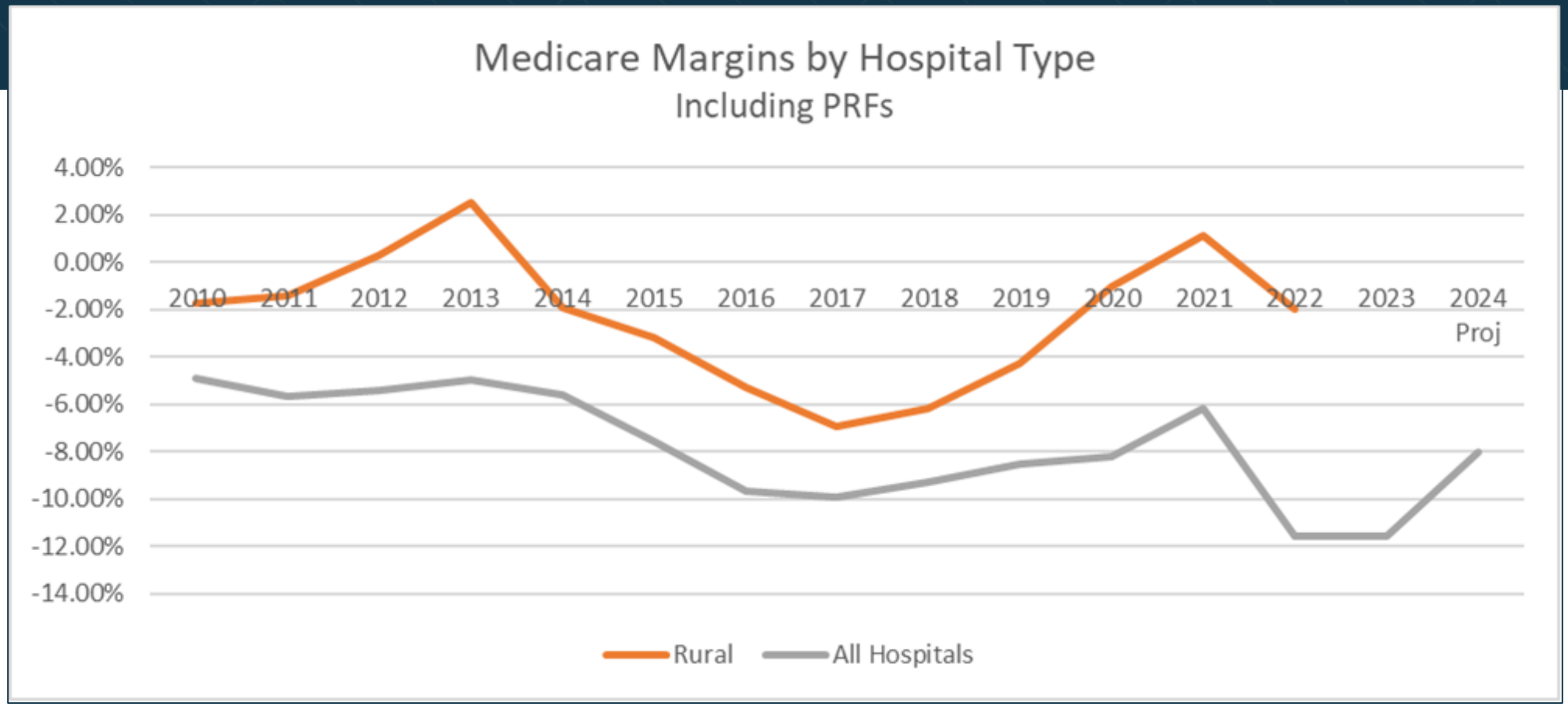
Providers are mistrusting of incentive compensation due to data issues and a lack of information regarding what they could control.

