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

NRHA

STROUDWATER

SECOND ANNUAL RURAL PROVIDER COMPENSATION SURVEY

NOSORH

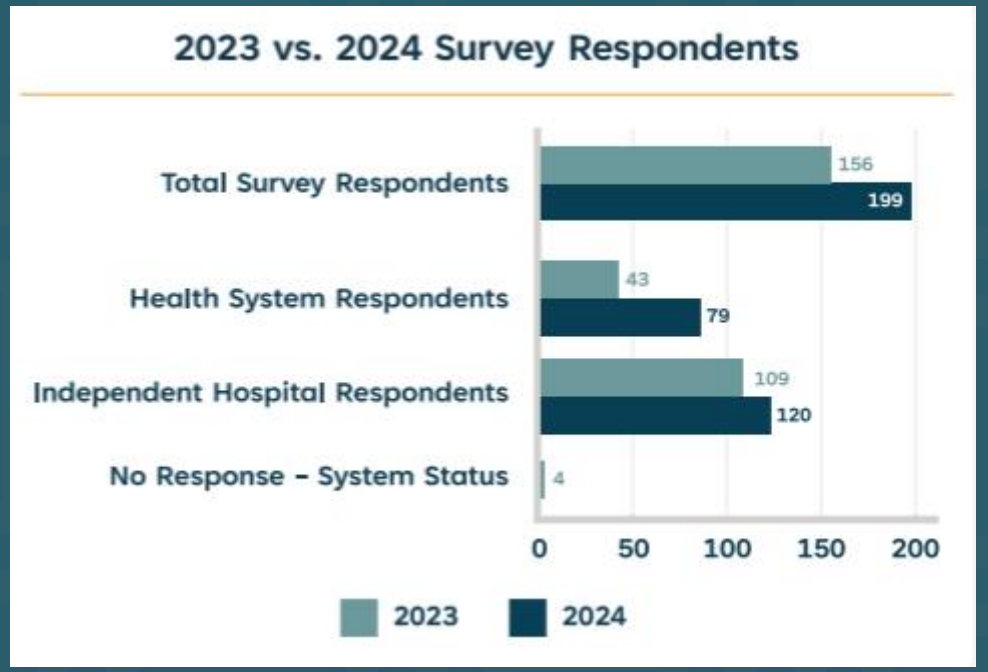
AGENDA

- Provider Compensation Survey
- Review of Findings: Primary Care
- Review of Findings: Specialty Care
- Other Compensation
- Q&A

PROVIDER COMPENSATION SURVEY

SCOPE AND PURPOSE

- This presentation is based on the 2024 Provider Compensation Survey issued by Stroudwater Associates in Spring 2024
- The Survey is sponsored by the National Rural Health Association (NRHA) and the National Organization of State Offices of Rural Health (NOSORH)
- The survey's purpose is to provide insight into rural hospitals and promote more informed decisions when considering physician and advanced practice provider (APP) compensation
- Respondents ranged from independent hospitals that reported fewer than 10 staffed beds to system-affiliated hospitals with more than 150 staffed beds
- 43 more organizations responded in 2024 than in 2023, with responses skewing still toward independent hospitals

