NRHA

NOSORH

STROUDWATER

# CRITICAL ACCESS HOSPITAL

## FINANCIAL AND OPERATIONAL VIRTUAL CONFERENCE

June 2024

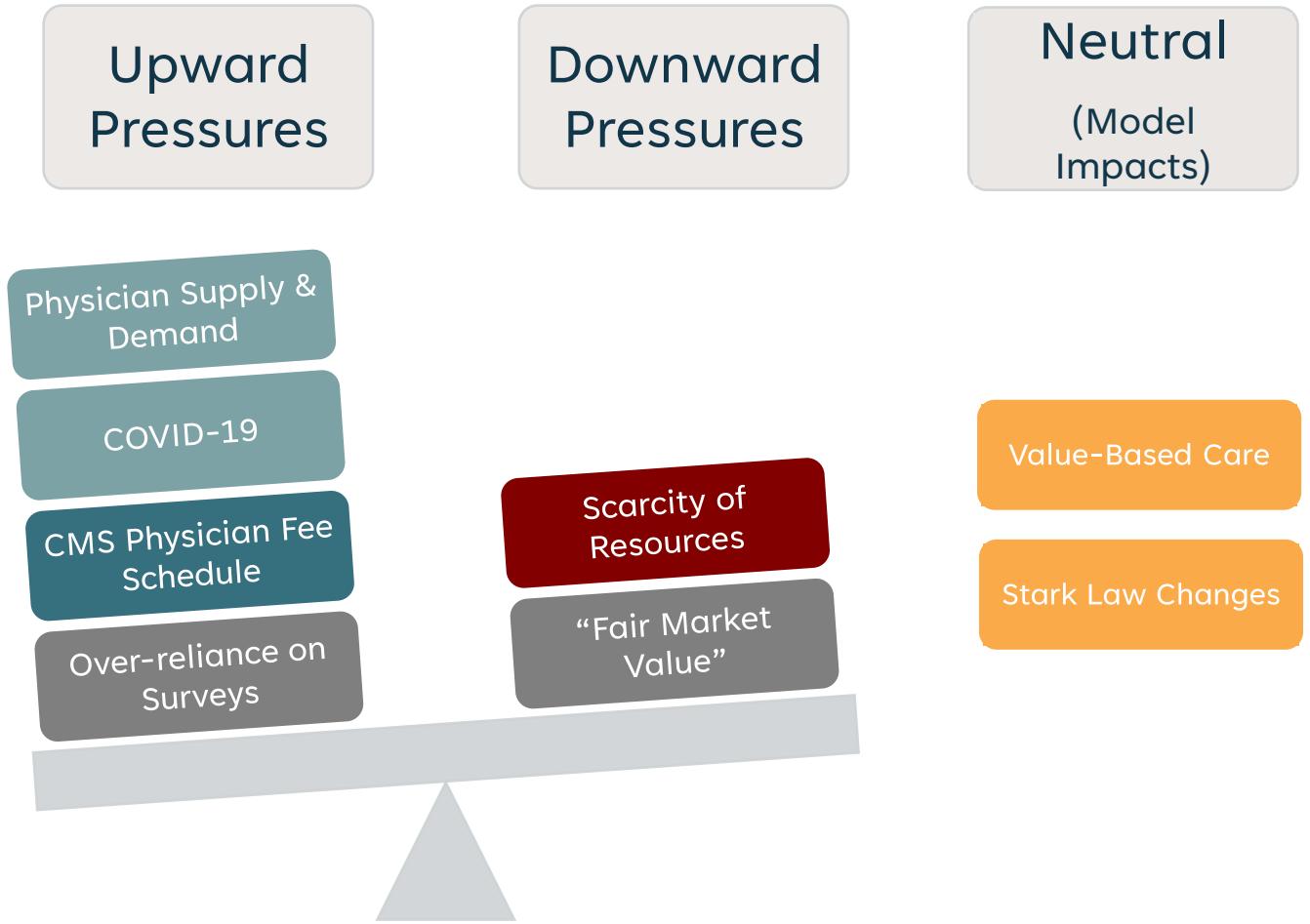
# AGENDA

- Current Compensation Market
- Provider Compensation Survey
- Review of Initial Findings: Primary 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) | 92 | 341 |
| Family Medicine (without OB) | 76 | 264 |
| Internal Medicine: General | 32 | 83 |
| Certified Registered Nurse Anesthetist | 14 | 83 |
| Surgery: General | 38 | 80 |
| Emergency Medicine | 19 | 78 |
| Hospitalist: Internal Medicine | 20 | 76 |
| Pediatrics: General | 30 | 71 |
| Family Medicine: Ambulatory Only (No Inpatient Work) | 5 | 66 |
| Obstetrics/Gynecology: General | 29 | 66 |
| PA: Family Medicine (without OB) | 33 | 64 |
| Physical Therapist | 10 | 63 |
| Orthopedic Surgery: General | 26 | 56 |
| NP (Primary Care) | 23 | 56 |
| Family Medicine (with OB) | 16 | 47 |
| Urgent Care | 15 | 43 |
| NP: Psychiatry | 17 | 32 |
| Urology | 20 | 30 |
| Otorhinolaryngology | 15 | 29 |
| Licensed Clinical Social Worker | 8 | 27 |

Source: MGMA 2024 Provider Compensation and Productivity Survey (Based on 2023 Data)