CURRENT STATUS OF COMPENSATION IN RURAL



SCARCITY HITTING RURAL

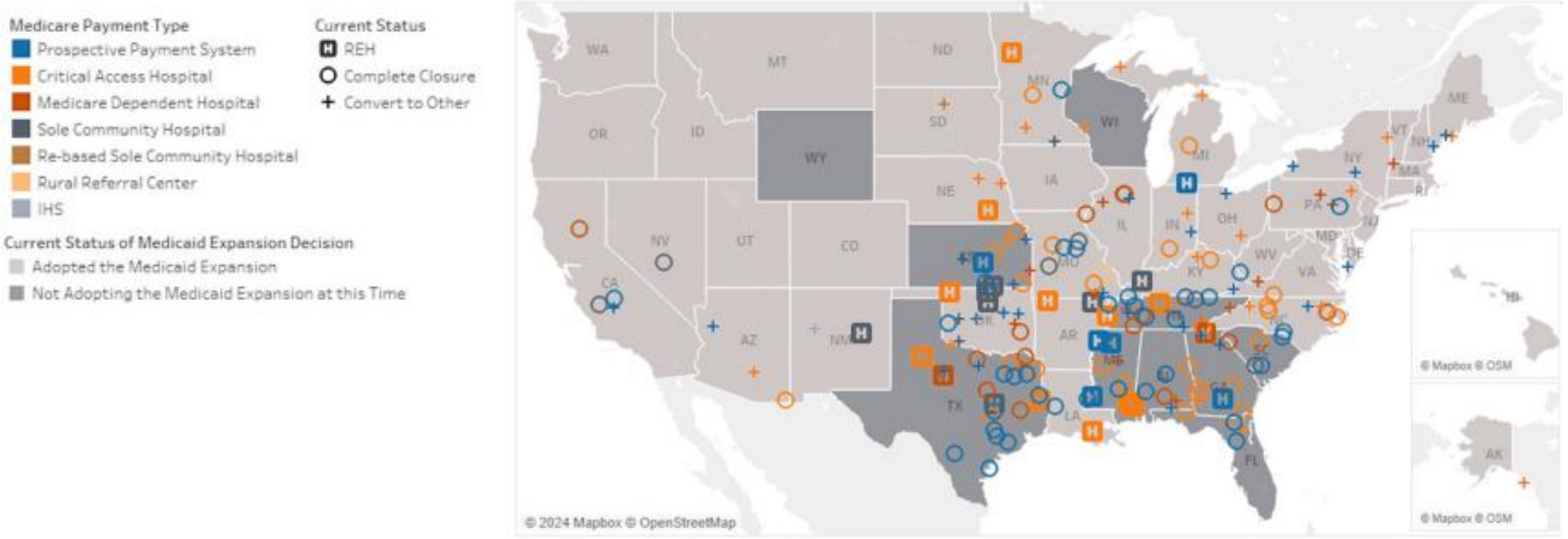
According to the Bipartisan Policy Center, 441 rural hospitals at risk of closure



Source: MedPAC Report to the Congress: Medicare and the Health Care Delivery System, March 2024

HOSPITALS CLOSING AS A RESULT

There have been 178 Rural Hospital closures or conversions since 2010, and 217 since 2005. These numbers include 26 Rural Emergency Hospital Conversions since 2023.



Merative; as of May 13, 2024

BENEFITS OF INCENTIVE COMPENSATION

- Not limited to one kind of incentive
- Creates a mechanism for enhancing provider engagement
- Productivity based compensation ensure payments are for work performed and discourages non-productive behavior
- Can promote data-driven culture
- Can promote healthy competition within a group
- Grounded in pay equity

CHALLENGES TO INCENTIVE COMPENSATION

- Unclear or overly complicated incentives
- Unreachable incentives
- Requires data analytics
- Providers feel it impacts the quality of their care – wRVUs are a distraction
- What do you do if it doesn’t change behavior?