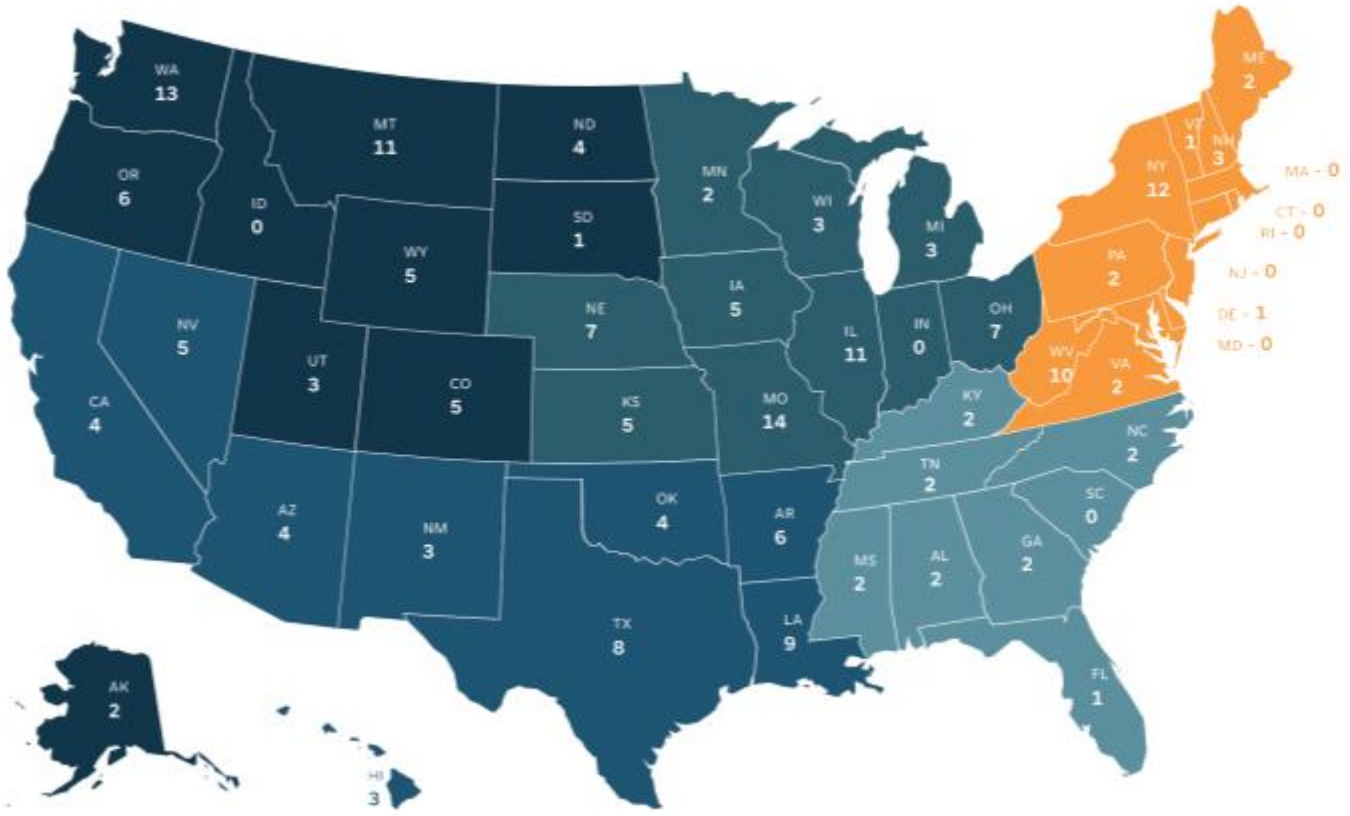


REGIONAL RESPONDENTS

FORHP REGIONAL RESPONDENTS

REGION INDEX

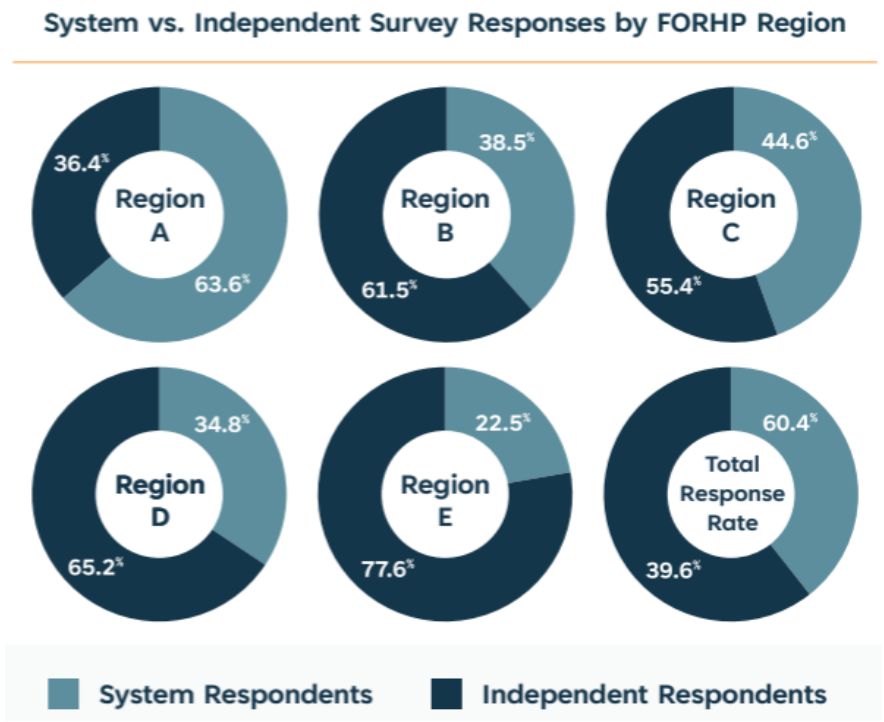
- Region A
- Region B
- Region C
- Region D
- Region E

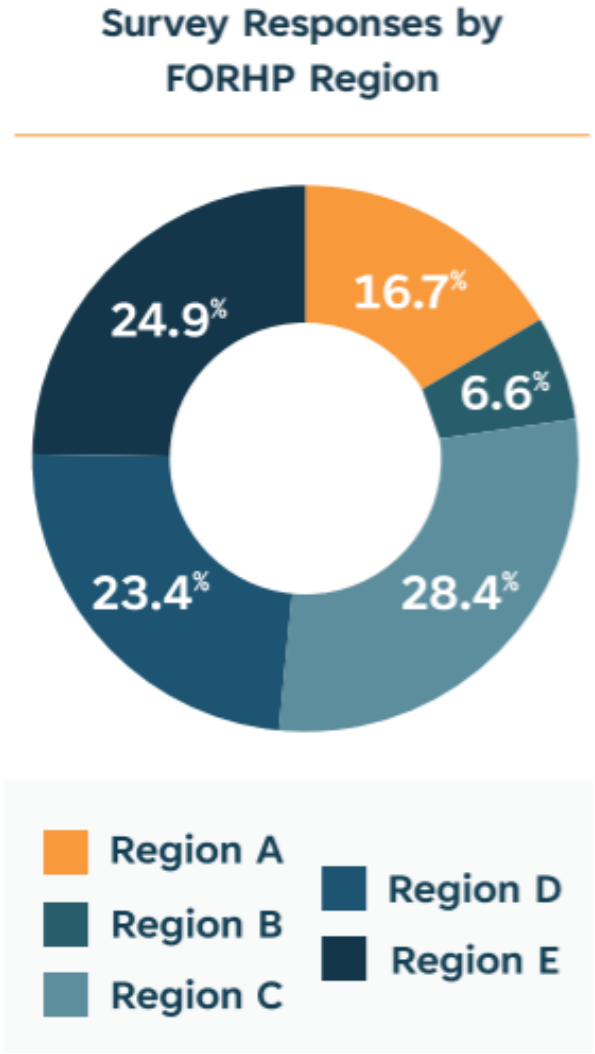


- Respondents represent 42 out of 50 states
  - 5 of the states that did not respond do not have any Critical Access Hospitals (CAHs)
- 5 of 5 (100%) Federal Office of Rural Health Policy (FORHP) regions had at least one respondent

REGIONAL RESPONDENTS (CONT.)

- Regional Response Detail
  - Region C still had the most respondents, comprising 28.4% compared to 36% last year
  - Only Region A had more system respondents than independent hospitals, with 63.6% of respondents belonging to a health system





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 • Organizations reported their size based on revenue and bed numbers, indicated system status, CAH status, and whether the organization had any Rural Health Clinics (RHCs)	• 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, individual State Offices of Rural Health, and directly based on providing responses in the 2023 survey	• First year conducting survey in-house; prior year survey does not allow for an apples-to-apples comparison • Data is self-reported by organizations without validation • N/A indicates insufficient responses for the category

TYPES OF COMPENSATION

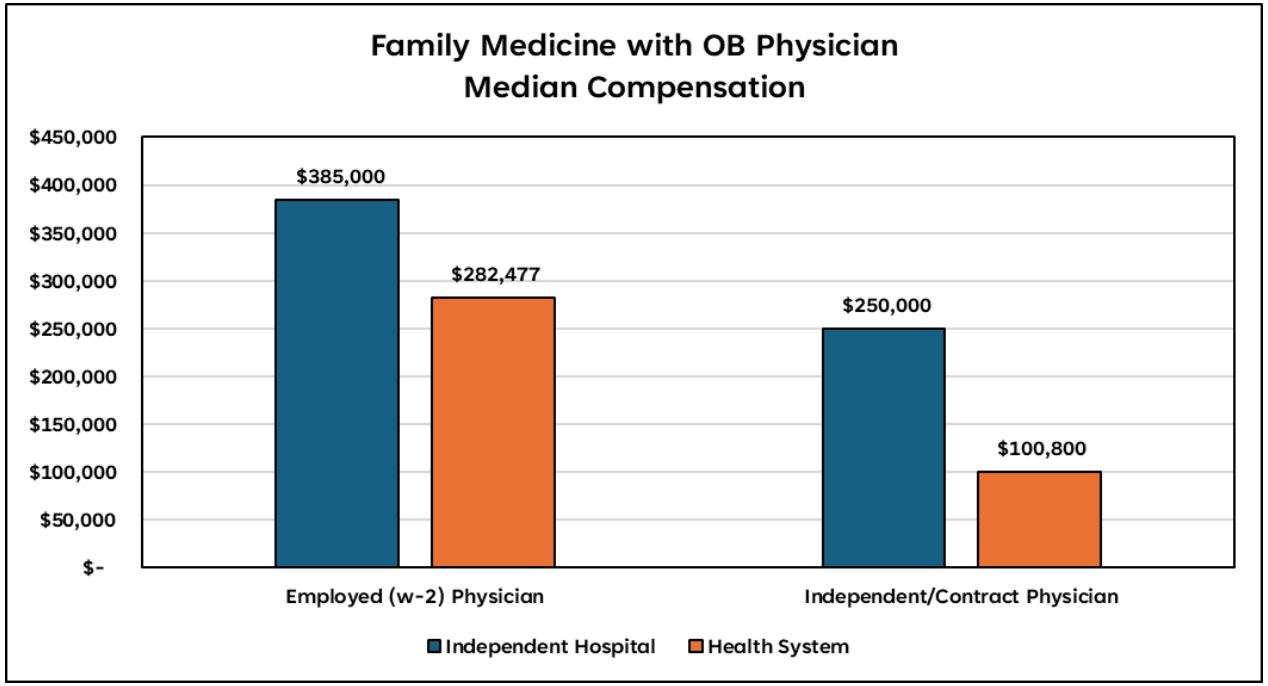
- When asked what types of compensation are provided to your employed providers, 54.7% of respondents reported paying providers entirely on a straight salary (a slight decline from 2022 data showing 56%)
- 32.1% (down from 37%) of respondents provide some form of incentive compensation
  - 31% provide 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 (the 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 FINDINGS:
PRIMARY CARE