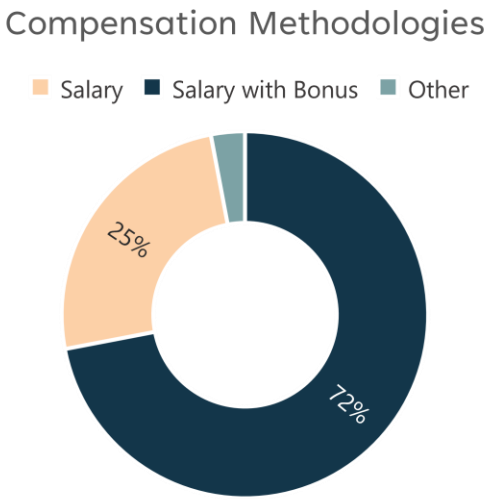
# LIMITATIONS TO SURVEY DATA

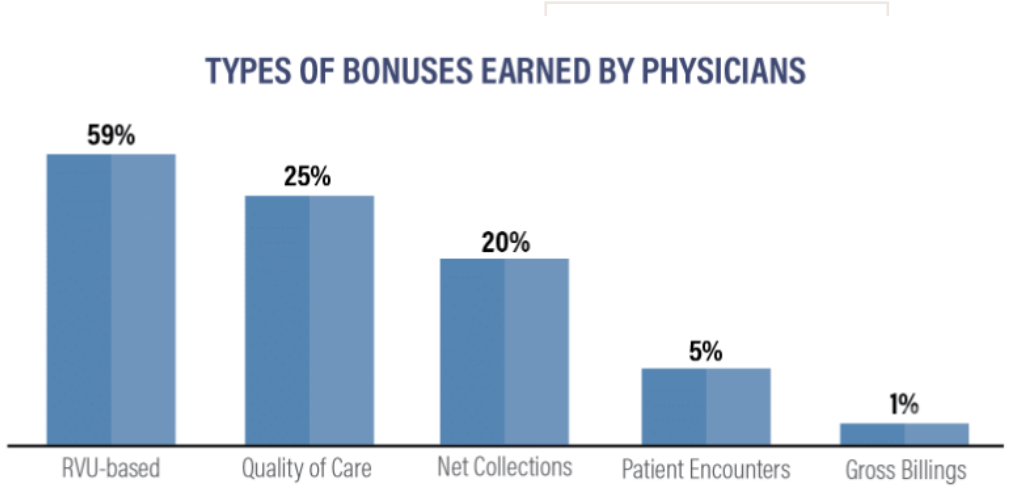
- Survey data typically publishes total *cash* compensation for professional services
- What is in cash compensation?
  - W-2 wages
  - K-1 compensation
  - Medical director stipends
  - Research income
  - Call compensation
  - APP supervision stipends
- Not many rural respondents (servicing populations 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 1,165 providers
  - Women's Health** data represents 93 providers

*Primary care includes family medicine w/ and w/o OB, urgent care, pediatrics, dietitian/nutritionist, and internal medicine for both physicians and APPs.
** Women's Health includes OB/GYN, nurse midwives and NP: OB/GYN/Women's Health

# 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** (57% of specialists, 53% of PCPs)[1]
  - Productivity metrics need to be consistently measurable
  - Types:
    - % of net professional collections
    - wRVUs – in metro markets this is down from 70% from 2020 report
    - Encounters – down from 9% previously
    - Panel size
- **Quality Compensation**
  - This has declined to from 64% of providers receiving this in 2019/2020




1. Physicians Thrive 2024 Physician Compensation Report

# 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

# PROVIDER COMPENSATION SURVEY

# SCOPE AND PURPOSE

- This presentation is based on the 2024 Provider Compensation Survey issued by Stroudwater Associates in January 2024
  - This survey is a follow-up to the 2023 Provider Compensation Survey
- 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

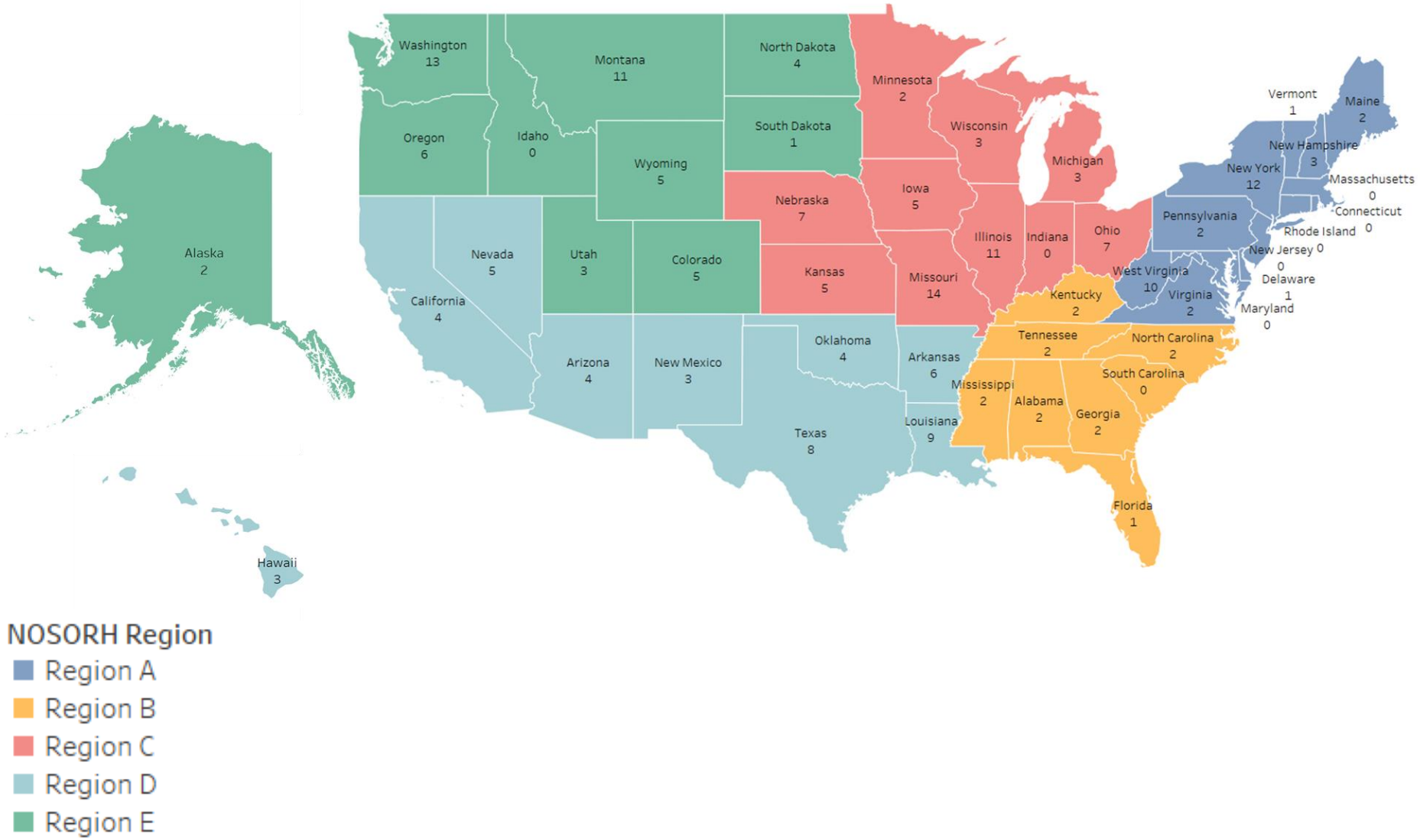
| | 2023 | 2024 |
|---|---|---|
| Total Survey Respondents | 156 | 199 |
| Health System Respondents | 43 | 79 |
| Independent Hospital Respondents | 109 | 120 |
| No Response – System Status | 4 | 0 |

