STROUDWATER

The State of Rural Provider Compensation in 2023:

# Rural Physician & Advanced Practice Provider Compensation Survey Results

**A new survey from Stroudwater Associates and the National Rural Health Association (NRHA) illustrates the enormous variability in provider pay across rural organizations and the pressing need for rural healthcare to align provider pay with the organization's goals.**

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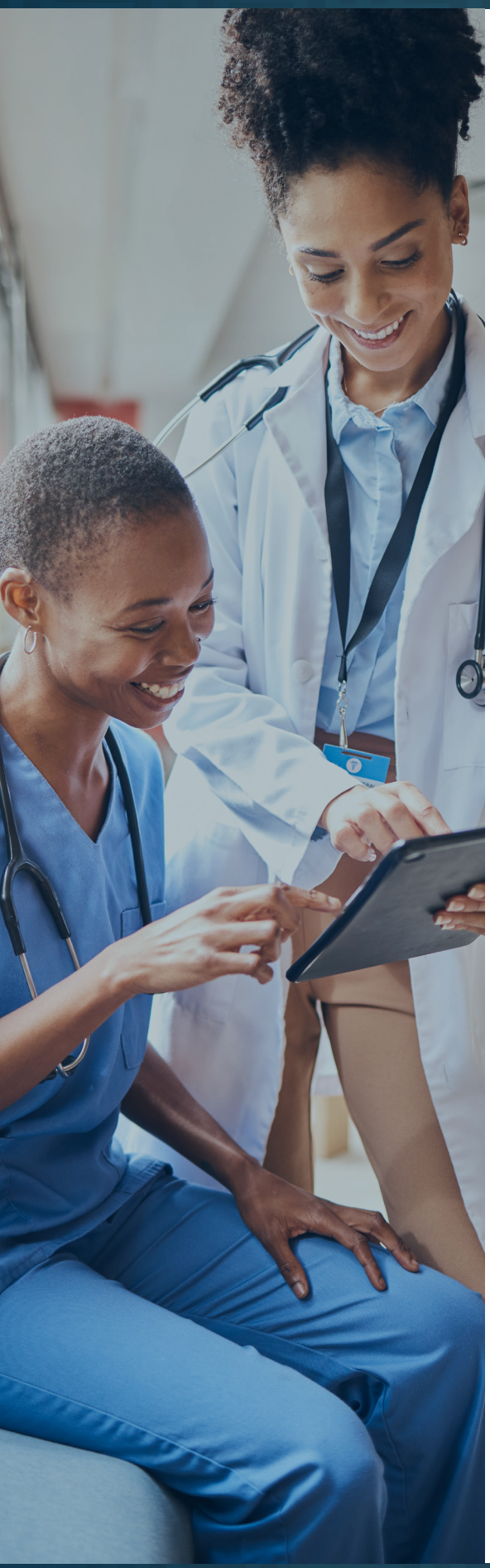


# Key Takeaways from the 2023 SURVEY DATA

**The majority of rural provider compensation is not tied to incentives.**

» 56% of respondents pay providers a straight salary with no performance or quality incentives.

**Salary variability continues to increase.**

» While the average family medicine physician makes less than $300,000, the survey uncovered a rural variance of $234,000 - $442,000.

**Salary increases are not necessarily tied to position shortages.**

» Although CRNAs are plentiful, their compensation in the rural space has grown from a pre-pandemic salary of $150,000 - $180,000 based on client data, to a salary of over $234,000 at over 65% of survey respondent organizations.

**Independent and affiliated rural hospitals may not know what they are paying providers covered under Professional Service Agreements (PSAs).**

» The survey found that many organizations were unaware of the contractual status of their PSAs, including large organizations that own rural hospitals.

Current rural provider compensation strategies are unsustainable, defy best practices, and could lead to compliance risks for hospitals. With more than 104 rural hospital closures since 2005,[1] rural leaders must take a step back, consider the big picture, and align provider compensation with the evolving market forces and their own organizational goals to best position their organizations and communities for success.

**A data-informed compensation strategy is the way forward for rural healthcare organizations**

[1] Rural Hospitals in crisis mode. Becker's Hospital Review.

A new, first-of-its-kind rural provider compensation survey by Stroudwater Associates, in partnership with the National Rural Health Association (NRHA), provides a path forward for rural healthcare organizations facing supply and demand headwinds made more complicated by escalating compensation demands among physicians and advanced practice providers (APPs).

**The First Annual Rural Provider Compensation Survey was released in September 2023.**

> "While there is information about physician compensation in urban or suburban settings, the rural healthcare space has severely lacked data in this arena," says Stroudwater Principal Opal H. Greenway, J.D., M.B.A, C.V.A. "We set out to change that by focusing our survey solely on rural providers to better understand their specific needs and empower them with the data they need to continue to provide care for the 46 million Americans who rely on it."

Before the First Annual Rural Provider Compensation Survey, rural healthcare organizations historically relied on data and information from groups like the Medical Group Management Association (MGMA). While such information can be used directionally for compensation, it is often skewed by larger systems or providers and urban/suburban organizations, minimizing its effectiveness and even driving up rural compensation in some cases. As a point of comparison, Stroudwater Associates' Rural Compensation Survey had over 6,000 rural provider respondents compared to 2,632 rural providers in the 2023 MGMA data.

## FORCES INFLUENCING COMPENSATION

Physician shortages, along with the highly competitive post-pandemic labor market, add a layer of complexity for rural healthcare organizations. Over 80% of American counties are considered "healthcare deserts," where access to healthcare is limited or nonexistent.[2] People living in rural locations – a disproportionate number of whom live under the poverty level and are in poorer health [3] – are often forced to travel significant distances to receive routine care or specialty care for chronic or complex conditions.