PRIMARY CARE PHYSICIANS WITH OB

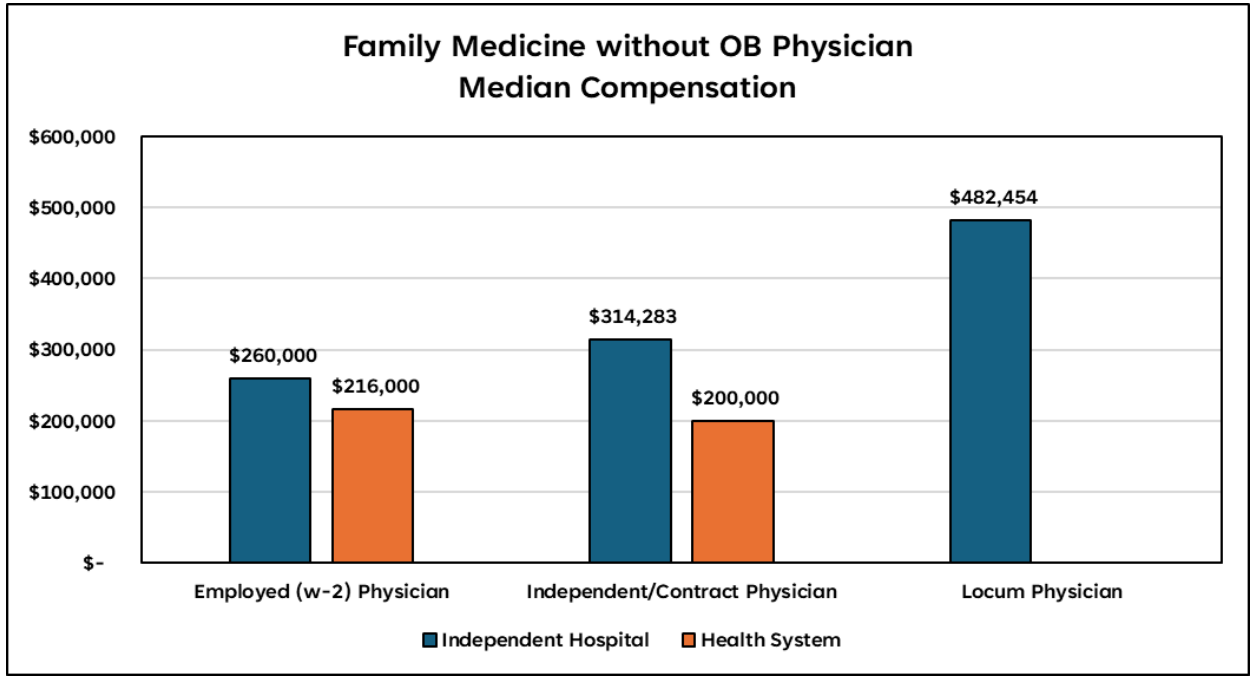
- Independent hospitals report paying more for employed Family Medicine physicians with OB than their health system counterparts
- Few health systems reported contracted compensation for Family Medicine with OB physicians, likely indicating a deference to employment
- Organizations reported higher compensation 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
- Having an RHC greatly impacted the compensation paid
  - For organizations with RHCs, Family Medicine w/OB physician compensation ranged from $104,000 to $621,976
  - Those without RHCs pay a much narrower range of $258,316 to $295,152



	MD: Fam Med W/ OB		
	Min	Median	Max
RHC	$ 104,000	$ 382,500	$ 621,976
No RHCs	$ 258,316	$ 284,953	$ 295,152

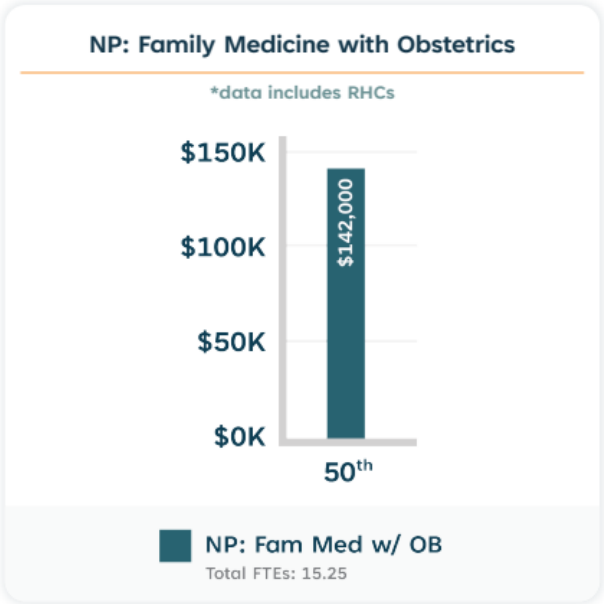
PRIMARY CARE PHYSICIANS W/O OB

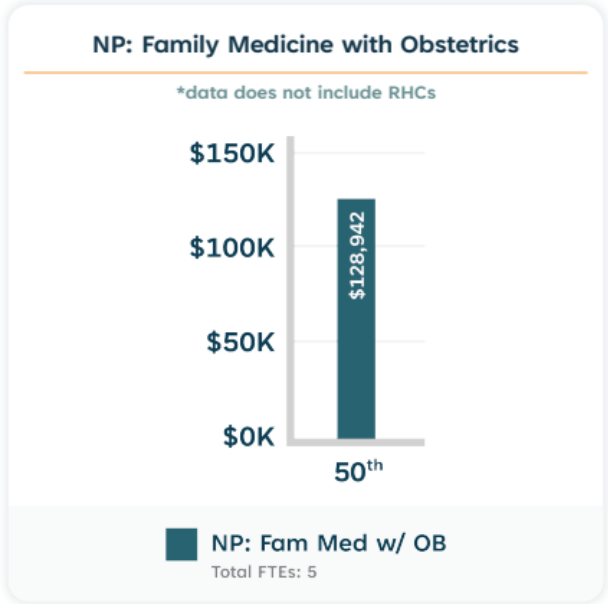
- Independent hospitals report paying more for employed Family Medicine physicians without OB than their health system counterparts
- No health systems reported 1099 or locum compensation for Family Medicine without OB physicians, likely indicating a deference to employment
- Having an RHC greatly impacted the compensation paid
  - For organizations with RHCs, Family Medicine w/o OB physician compensation ranged from $125,000 to $638,549
  - Those without RHCs pay a much narrower range of $240,000 to $377,618

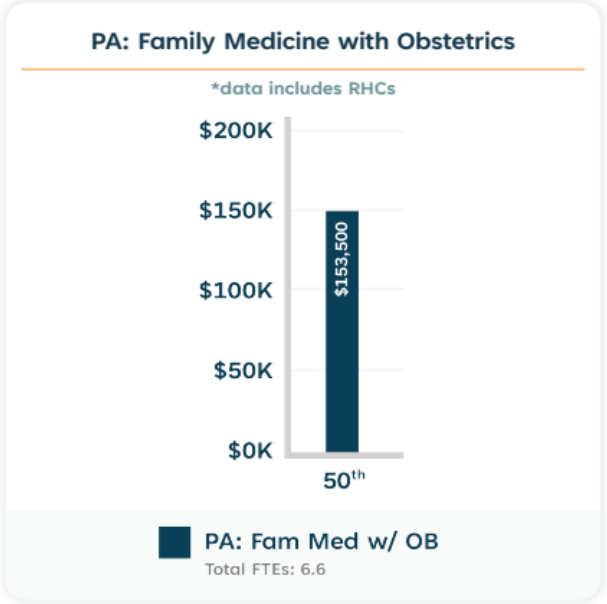


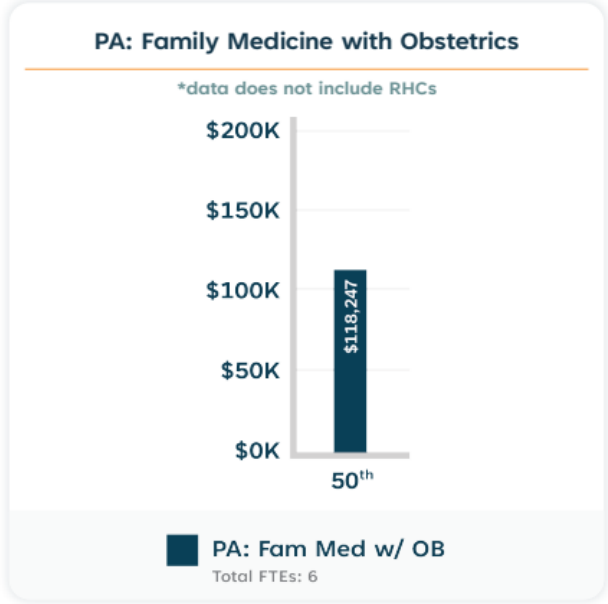
	MD: Fam Med w/o OB		
	Min	Median	Max
RHC	$ 125,000	$ 259,375	$ 638,549
No RHCs	$ 240,000	$ 300,000	$ 377,618