# PROVIDERS REPRESENTED

- Based on respondent feedback, this survey represents, at minimum, approximately 2,841 provider FTEs
  - Responses showed that independent hospitals represented 1,762 (62%) of the total provider FTE count

| | Reported as Independent | Reported as System | Nationally |
|---|---|---|---|
| Minimum Provider FTEs Represented | 1,762 | 1,079 | 2,841 |

# 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 28.43% of surveys returned
- Region A was the only region with a higher percentage of health system respondents than independent respondents (this is consistent with 2023's survey)
- Region E had the highest percentage of independent respondents

## Overall, independent hospitals accounted for approximately 60% 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 | % of System Respondents | % of Independent Respondents | Total Response Rate (of surveys returned) |
|---|---|---|---|---|---|---|
| A | 33 | 21 | 12 | 63.64% | 36.36% | 16.75% |
| B | 13 | 5 | 8 | 38.46% | 61.54% | 6.60% |
| C | 56 | 25 | 31 | 44.64% | 55.36% | 28.43% |
| D | 46 | 16 | 30 | 34.78% | 65.22% | 23.35% |
| E | 49 | 11 | 38 | 22.45% | 77.55% | 24.87% |
| Total | **197** | **78** | **119** | 39.59% | 60.41% | 100.00% |

# STUDY PROCESS

| Measures | Sources | Limitations |
| --- | --- | --- |
| • **Average Compensation:** the average compensation paid within a calendar year to a specific specialty and provider type<br>• Number of providers by specialty<br>• **Provider employment status:** Providers were identified as W-2, contracted (1099) or locums | • Stroudwater Associates 2024 Provider Compensation survey, 199 responses reflective of 42 of 50 states<br>• AANP State Practice Environment map<br>• Rural organizations were contacted through NRHA, NOSORH, and individual State Offices of Rural Health | • First year conducting survey in-house; prior year survey does not allow for an apples-to-apples comparison<br>• Data is self-reported by organizations without validation<br>• For results indicating an "*" the value needs further validation, but additional data is available; N/A indicates insufficient responses for category |

# TYPES OF COMPENSATION

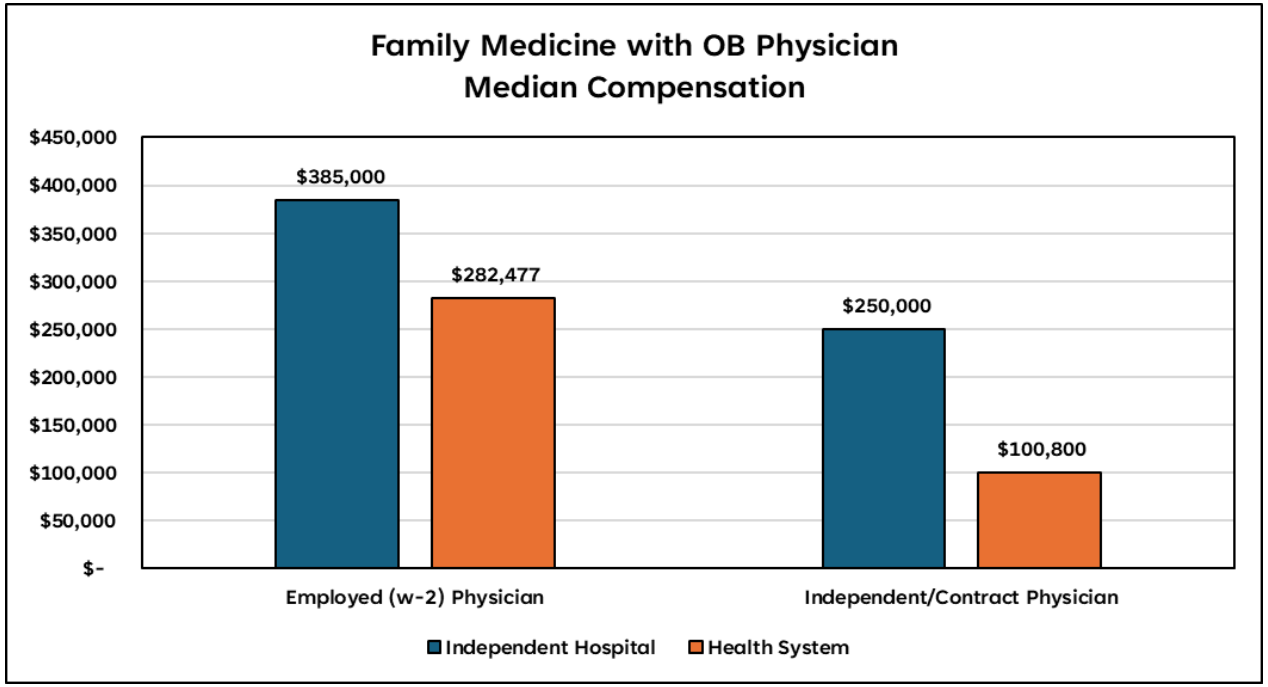
- When asked what types of compensation are provided to your employed providers, 54.7% of respondents reported paying providers entirely on a straight salary (slight decline from 2022 data showing 56%)
- 32.1% (down from 37%) of respondents provide some form of incentive compensation
  - 31% provide production bonuses
  - 13.1% provide quality incentives
- Additional compensation provided:
  - 54 respondents provide student loan repayment ($41K on average)
  - 68 respondents provide sign-on bonuses (average amount was $36K)
  - 31 respondents pay a retention bonus ($20K on average)

| Types of Productivity Comp |
| --- |
| wRVU/RVU Based |
| Patients per Hour |
| Charts Closed per Hour |
| RHC Visits |
| Patient Panel Size/Growth |
| % of Collections |

# REVIEW OF INITIAL FINDINGS:
## PRIMARY CARE

# PRIMARY CARE PHYSICIANS WITH OB

- Independent hospitals report paying more for employed Family Medicine physicians with OB than their health system counterparts
- Few health systems reported contracted compensation for Family Medicine with OB physicians, likely indicating a deference to employment
- Organizations reported higher compensation of employed Family Medicine with OB physicians than 1099 physicians
- Organizations not affiliated with a health system reported a maximum compensation of $621,976 versus the reported health system maximum compensation of $400,000