Attracting and retaining physicians, as well as nurse practitioners and physician assistants, is a formidable task for rural health leaders; an effective compensation strategy that is attuned to both market forces and organizational goals can be a powerful recruitment and retention tool. Approximately one-fifth of Americans live in rural areas, but only about 10% of the nation's physicians are located there.[4] A growing demand for care and inadequate supply to meet that demand lead to higher rates of death, disability, and chronic disease -- impacting the health of rural Americans compared to their urban counterparts.

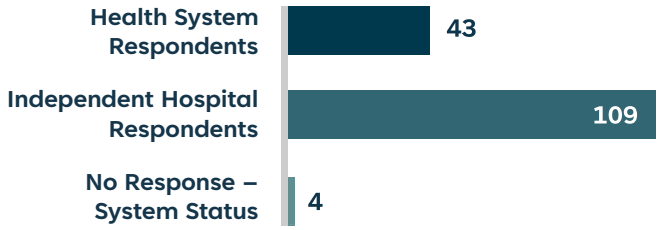
Lacking rural-specific data, healthcare organizations have been establishing compensation blindly and very few have established compensation strategies. Greenway explains: "Rural leaders are setting compensation based on provider requests – the doctors are in the driver's seat. Aligning compensation with incentives that support an organization's goals is where we are headed and where we should be headed. Data. Strategy. Alignment. These milestones are the way forward for rural healthcare leadership to recruit and retain primary care physicians and advanced practice providers and empower them to do what they do best, care for patients."

[2] GoodRX, Mapping Healthcare Deserts: 80% of the Country Lacks Adequate Access to Healthcare.
[3] Mapping Healthcare Deserts: 80% of the Country Lacks Adequate Access to Healthcare. CDC.
[4] National Conference of State Legislators

## SURVEY BACKGROUND

The 2023 Provider Compensation Survey was issued by Stroudwater Associates in January/February 2023 to provide insight into rural healthcare organizations and promote evidence-based, informed decisions when considering physician and advanced practice provider compensation.

### Total Surveys: 156



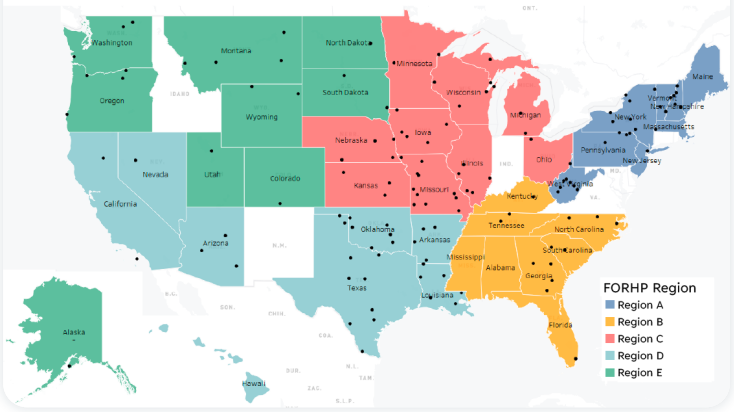

Respondents ranged from independent hospitals that reported fewer than 10 staffed beds to rural systems with over 150 staffed beds combined. No independent respondent reported more than 150 staffed beds.

The survey represents, at minimum, approximately 4,234 physicians and 1,833 advanced practice providers.

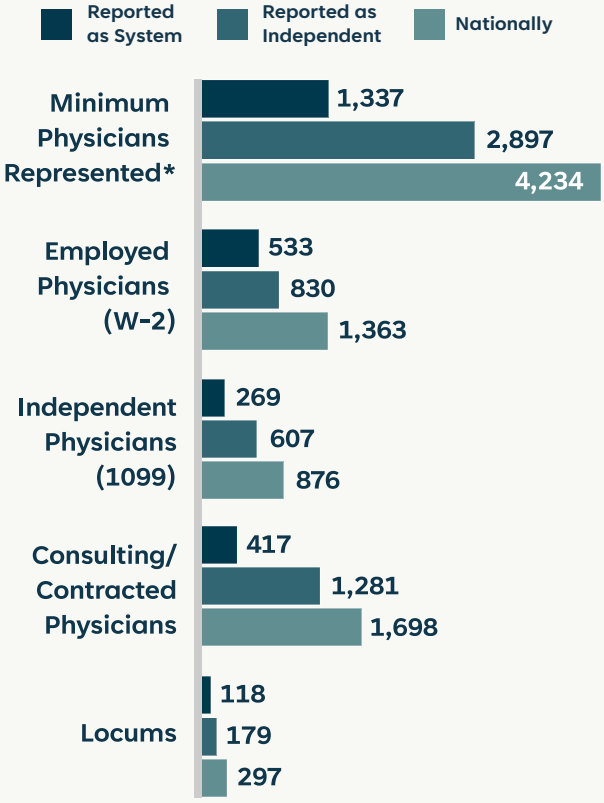
Respondents represent 42 out of 50 states, and Stroudwater has a goal of increasing responses in states that are known as rural moving forward.

Five out of five Federal Office of Rural Health Policy (FORHP) regions had at least one respondent.