TYPES OF COMPENSATION MODELS

Annual Guarantee

Starting base salary

Base compensation – may or may not be readjusted

Productivity Incentive

% of NPSR or Gross Charges – mostly replaced by:

- Compensation per Work RVU (“wRVU”)
- Compensation per visit
- Panel size compensation

Value-Based Compensation

Quality Incentives

Value-based reimbursement (“VBR”) adjusted wRVU

Distributions of ACO dollars

Administrative & Other Duties

Medical Directorships

APP Supervision

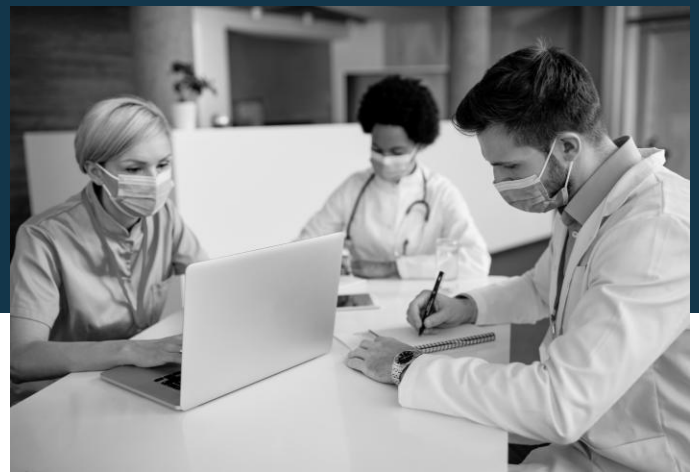
Call Compensation

COMPLIANCE REQUIREMENTS

RELEVANCE OF PROVIDER CONTRACTS

Provider remuneration expense is significant & increasing

Provider remuneration is highly regulated



The pace of change is significant

Many organizations find that their provider alignment & compensation are misaligned with organizational strategy and industry trends

PRIMARY LAWS & STATUTES

Stark Law	• Prohibits physicians from referring patients to receive "designated health services“ (“DHS”) payable by Medicare or Medicaid from entities with which the physician (or an immediate family member) has a financial relationship, unless an exception applies (such as Fair Market Value) • Strict liability statute – this is where the technical violations happen!
Anti-Kickback Statute (“AKS”)	• The AKS is a criminal law that prohibits the knowing and willful payment of "remuneration" to induce or reward patient referrals or the generation of business involving any item or service payable by the federal healthcare programs (e.g., drugs, supplies, or healthcare services for Medicare or Medicaid patients)
False Claims Act (“FCA”)	• Triple the damages caused for anyone who commits Medicare fraud • Any violation of Stark or AKS are considered on their face false or fraudulent and violations of the FCA
Private Inurement	• Applicable to not-for-profit organizations only • Compensation that exceeds a typically fair salary for comparable positions • Consequence is revocation of not-for-profit status

Settlements and judgments under the False Claims Act exceeded $2.9 billion in the fiscal year ending Sept. 30, 2024. The government and whistleblowers were party to 566 settlements and judgments, the 2nd highest number of settlements and judgments in a single year. Of the more than $2.9 billion in False Claims Act settlements and judgments reported by the Department of Justice this past fiscal year, over $1.7 billion related to matters that involved the healthcare industry.

Department of Justice, January 15, 2025

POLL QUESTION 3

FMV PROVIDER COMPENSATION

- Hospital considerations when determining FMV for provider services:

Specialty/subspecialty	Duties & responsibilities	Community need (e.g., deficits, wait times, closed specialties, high disease incidence, outmigration, seasonality)	Community benefit (e.g., new specialty or service)
Time it takes to recruit	Training & experience	Compensation methodology & amount (including cash and in-kind compensation)	Benchmark comparison using a nationally recognized source

FMV opinions must be documented with the physician's contract, especially if compensation is ≥70th percentile of benchmark and/or compensation to productivity variance is >10%

CASE STUDY: MIDWEST HOSPITAL COMPENSATION ENGAGEMENT

ENGAGEMENT BACKGROUND

- Midwest Hospital is a 25-bed CAH in a rural community, with the next PPS hospital over 45 minutes away
- The new CEO joined the hospital as a first-time CEO, but with a background as a director of outpatient services
- The CEO was concerned about inconsistent pay practices across providers
  - The hospital was losing money and had approved a negative operating budget for the first time
  - No set strategy
  - No transparency for providers on how to earn increases in compensation
  - No fair market valuations in place