FAMILY MEDICINE W/OB: APPS



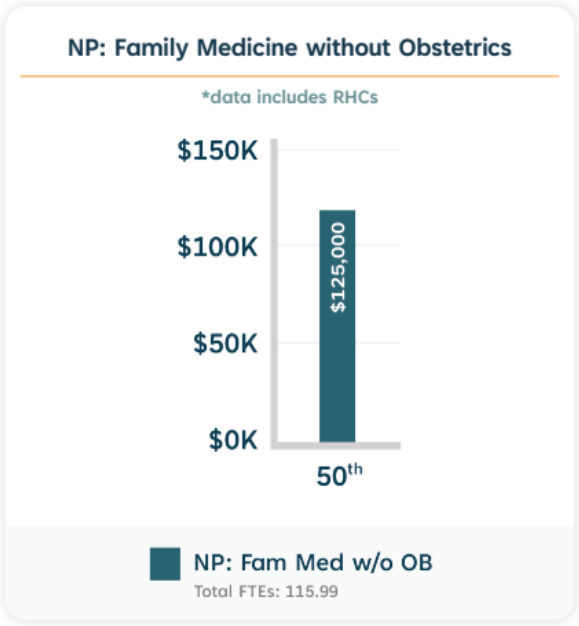


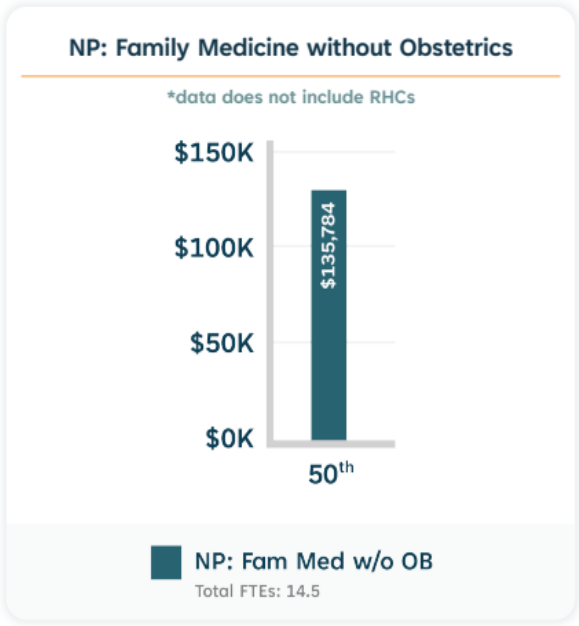


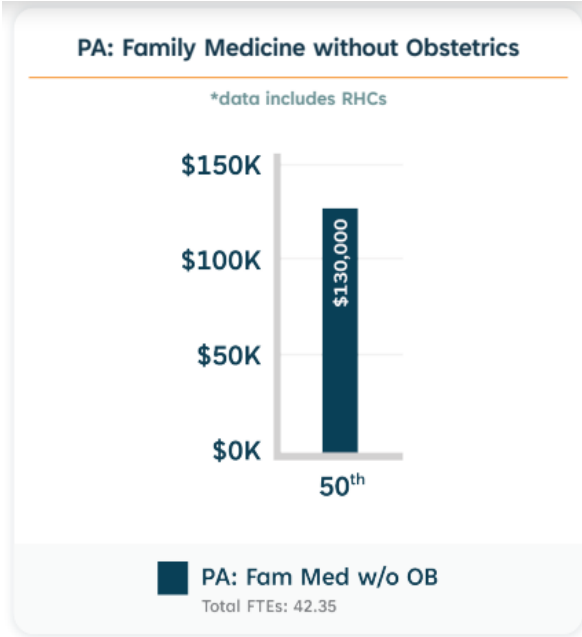


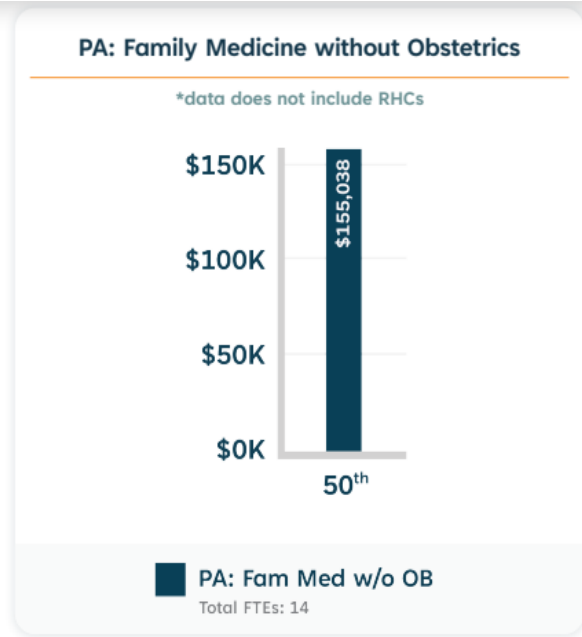
- Overall reporting organizations employ fewer FM w/OB APPs than APPs who do not provide OB services
- Consistent with physician data, median compensation for organizations with RHCs is higher than non-RHCs, with NPs making ~$14K more and PAs making ~$35K more