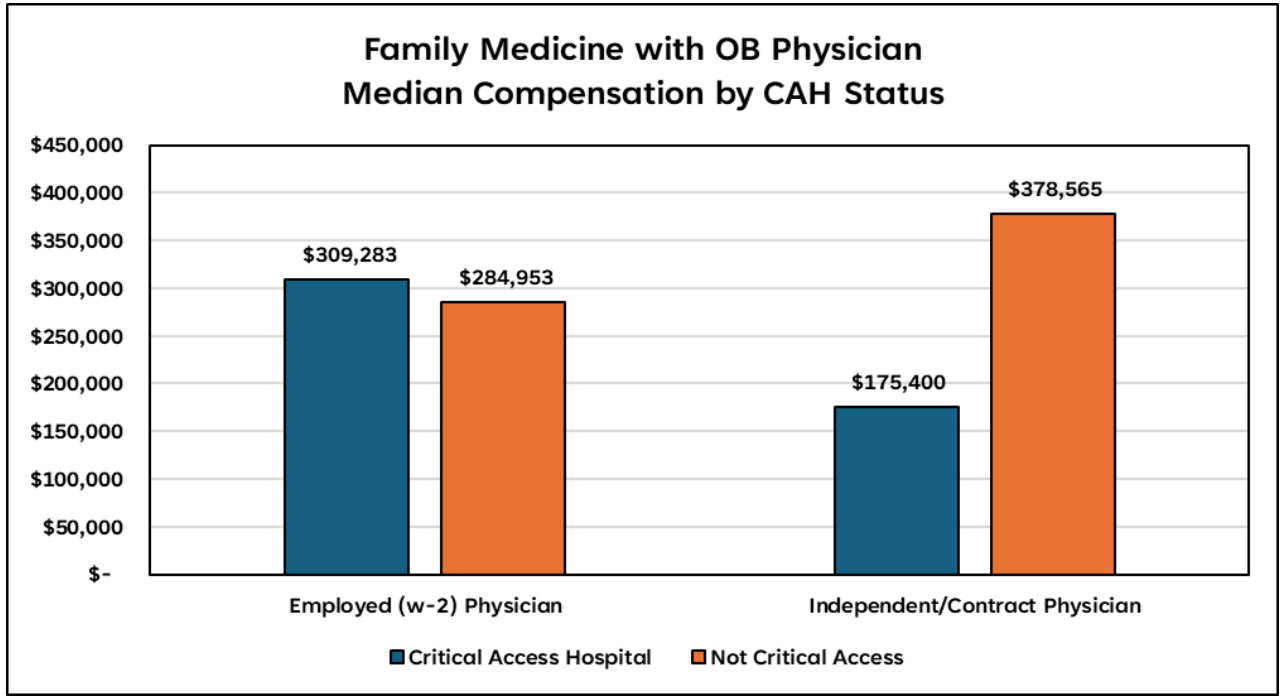



| Employment Status | Independent Hospital | | | Health System | | |
|---|---|---|---|---|---|---|
| | Min. Com. | Median Comp. | Max. Comp. | Min. Com. | Median Comp. | Max. Comp. |
| Employed (W-2) | * | $385,000 | $621,976 | $104,000 | $282,476 | $400,000 |
| Independent/Contract | * | $250,000 | $500,000 | * | $108,000 | * |

* Indicates data point requiring verification

# PRIMARY CARE PHYSICIANS WITH OB (CONT.)

- Independent physicians are shown to receive higher compensation at organizations that are not Critical Access Hospitals (CAHs)
- CAHs report higher average compensation for employed Family Medicine with OB across the board
- Interestingly, independent contractors at the maximum end of the spectrum are paid less than employed providers; typically 1099/contracted providers are paid an amount equivalent to base and additional amounts to cover benefits, medical malpractice, and other expenses