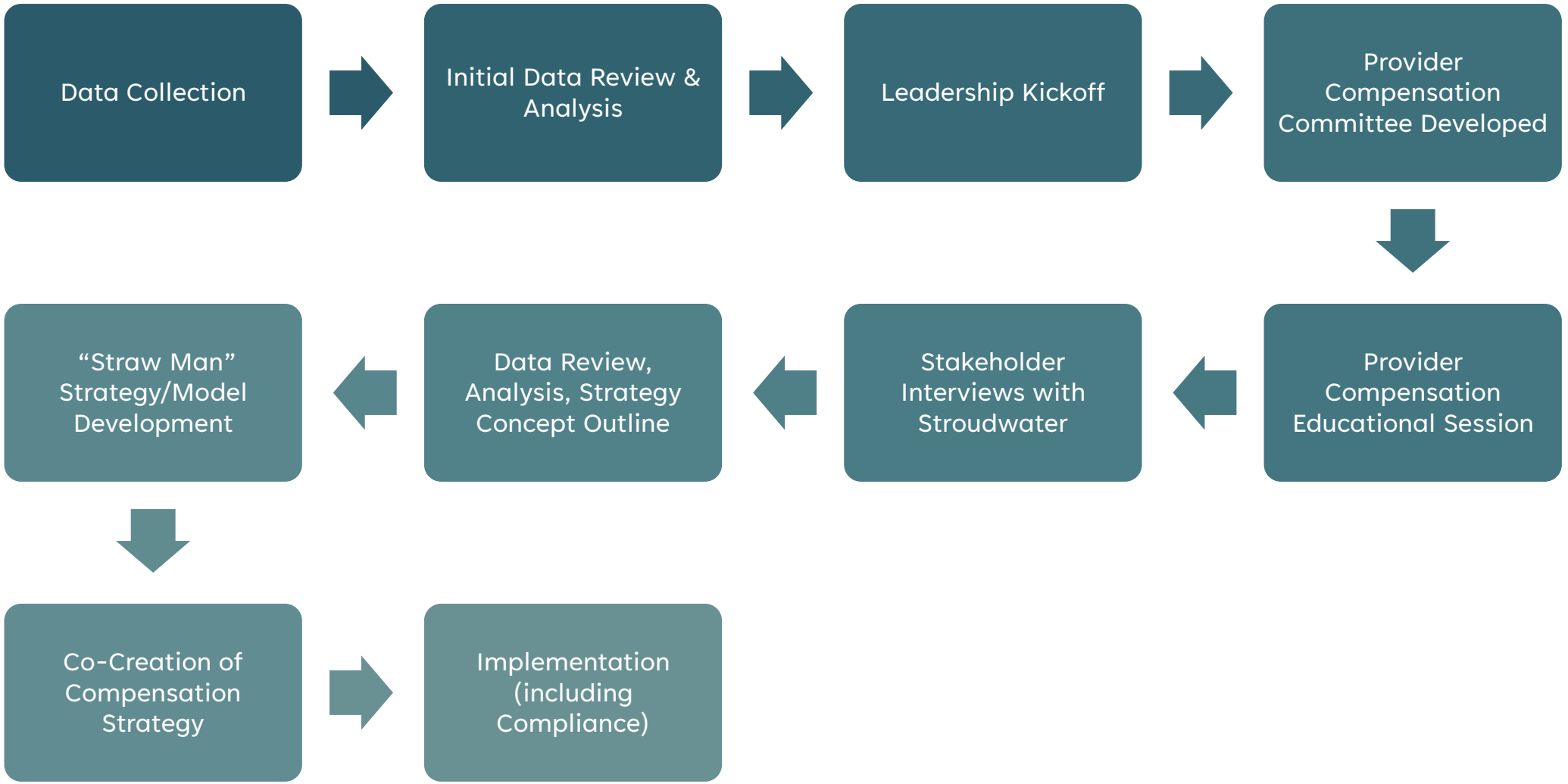
There are two buttons I never like to hit: that’s panic and snooze.