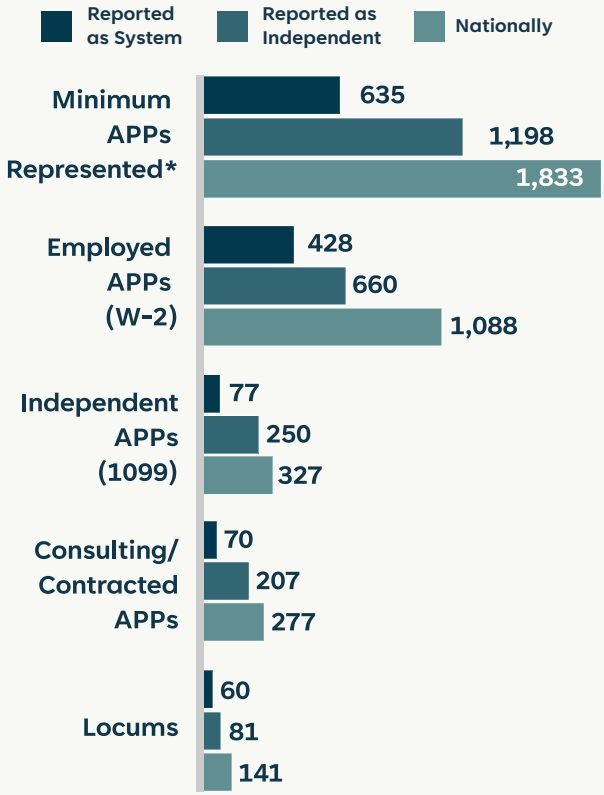
### FORHP Region Map




### Physicians Represented




### Advanced Practice Providers Represented



## STUDY PROCESS

### Measures

- **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

### Sources

- 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

### Limitations

- 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 FOR EMPLOYED PROVIDERS

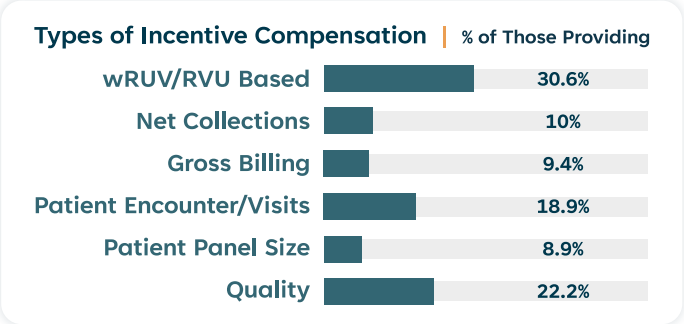
**56%** **of respondents pay providers entirely on a straight salary, not tied to performance or quality**

According to Greenway: "Straight salary is not aligned with best practices. At the end of the day, compensation is what you pay for employees to do what you need them to do. Rural healthcare organizations are struggling, and hospitals need providers to do more than show up. The people who are generating revenue are not aligned with or informed by how revenues are generated. Providers don't understand the goals of the organization and therefore, are not incentivized to see more patients, to change how they see patients, or to have quality outcomes, for example. When you have a straight salary that is not aligned with the organization's goals, this will impact the overall performance of the organization. The organization will suffer, not from lack of desire but lack of alignment."

According to the PayScale 2023 Compensation Best Practices Report, 78% of organizations offer some form of incentive pay, with 64% tied to individual incentive bonuses.[5] Top performers in organizations with incentive compensation are more confident in their total rewards packages (53% compared to 48% overall).

**37%** **of respondents provide some form of incentive compensation**

Using work relative value units (wRVUs), which are measurable and set by CMS, is a standardized way to assign productivity credit. wRVU-based models are the most commonly used incentives to promote patient volume. The downside of a wRVU-based model is that it ties provider compensation to patient volume rather than the quality of care provided or outcomes achieved.




"Work relative value units can underscore a fee-for-service mindset. For rural hospitals moving toward value-based payments and controlling the cost of care, wRVUs should only be a portion of the incentive," says Greenway. "Quality is factored into compensation for 22.2% of rural organizations that provide incentive compensation, and we anticipate this could grow over time as the industry shifts focus from 'volume to value.' However, for most organizations, due to reimbursement structure, volume is still the key driver." Quality measures, according to CMS, are "tools that help measure or quantify healthcare processes, outcomes, patient perceptions, and organizational structure and/or systems that are associated with the ability to provide high-quality healthcare and/or that relate to one or more quality goals for healthcare."[6] Tying a percentage of provider compensation to quality data ensures that rural organizations and providers are accountable for the quality of care they are providing and aligned with the industry's transition to population health.

[5] https://www.payscale.com/content/report/2023-compensation-best-practices-report.pdf
[6] Quality Measures CMS. 09/06/2023.

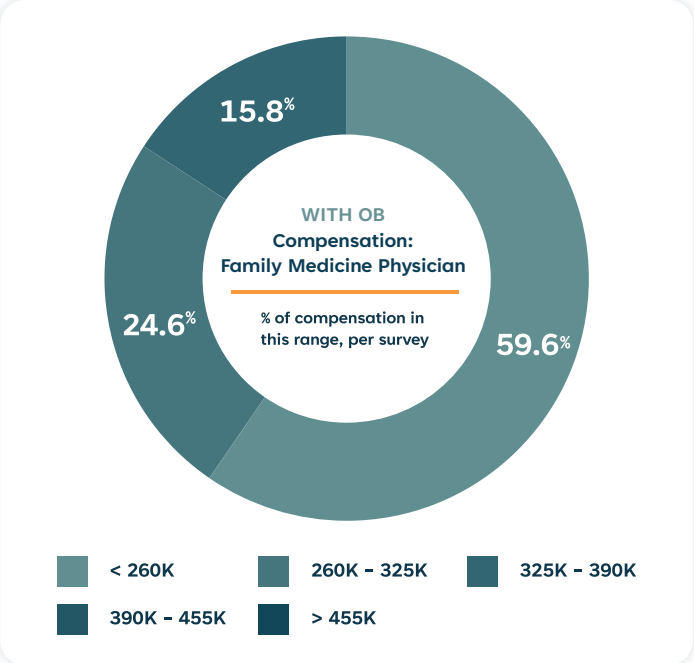
### Additional compensation provided:

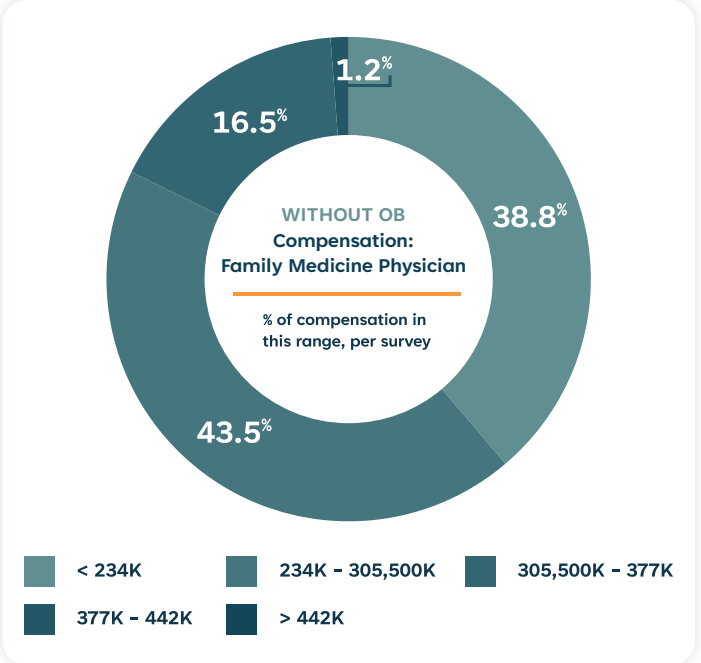
- 125 respondents provide relocation stipends (over half of which exceed $5K)
- 121 respondents provide student loan repayment (over half pay less than $45K per provider per year)
- 91 respondents provide sign-on bonuses (58% pay less than $5K in sign-on per provider)

"A $5,000 sign-on bonus for rural is well below what other physician compensation surveys reported, particularly when some providers were receiving a 10%-of-base-salary signing bonus. While rural may not be overpaying sign-on bonuses, we urge rural organizations to think about how they are structuring their overall compensation packages, including an at-risk model where a physician would have to repay a sign-on bonus should they leave before the end of their contract," says Greenway.

## PRIMARY CARE COMPENSATION WITH AND WITHOUT OBSTETRICS

As recently as 2019, median compensation for rural primary care physicians was roughly $240K based on MGMA data[7]; this was widely considered average pay before the pandemic and before significant CMS fee changes greatly increased the value of primary care on a wRVU basis. The survey revealed interesting data regarding primary care for rural:

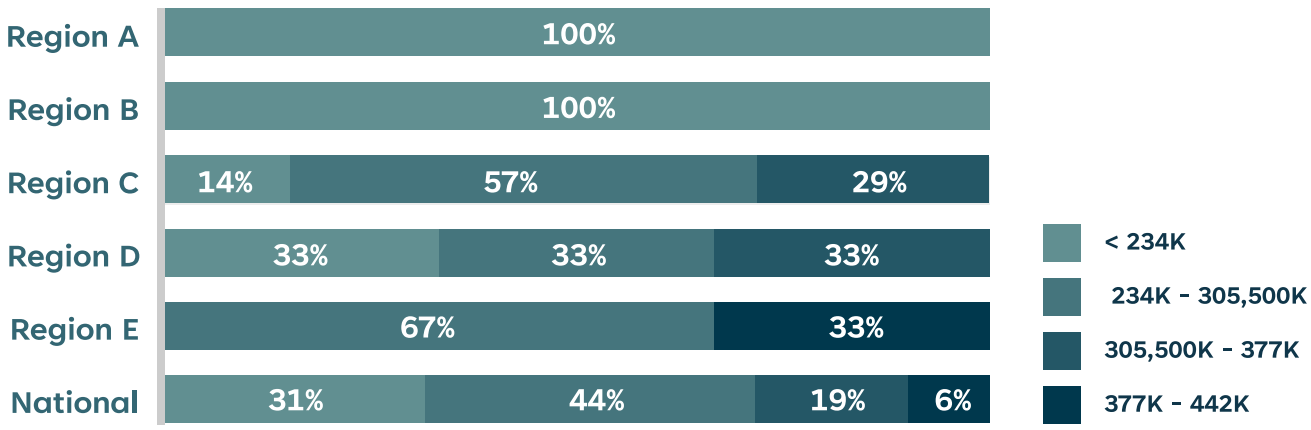


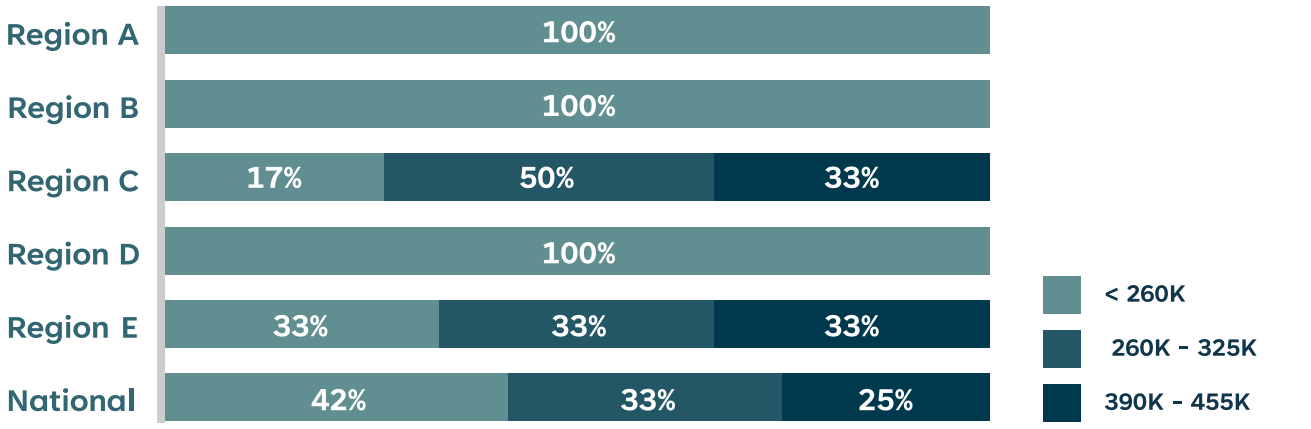

17.7% of primary care providers without OB are making over $300K – a sharp uptick to the PCP norm of $240K, a 25% increase. Historically, providers in rural areas were assumed to earn less than their urban and suburban counterparts, as rural volumes are lower and the cost of living is less. Organizations that have not given primary care providers a raise since before the pandemic may find themselves at a significant disadvantage in recruitment and retention. The data is more interesting when comparing independent versus health-system-owned hospitals. 21.4% of independent hospitals are paying family medicine providers with OB over $390K, while no hospital respondents who are part of a system report paying over $325K. For family medicine providers without OB, 53% of health-system-owned rural hospitals pay less than $234K compared to 36.2% of independent hospitals.