FAMILY MEDICINE W/O OB: APPS

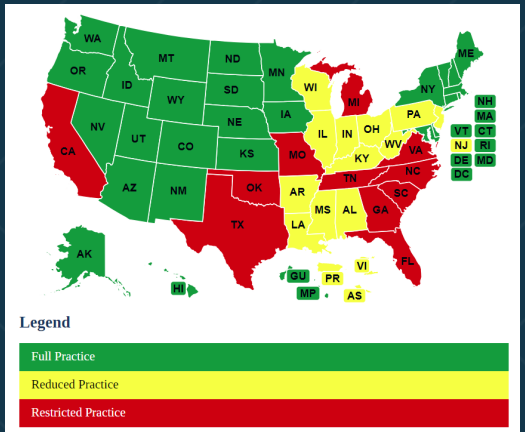






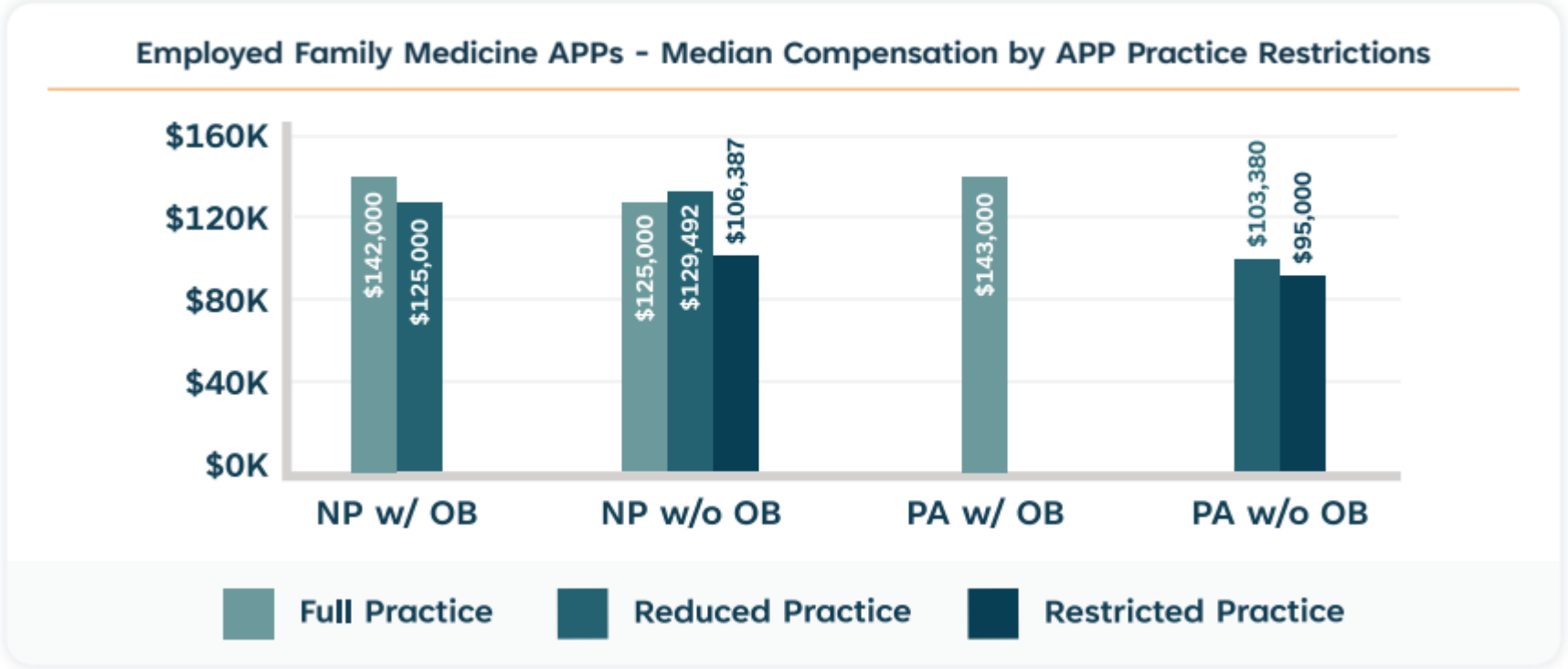


- The trend of higher compensation in RHC organizations does not hold for primary care w/o OB services for APPs; However, we note that there are substantially more respondents for organizations that do include RHCs
- NPs make approximately $5k less than PAs in RHC organizations and make approximately $20K less in non-RHC organizations



RESTRICTED PRACTICE STATES

Full-practice states overall pay more than restricted or reduced-practice states, except for NPs w/o OB. NPs providing FM w/o OB in reduced practice states earn 3.5% more than those in full practice states.

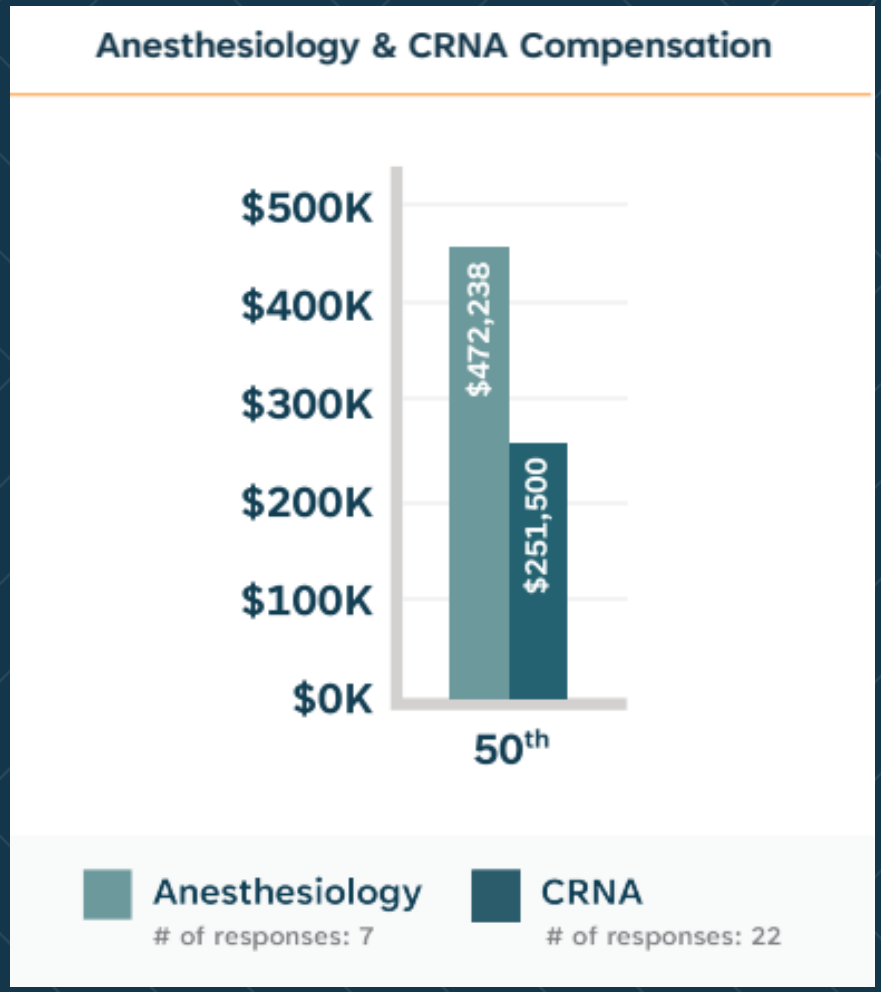


- Please see the Appendix for the full state practice environment map

REVIEW OF FINDINGS:
SPECIALTY CARE

ANESTHESIOLOGY

- Rural areas tend to rely heavily on CRNAs for providing anesthesiology services
- CRNA compensation ranged from $200K to nearly $300K
- Physician anesthesiology compensation ranged from approximately $385K to just under $600K