-Ted Lasso

ENGAGEMENT OVERVIEW

- Midwest Hospital wanted to adopt a new compensation strategy and model that would achieve the following:
  - Align with the Hospital's overarching strategy;
  - Address specialty-specific considerations to employ CRNA providers;
  - Competitively and fairly compensate providers for their work while balancing organizational needs;
  - Incorporate productivity incentives that reward high performers;
  - Consider the organization's total remuneration, including compensation and benefits;
  - Address provider expectations and demands;
  - **Align with industry best practices and compliance requirements**; and
  - Enhance the consistency and understanding of provider employment contracts.

PROCESS


Data Collection
Initial Data Review & Analysis
Leadership Kickoff
Provider Compensation Committee Developed
Provider Compensation Educational Session
Stakeholder Interviews with Stroudwater
Data Review, Analysis, Strategy Concept Outline
“Straw Man” Strategy/Model Development
Co-Creation of Compensation Strategy
Implementation (including Compliance)

PROVIDER INTERVIEWS AND COMP COMMITTEE

SUGGESTIONS AND FEEDBACK

1. Benefit Package (i.e., health insurance, tuition payment)
    a) “Health insurance is pricier [for the organization] than it should be.”
    b) “We all have terminal degrees” – Tuition payment is not an attractive benefit
2. Competition Compensation Comparison
    a) “Where is our comp compared to the clinic across the street?”
3. Productivity Incentives
    a) Concern about the validity of data, inconsistent
    b) Used to seeing this in larger/previous organizations
    c) Denial/Coding management - “We used to get emails about this but don’t anymore, worried we are missing things,” “I don’t get any feedback on my notes here”
    d) Prior Authorization management - “I’m concerned we are getting denials [based on this] and are not being made aware of it”
    e) Ensure the threshold aligns with rural

WHERE DO WE GO FROM HERE?

Specialty	Goals	Current Model	New Model
Family Medicine	1. Compliant (FMV) 2. Competitive (recruitment) 3. Growth (diversify services) 4. Financially sustainable 5. Operational Efficiency 6. Community Partners & Care coordination 7. CHNA Integration 8. Loyalty/retention/engagement (good citizenship) 9. Tenure/Education/Years of experience	1. Base salary & benefits 2. No incentives 3. Add-on's (if applicable) • Loan repayment • Medical Directorships • Housing • Sign-on bonus • Retention bonus • Relocation	1. Base salary & benefits 2. Productivity incentives 3. Quality incentives
Behavioral Health			1. Base salary & benefits 2. Productivity incentives 3. Quality incentives
Emergency Medicine			1. Base salary & benefits 2. Quality incentives 3. Excess shifts/shift premiums
Hospitalists			
Wound Care			

ENGAGEMENT RESULTS

Committee determined to set compensation tying to MGMA data

Base Salary adjusted by up to 10% for specific criteria important to Midwest Hospital

- Rural experience
- Tenure at organization
- Working in multiple departments

Productivity Incentives for clinic-based providers

Extra compensation for taking extra shifts

One-year guarantee of current compensation before moving over to the compensation plan

Board approved contingent on undergoing operational improvement initiatives

Redrafted all contracts and developed compensation plans by specialty

Met with each provider individually to show side-by-side comparisons with scenario modeling

The organization has been able to recruit additional providers under the new comp plan successfully

Q&A

STROUDWATER

COMMITTED TO INCREASING THE IMPACT OF RURAL AND COMMUNITY HEALTHCARE.

Our team of rural and community healthcare experts support the leadership of hospitals, health systems with a rural footprint, and the groups and clinics that form an essential care network across the 97% of the US that is defined as rural.

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