[7] 2019 MGMA DataDive Cost and Revenue. Used with permission from MGMA, 104 Inverness Terrace East, Englewood, Colorado 80112. 877.275.6462. www.mgma.com. © 2019.

## Avg. Total Compensation per Family Medicine Physician - WITHOUT OB



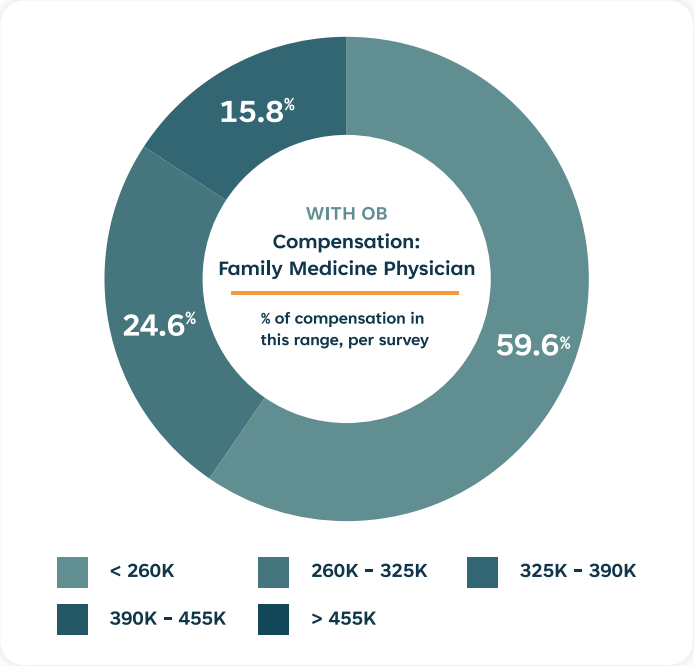

## Avg. Total Compensation per Family Medicine Physician - WITH OB

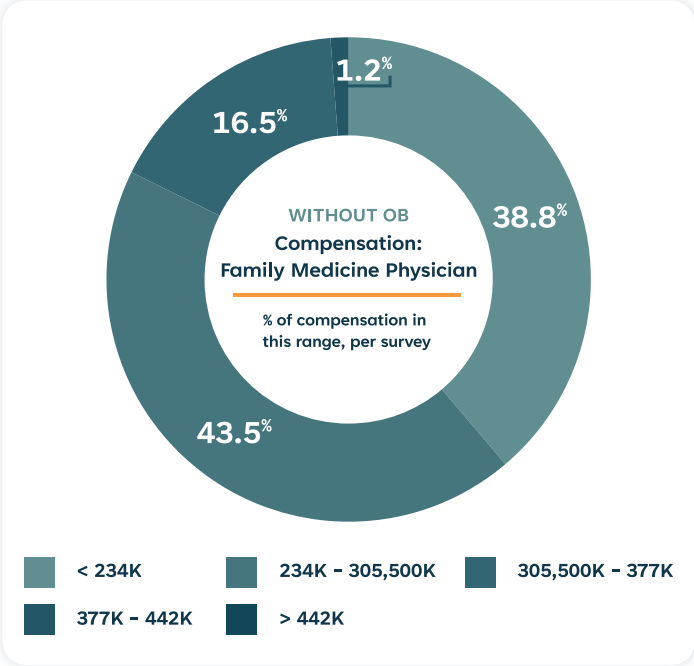



"Structuring compensation becomes critical, particularly as some rural PCPs are earning over $300K. These amounts are greater than what is reported in MGMA data. For rural to pay a higher premium for family medicine shouldn't come as a complete surprise given how much is required of PCPs for the services that they are providing. If compensation is tied to the services they're providing in a way that's meaningful, that provides some protection. As data becomes available around overall patient health management, primary care will begin expecting higher salaries similar to specialists," cautions Greenway.