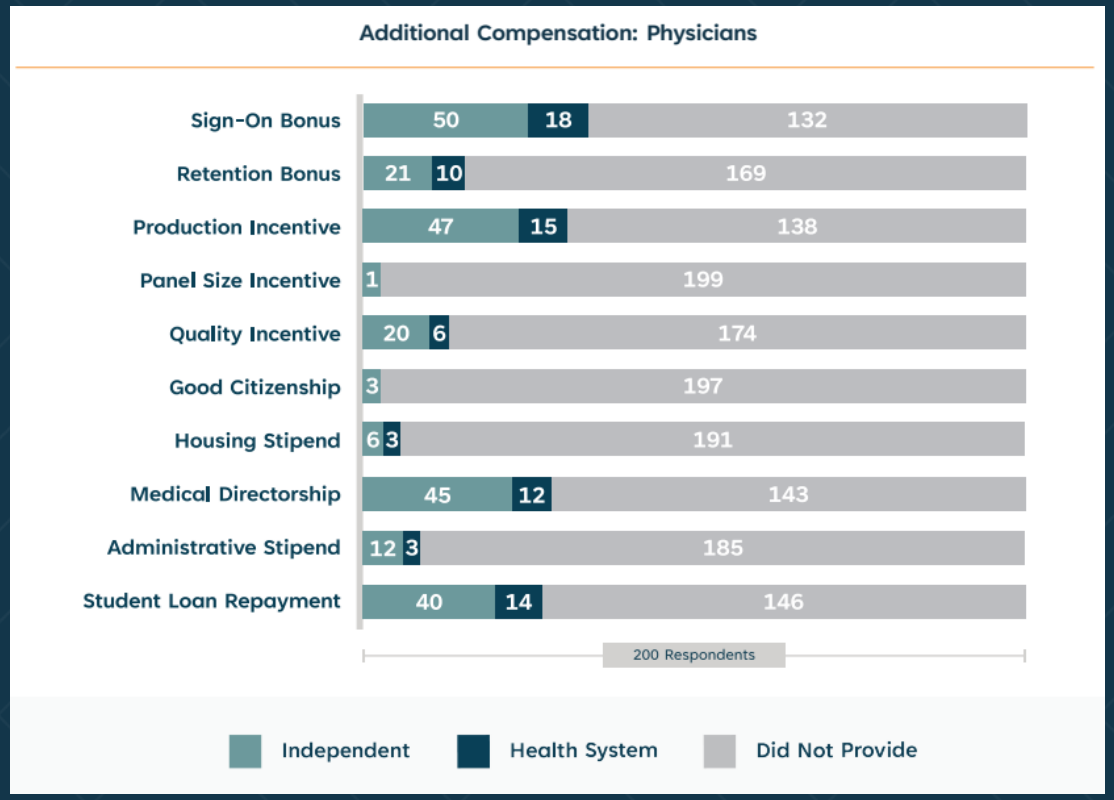
OTHER SPECIALTIES: MEDIAN COMP

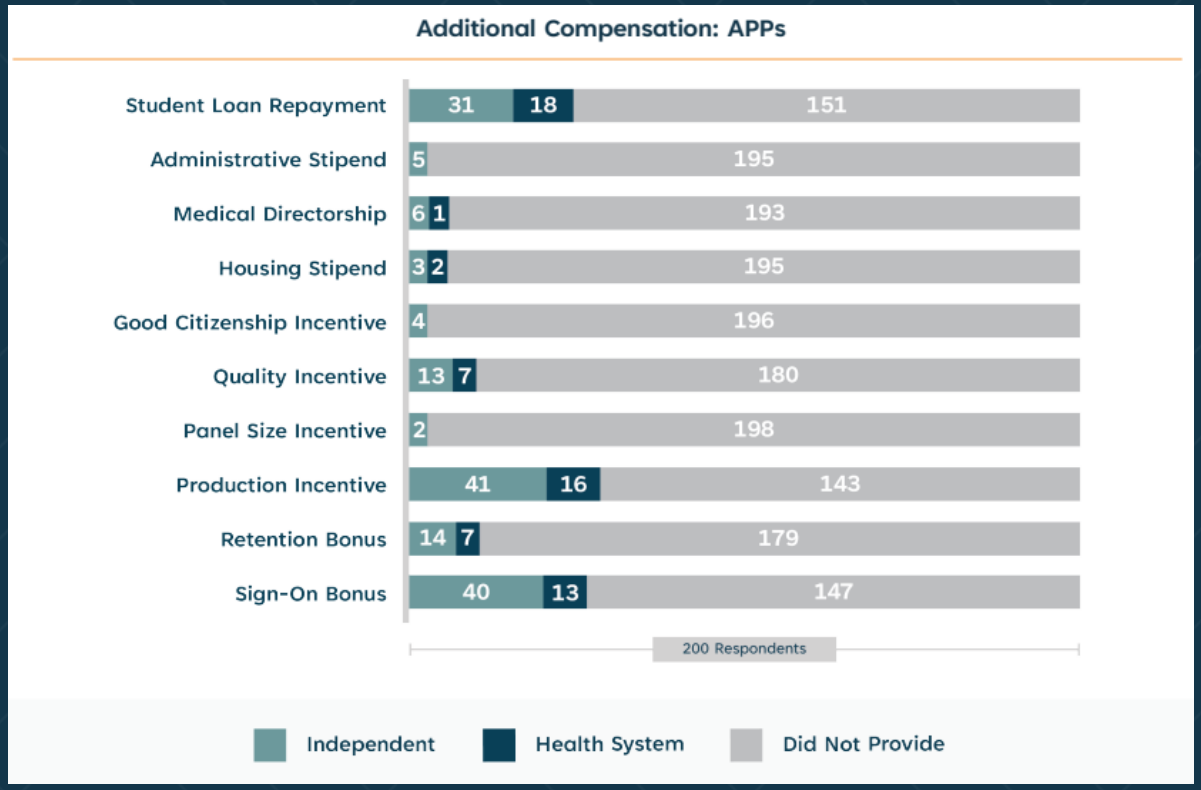
Specialty	MD	PA	NP
Cardiology	$ 684,750	$ 112,280	$ 122,500
Emergency Medicine	$ 360,192	$ 156,000	$ 152,880
ENT	$ 240,000	$ 123,288	$ 120,931
Gastroenterology	$ 600,000		
General Survery	$ 432,213	$ 127,296	$ 147,000
Hospitalist	$ 297,537	$ 137,488	$ 145,392
Neurology	$ 476,400		$ 122,500
Orthopedics	$ 600,000	$ 129,500	$ 154,600
OB/GYN	$ 422,880		$ 121,200
Psych*	$ 300,000	$ 81,500	$ 81,500
Radiology	$ 750,000	$ 105,210	
Urology	$ 460,000		$ 143,304

Psych APP data is based on LCSWs

OTHER COMPENSATION

ADDITIONAL COMPENSATION





- Student loan repayments, productivity incentives, and sign-on bonuses are the most frequently paid forms of additional compensation for both physicians and APPs
- Independent hospitals and health systems seem to provide production incentives to APPs and physicians equally
- Far more medical directorships are provided to physicians, consistent with overall industry observations

MEDICAL DIRECTORSHIP

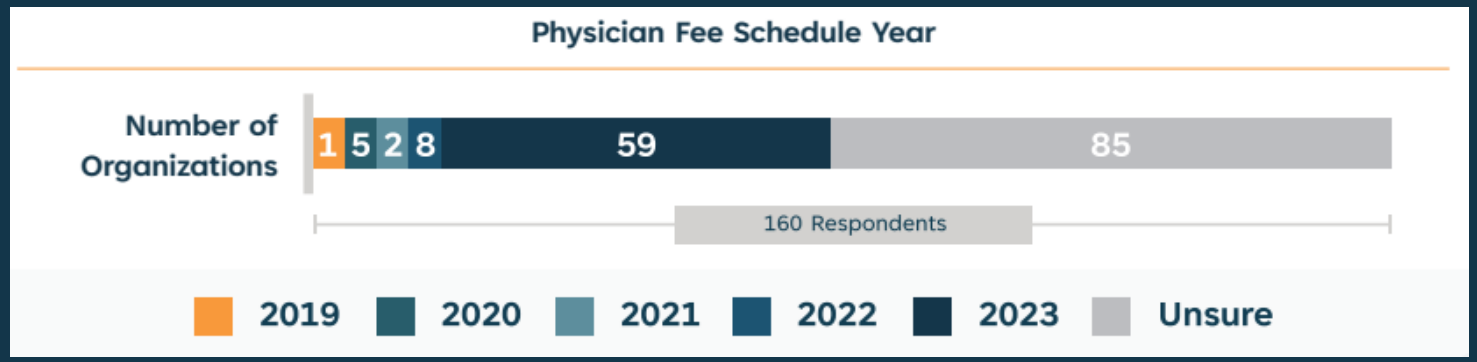
	Organization Count	Min	Median	Max
Physician	56	$ 1,500	$ 19,000	$ 76,000
APP	7	$ 8,000	$ 13,000	$ 60,000