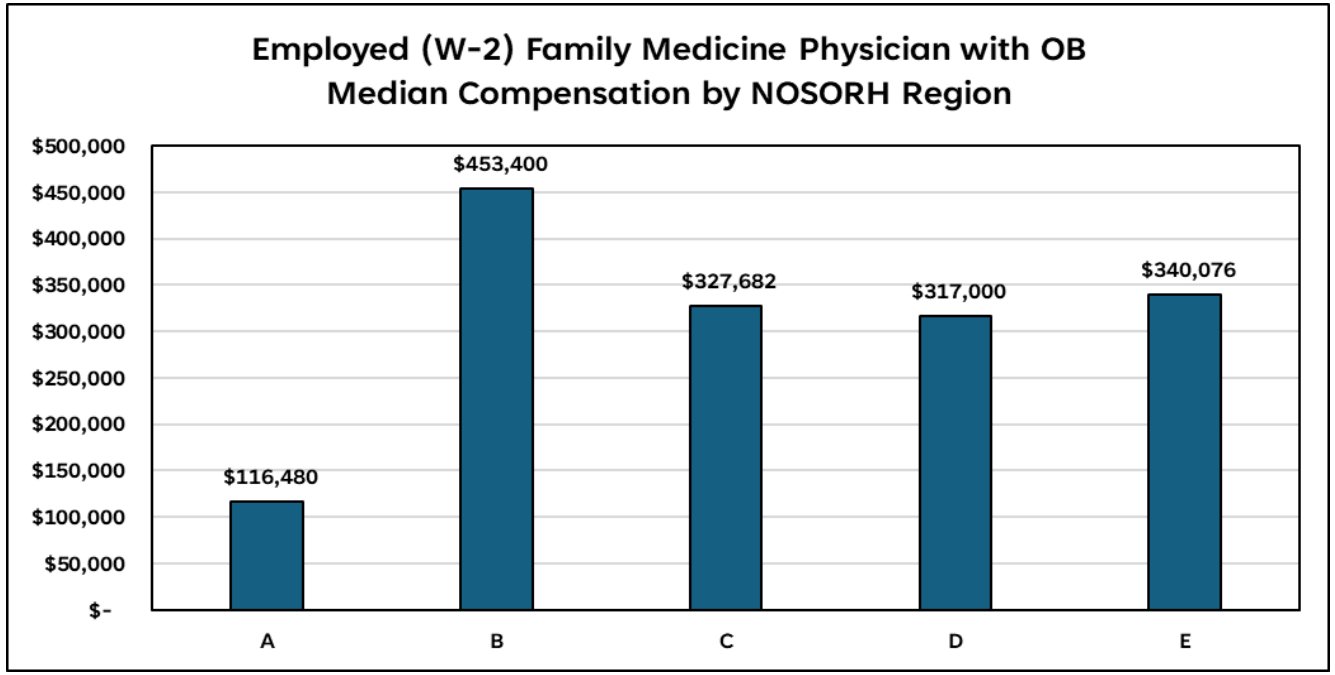



| Employment Status | Not Critical Access | | | Critical Access Hospital | | |
|---|---|---|---|---|---|---|
| | Min. Com. | Median Comp. | Max. Comp. | Min. Com. | Median Comp. | Max. Comp. |
| Employed (W-2) | $116,480 | $284,953 | $453,400 | * | $327,682 | $621,976 |
| Independent/Contract | $240,000 | $309,283 | $378,565 | * | $175,400 | $500,000 |

* Indicates data point requiring verification

# PRIMARY CARE PHYSICIANS WITH OB (CONT.)

- Only Region E had a respondent that reported a 1099 Family Medicine with OB physician, so only employed physicians are reflected
- Region B reports the highest average salary for employed (W-2) Family Medicine with OB physicians

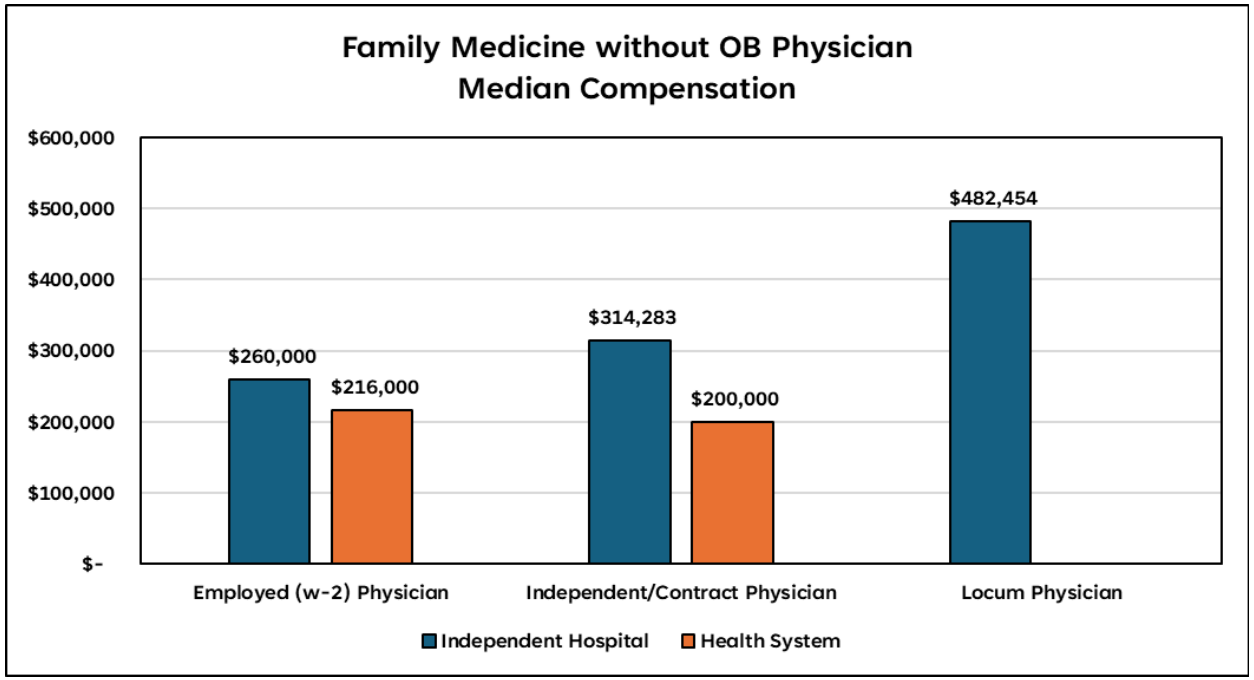



| Region | A | B | C | D | E |
|---|---|---|---|---|---|
| Min | * | * | * | $260,000 | $104,000 |
| Median | $116,480 | $453,400 | $327,682 | $317,000 | $340,076 |
| Max | * | * | $ 621,976 | $389,000 | $492,910 |

* Indicates data point requiring verification

# PRIMARY CARE PHYSICIANS WITHOUT OB

- Independent hospitals report paying more for employed Family Medicine physicians without OB than their health system counterparts
- No health systems reported 1099 or locum compensation for Family Medicine without OB physicians, likely indicating a deference to employment