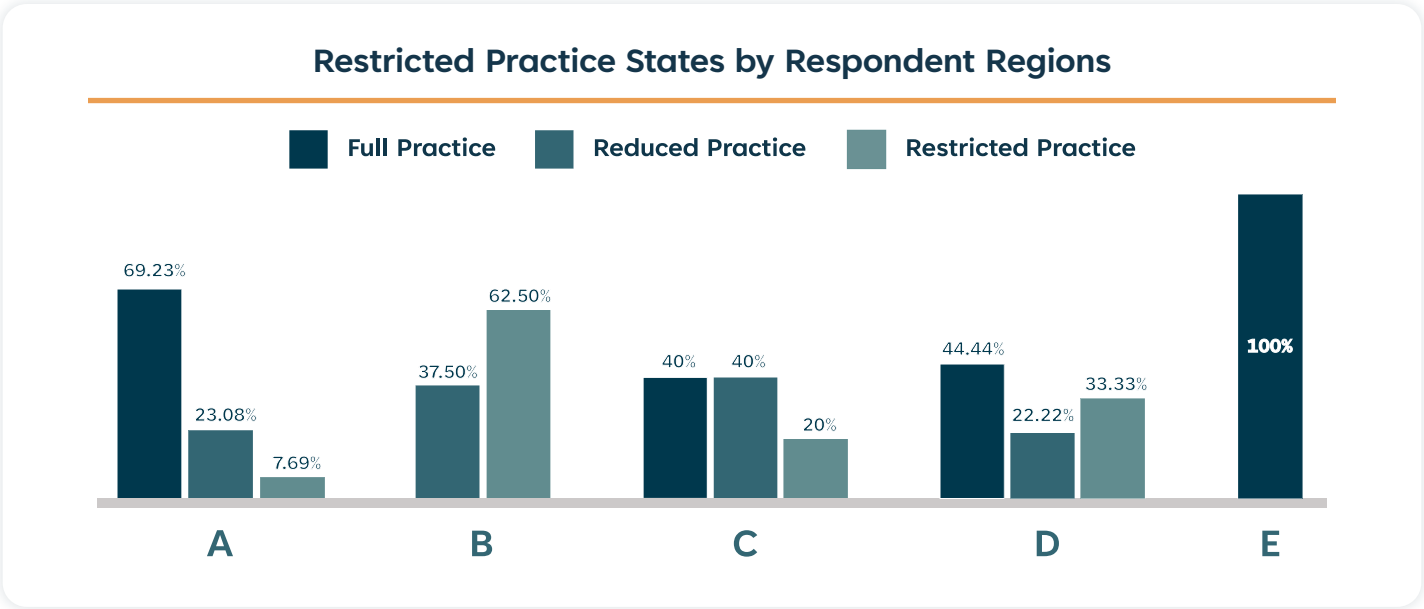
## ADVANCED PRACTICE PROVIDER COMPENSATION WITH AND WITHOUT OB

The majority of family medicine nurse practitioners (NPs) earn less than $150K per year, regardless of state of licensure or scope of service. A stagnant salary is driving some NPs to revert to their RN licensure or contract nursing, where they can average $132 per hour[8], an 83% increase over an NP hourly rate of $72.

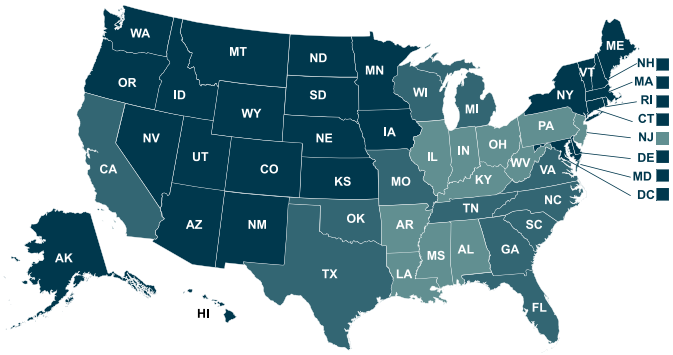



"NPs are thinking of hourly pay over salary, but rural healthcare leaders can change that," says Greenway. "A compensation strategy can incentivize NPs and enable some to make $200K and beyond, which aligns them more closely with their PCP colleagues."




[8] Condon, A. The cost of hospital contract labor in 22 numbers Becker's Hospital Review. 11/04/2022.

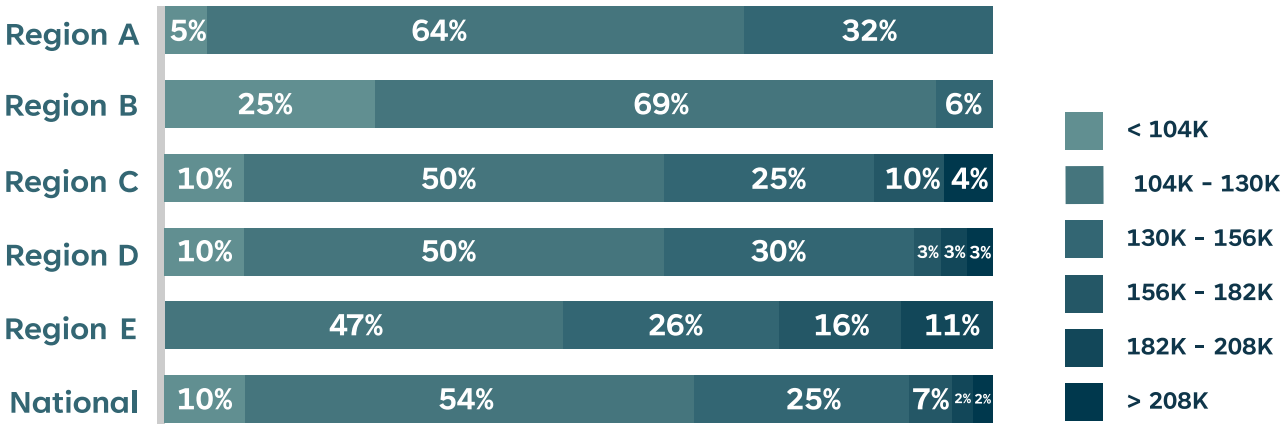



## State Practice Environmental Map

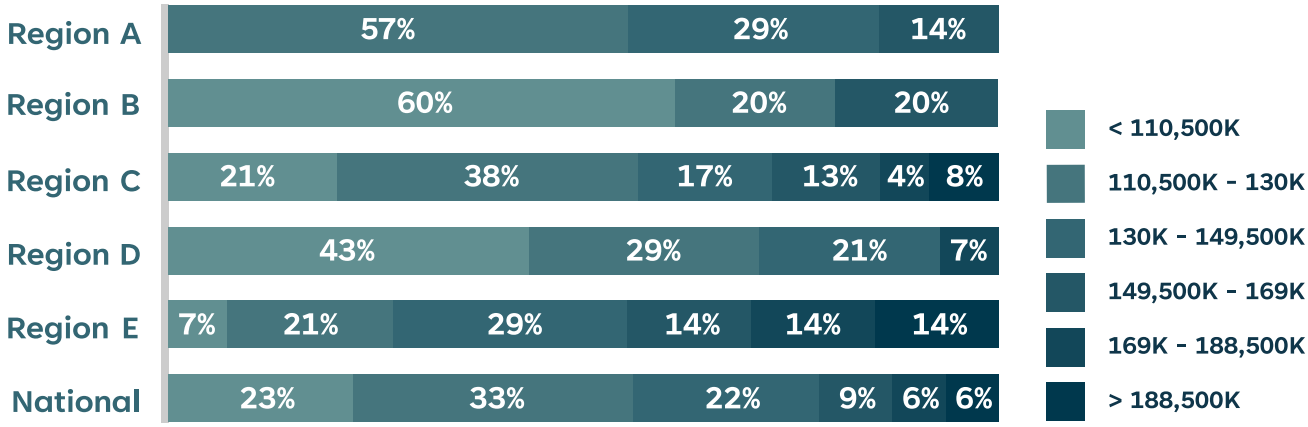
- Full Practice
- Reduced Practice
- Restricted Practice