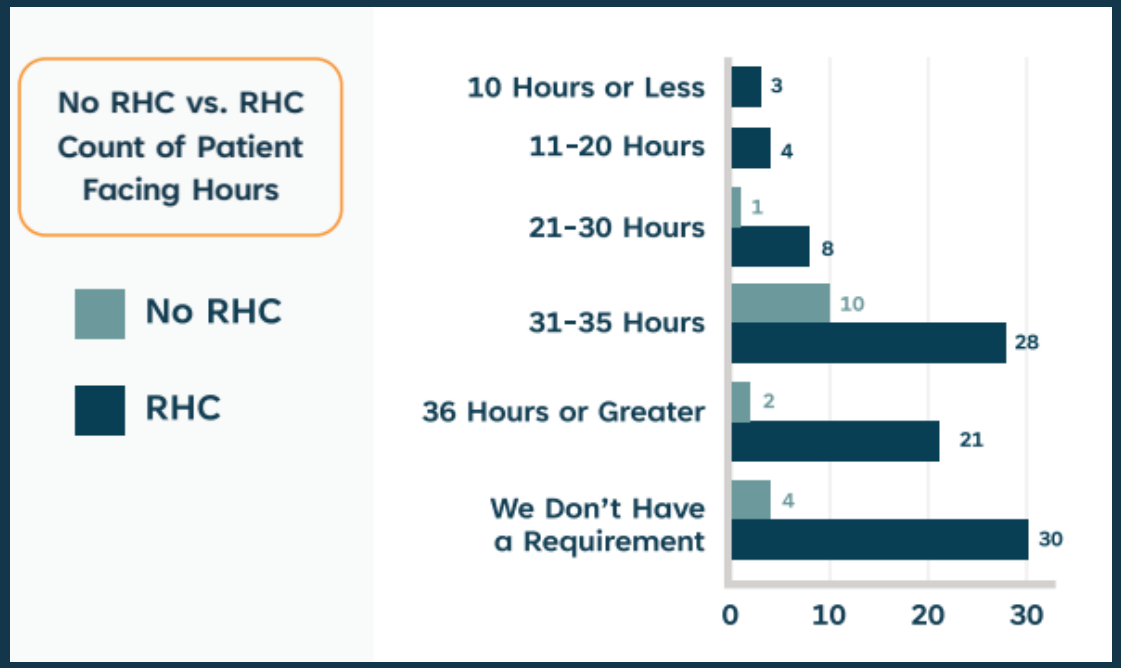
- Far more medical directorships are provided to physicians, consistent with overall industry observations
- For organizations that only utilize physicians for medical directorships, average medical directorship is overall higher
  - $23,900 for independent hospitals
  - $32,800 for system-owned hospitals
- CAHs reported paying physicians and APPs similarly for medical directorships, with compensation ranging by license as follows:
  - MDs: $5,000 - $72,000
  - APPs: $8,000 - $60,000

QUALITY INCENTIVE COMPENSATION

- Few organizations provide quality incentive compensation overall (13.1%)
- Quality incentives range from set amounts per year of up to $45,000
- Methods for quality incentives include:
  - Percentage of base compensation increase
  - Increase of wRVU conversion amount by up to 15%
- Metrics include:
    - Patient satisfaction
    - Hypertension Goals
    - Colon Screening goals
    - ACO metrics
    - Participation in closing quality gaps and completing documentation

OTHER CONTRACT PROVISIONS





- While more organizations are using the current Medicare Physician Fee Schedule than previously, an alarming number (53%) are still unsure of which fee schedule they use
- Patient-facing hours are a key measurement of services provided, but 38 organizations indicated they had NO requirement, and another 82 organizations did not respond

WHAT'S NEXT?

- The 2025 Survey will go live in mid-January 2025. Be on the lookout!
- Those who participate in the survey will receive full results not received by others, including 10th, 25th, 75th, and 90th percentile data
- Stroudwater plans to update and distribute this survey annually
- Based on feedback, Stroudwater plans on adding productivity information to the 2026 survey
- **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

STROUDWATER

THANK YOU

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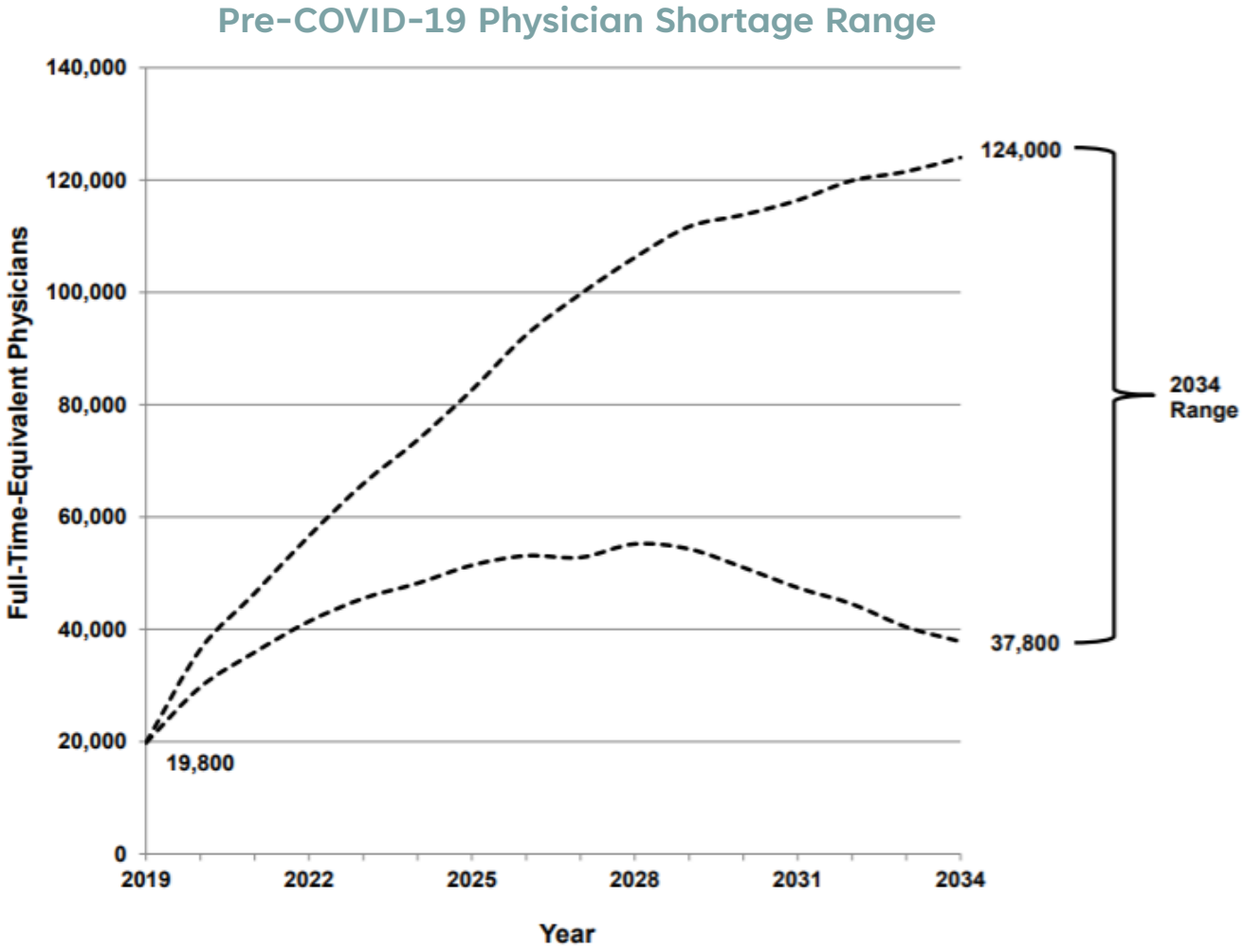
APPENDIX