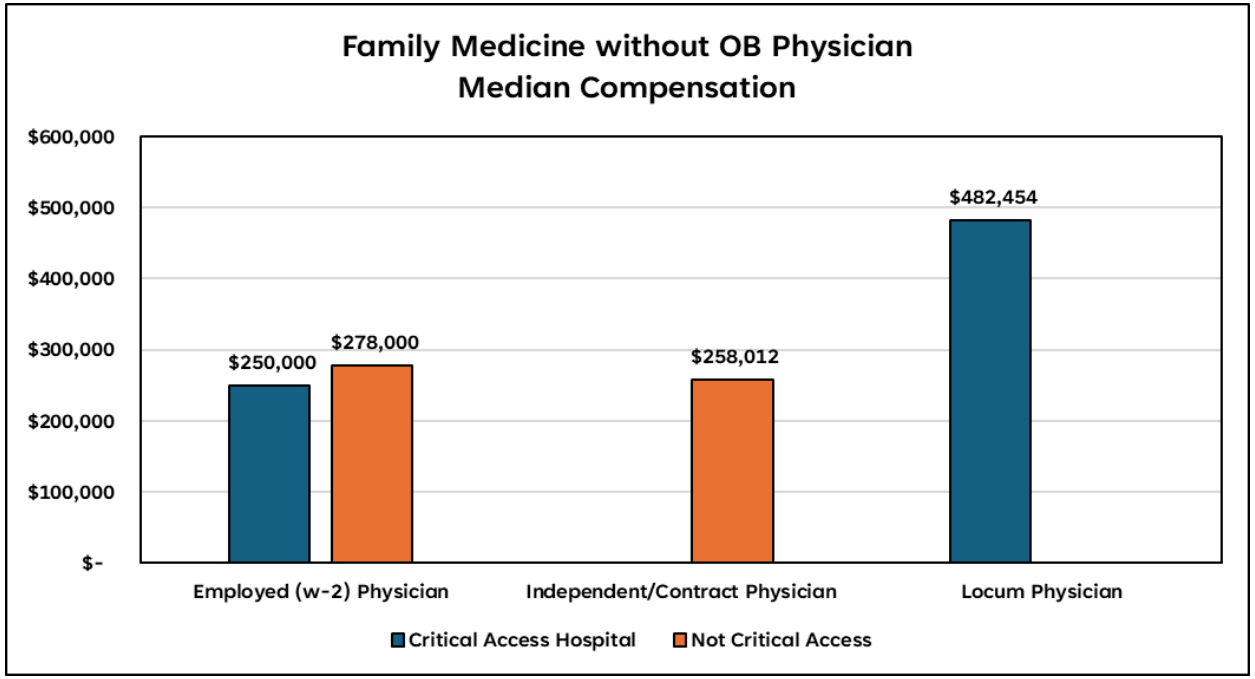



| Employment Status | Independent Hospital | | | Health System | | |
|---|---|---|---|---|---|---|
| | Min. Com. | Median Comp. | Max. Comp. | Min. Com. | Median Comp. | Max. Comp. |
| Employed (W-2) | * | $260,000 | * | * | $216,000 | $400,000 |
| Independent/Contract | * | * | $516,021 | * | $200,000 | * |
| Locum | * | * | $482,454 | N/A | N/A | N/A |

* Indicates data point requiring verification

# PRIMARY CARE PHYSICIANS WITHOUT OB (CONT.)

- CAHs report generally lower compensation for employed and 1099 Family Medicine without OB physicians than non-CAH organizations
  - However, only CAHs responded to having locums
- Employed Family Medicine without OB physicians earned more on average than their 1099 counterparts, regardless of designation

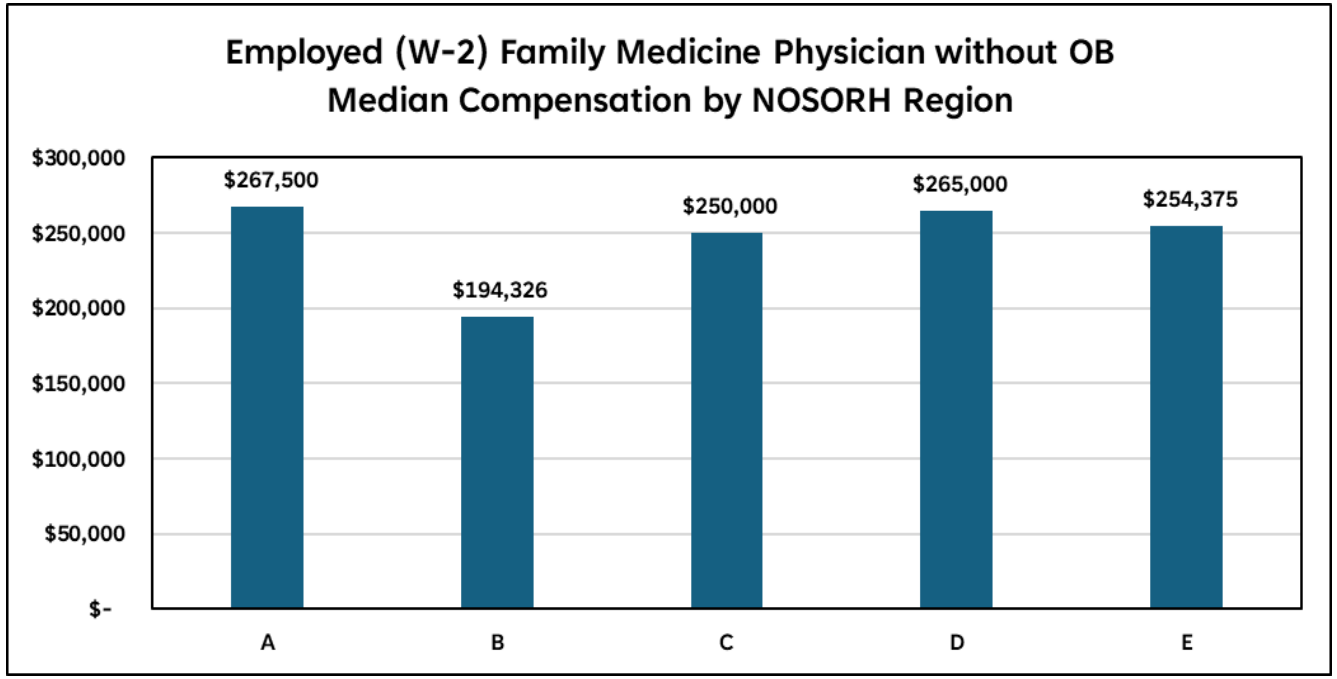



| Employment Status | Not Critical Access | | | Critical Access Hospital | | |
|---|---|---|---|---|---|---|
| | Min. Com. | Median Comp. | Max. Comp. | Min. Com. | Median Comp. | Max. Comp. |
| Employed (W-2) | * | $278,000 | * | * | $250,000 | $638,549 |
| Independent (1099) | * | $258,012 | $516,021 | * | * | $300,000 |
| Locum | N/A | N/A | N/A | * | $482,454 | * |

* Indicates data point requiring verification

# PRIMARY CARE PHYSICIANS WITHOUT OB (CONT.)

- Region A reports the highest median salary for employed (W-2) Family Medicine without OB physicians
- Region B reports the lowest compensation for Family Medicine without OB physicians