Most primary care Physician Assistants (PAs) with OB are reportedly compensated even less than their NP colleagues at an average of $130K annually. PAs without OB are reported to be compensated between $104K and $149.5K annually.

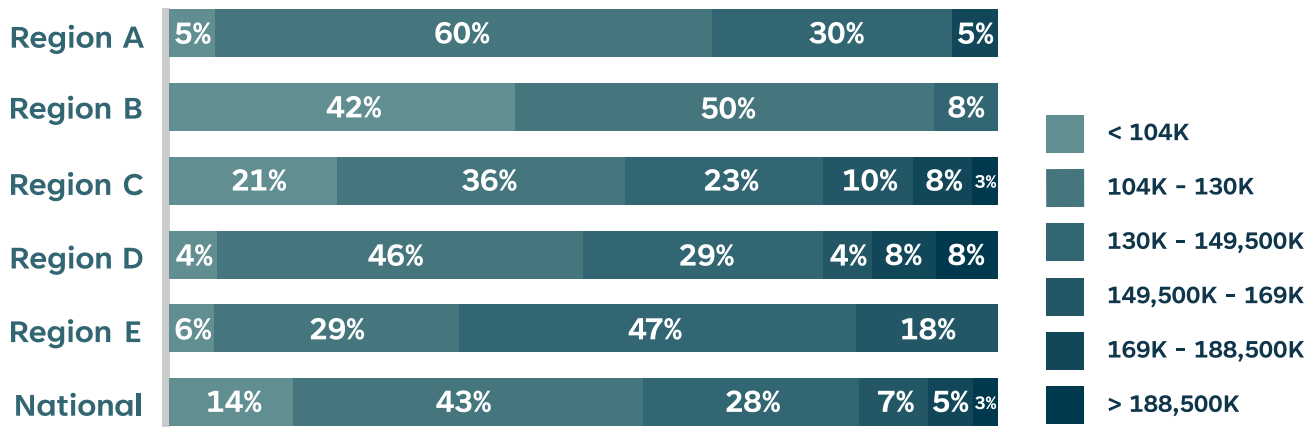
## Avg. Total Compensation per Family Medicine NP - WITHOUT OB



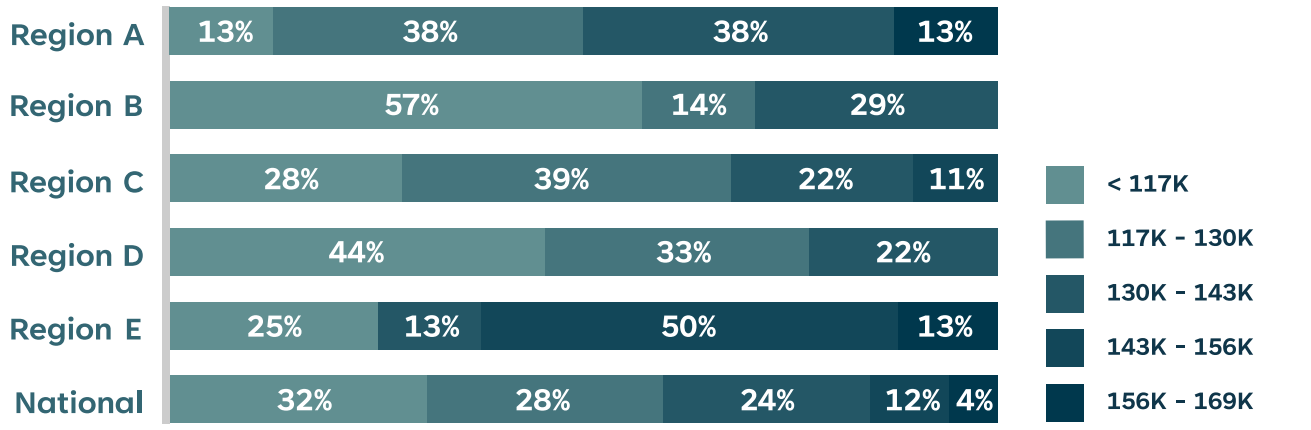

## Avg. Total Compensation per Family Medicine NP - WITH OB



## Avg. Total Compensation per Family Medicine PA – WITHOUT OB




## Avg. Total Compensation per Family Medicine PA – WITH OB




## SPECIALTY CARE AND PROFESSIONAL SERVICE AGREEMENTS

America's aging population fuels the demand for specialty care and helps drive up specialty care compensation. Independent hospitals are the most vulnerable, typically lacking the access to specialists that a health system can afford. Professional Services Agreements (PSAs) with provider groups are one solution for offering specialty care. Under a PSA, a physician or medical group remains independent (i.e., not employed by the rural hospital) and provides professional services to the hospital.

Regardless of system affiliation status, 53% of survey respondents indicated they have professional service agreements in place with providers, with general surgery and diagnostic radiology reported to be the most established specialties for PSAs.