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**

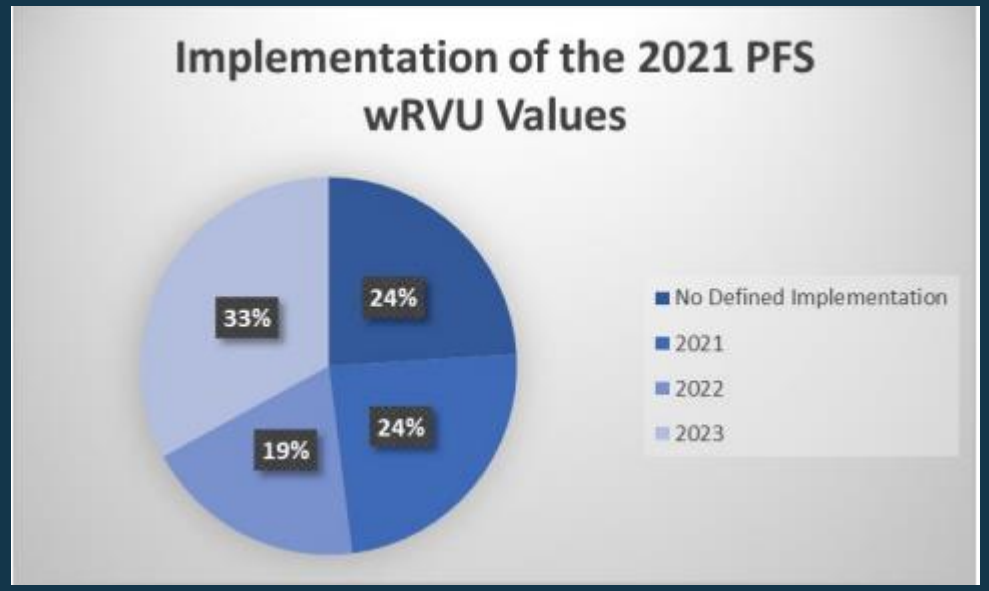
Specialty	% Change in Total wRVUs[2]
Urgent Care	24.4%
Family Medicine (w/o OB)	19.3%
Hematology/Oncology	17.4%
Internal Medicine: General	17.4%
Pediatrics: General	13.5%
Cardiology: Noninvasive	8.4%
Orthopedic Surgery: General	6.3%
OB/GYN: General	3.9%
Gastroenterology	3.8%
Surgery: General	3.0%

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

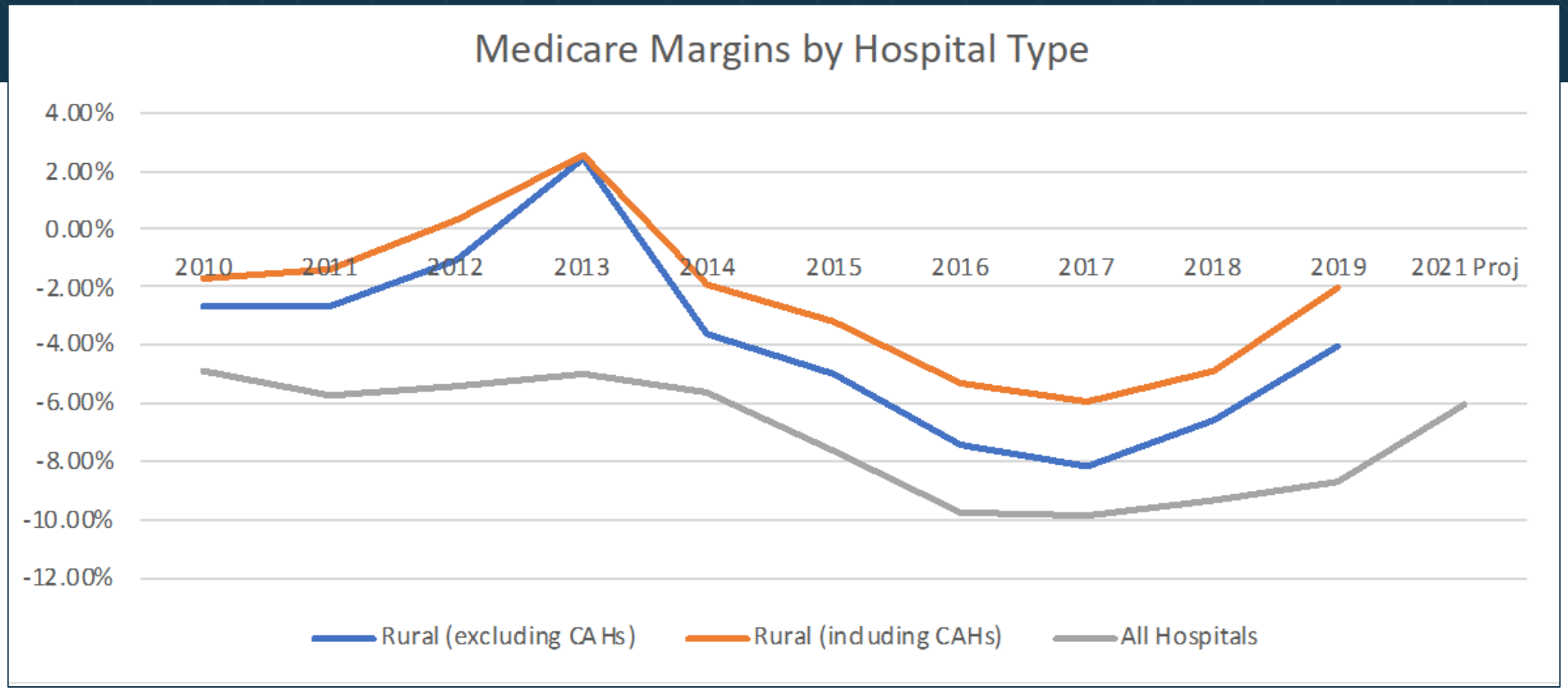
- Over a third of MGMA respondents have not gone live on the 2021 PFS!
- Only 12% allowed for providers to access a full increase in compensation resulting from changes in wRVU values



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

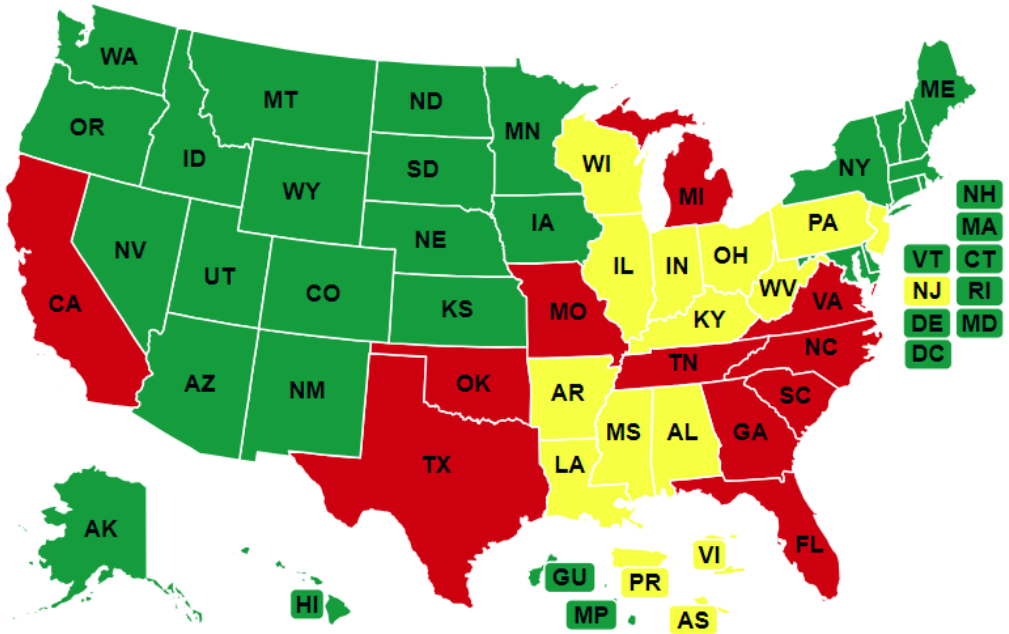
SCARCITY HITTING RURAL

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