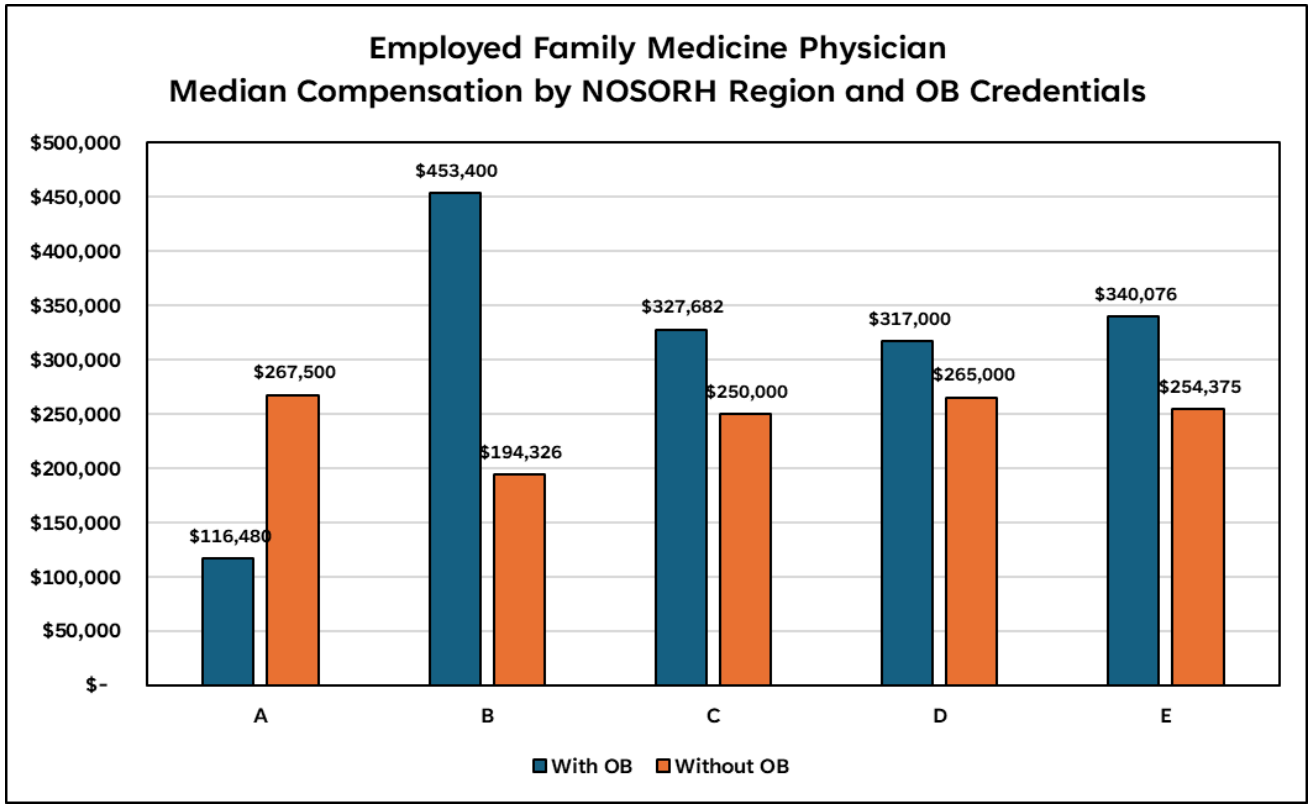



| Region | A | B | C | D | E |
|---|---|---|---|---|---|
| Min | $238,470 | * | * | * | * |
| Median | $267,500 | $194,326 | $250,000 | $265,000 | $254,375 |
| Max | $350,000 | $285,000 | $638,549 | $492,534 | * |

* Indicates data point requiring verification

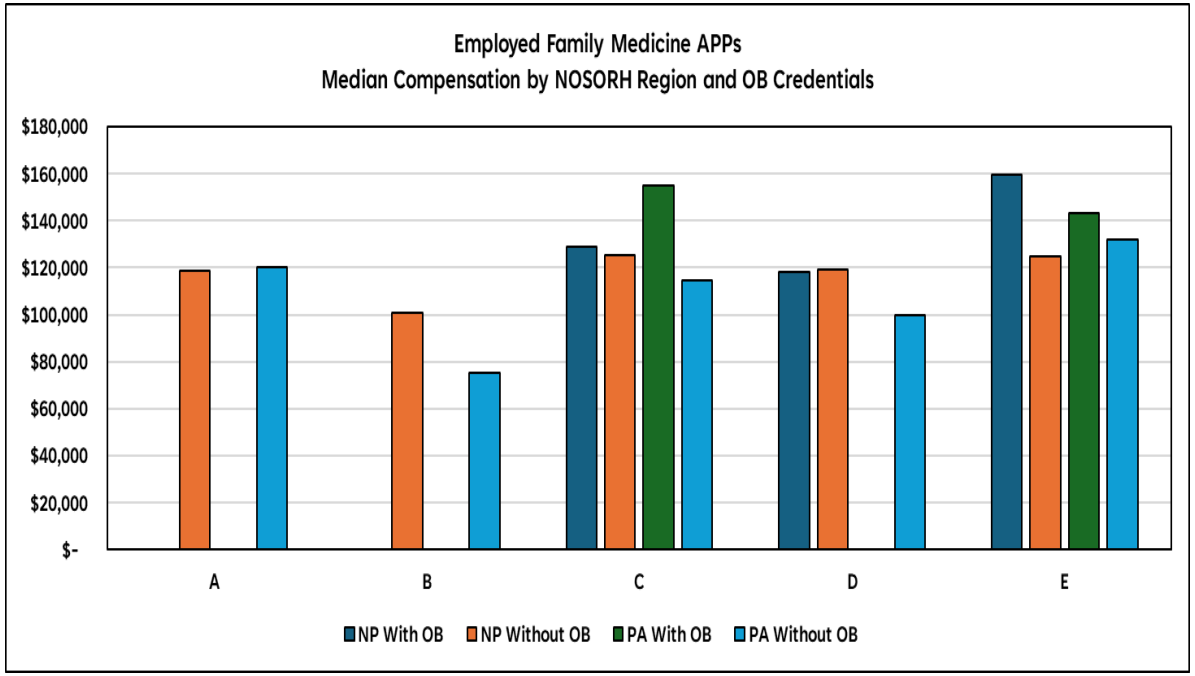
# WITH VERSUS WITHOUT OB CREDENTIALS

- Employed Family Medicine Physicians who have OB credentials are reported to have higher compensation in three of five NOSORH regions
- Regions A and E report paying Family Medicine physicians without OB credentials higher wages
- Independent Family Medicine data is not shown due to a lack of meaningful data to compare OB versus non-OB credentialed physicians who are not employed (W-2)



# ADVANCED PRACTICE PROVIDER COMPENSATION

- Survey data shows that more respondents have employed APPs that do not provide OB services than APPs that provide OB services
  - Generally, employed APPs with OB credentials are higher compensated than those without
- Region E and Region C generally report the highest compensation
- Only Regions B and E reported utilizing independent/contracted primary care APPs

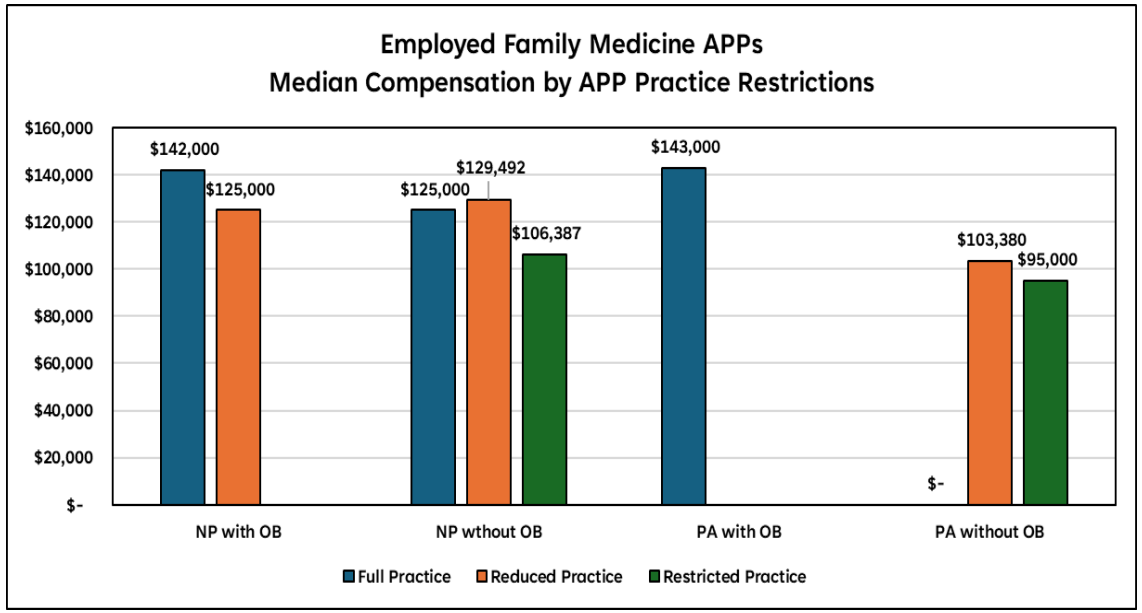



| Region | A | B | C | D | E |
|---|---|---|---|---|---|
| NP with OB | N/A | N/A | $128,942 | $118,000 | $159,500 |
| NP Without OB | $118,460 | $100,557 | $125,088 | $119,387 | $125,000 |
| PA with OB | * | N/A | $155,124 | N/A | $143,000 |
| PA Without OB | $120,000 | $75,001 | $114,420 | $100,000 | $ 132,000 |

* Indicates data point requiring verification

# ADVANCED PRACTICE PROVIDER COMPENSATION (CONT.)

- Full practice states are reported to compensate APPs higher than restricted and reduced practice states




| Region | Full Practice | Reduced | Restricted |
|---|---|---|---|
| NP with OB | $142,000 | $ 125,000 | * |
| NP Without OB | $125,000 | $129,492 | $106,387 |
| PA with OB | $143,000 | * | * |
| PA Without OB | $139,900 | $103,380 | $95,000 |

* Indicates data point requiring verification

# WHAT'S NEXT?

- Stroudwater will continue an extensive analysis of the results with feedback on the following:
  - Data break outs by organizations with Rural Health Clinics (RHCs)
  - Restricted Practice versus Unrestricted Practice states
  - Amounts for additional compensation such as medical directorship, APP stipends, etc.
  - Specialty Provider Compensation
- Stroudwater plans to continue to update and distribute this survey annually. 2025's survey will continue to build upon the information already gathered.

➢ **Action Requested**

- **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

STROUDWATER

# THANK YOU

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# THANK YOU

- Thank you for attending today's conference!
- We are committed to providing high-quality learning events. Please take a moment to share feedback about your experience with the 4th Annual Critical Access Hospital Regional Conference. The post-event survey will pop up when you exit the webinar.

# APPENDIX

# PRACTICE ENVIRONMENT DEFINITIONS

**Full Practice**

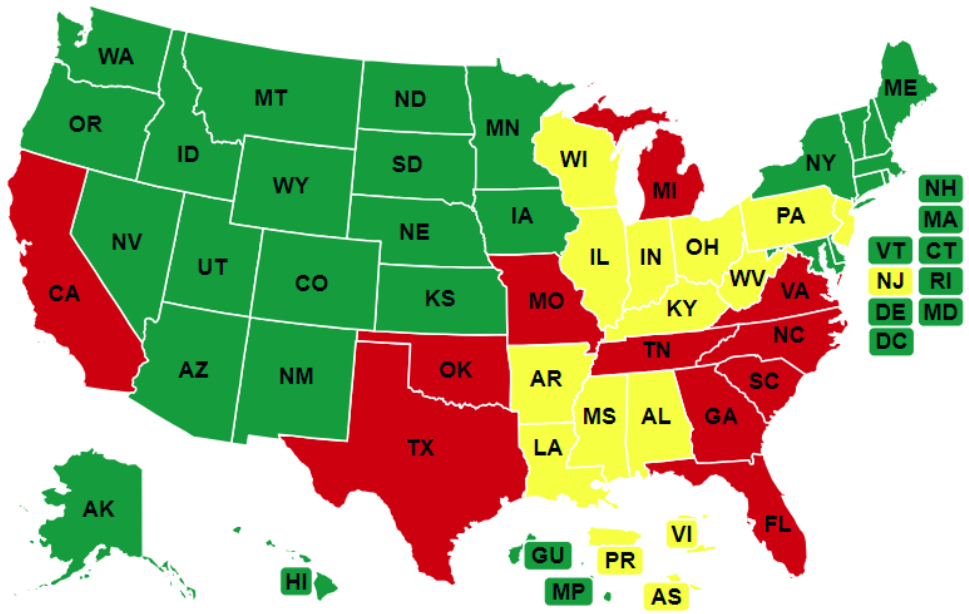
- State practice and licensure laws permit all NPs to evaluate patients; diagnose, order, and interpret diagnostic tests; and initiate and manage treatments, including prescribing medications and controlled substances, under the exclusive licensure authority of the state board of nursing. This is the 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.




**Legend**

| |
|---|
| Full Practice |
| Reduced Practice |
| Restricted Practice |

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