"We assume that most independent hospitals will use professional service agreements in order to have access to specialists. But what we found most interesting was that most organizations – independent or system affiliated – didn't know what agreement they had in place with specialists or if they did, they were unclear about the terms. Contracts were handshake deals and new providers weren't needed until the pandemic," says Greenway.

## 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.

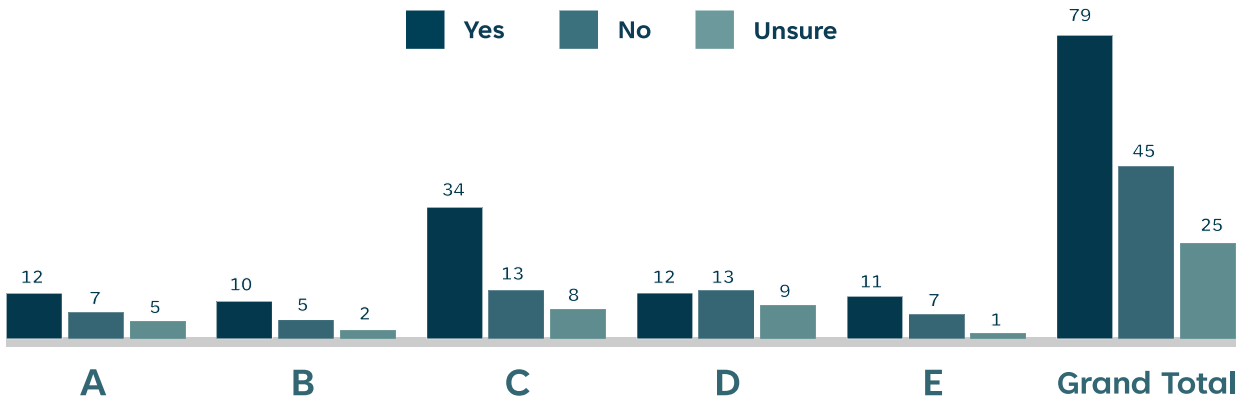
**Gastroenterology:** All regions, regardless of system affiliation status, pay less than $585,000 for gastroenterology physicians; MGMA median is $556,675.

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

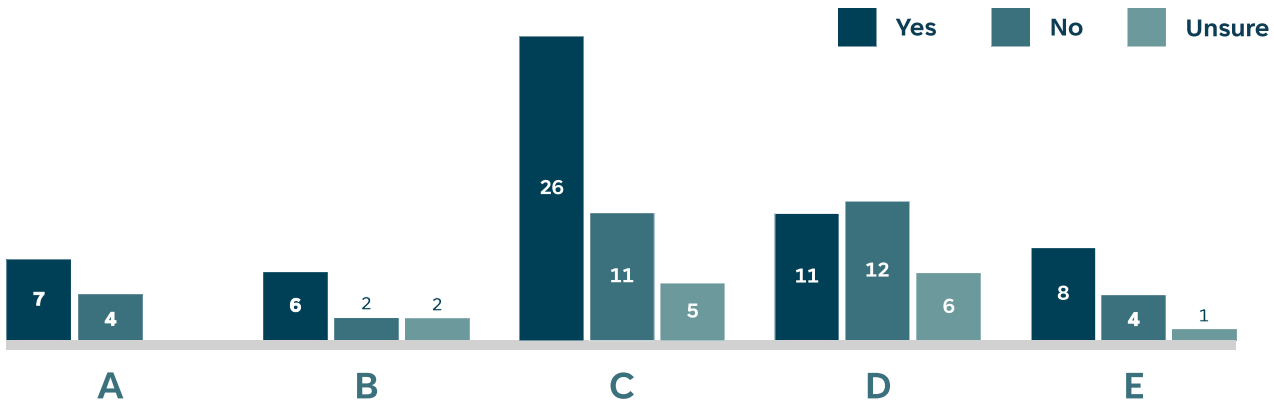
**OB/GYN:** Low rate of response amongst system status respondents. Independent respondents indicated OB/GYNs in Region D generally are compensated at a higher rate than their Region A and Region B colleagues. MGMA median is $369,179.

**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.

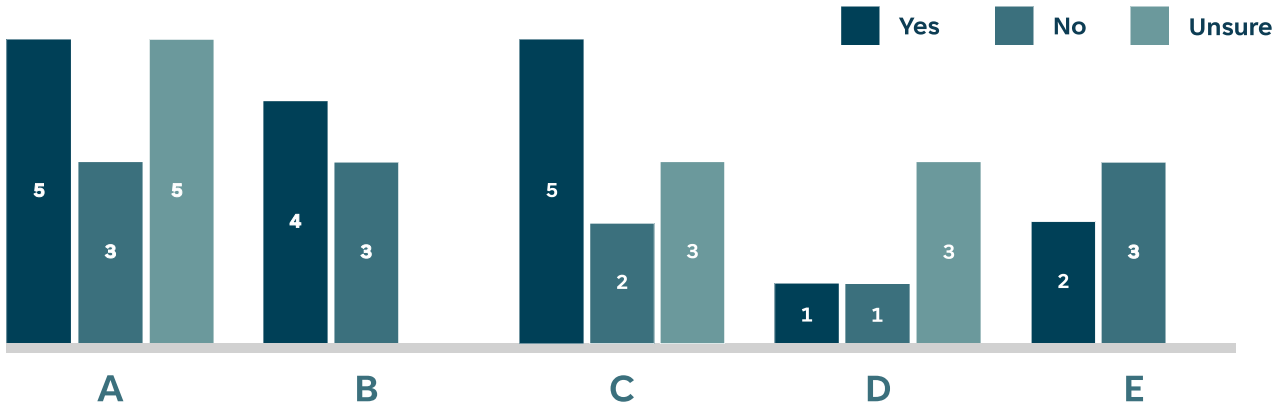
## Does your hospital have Professional Service Agreements with providers?



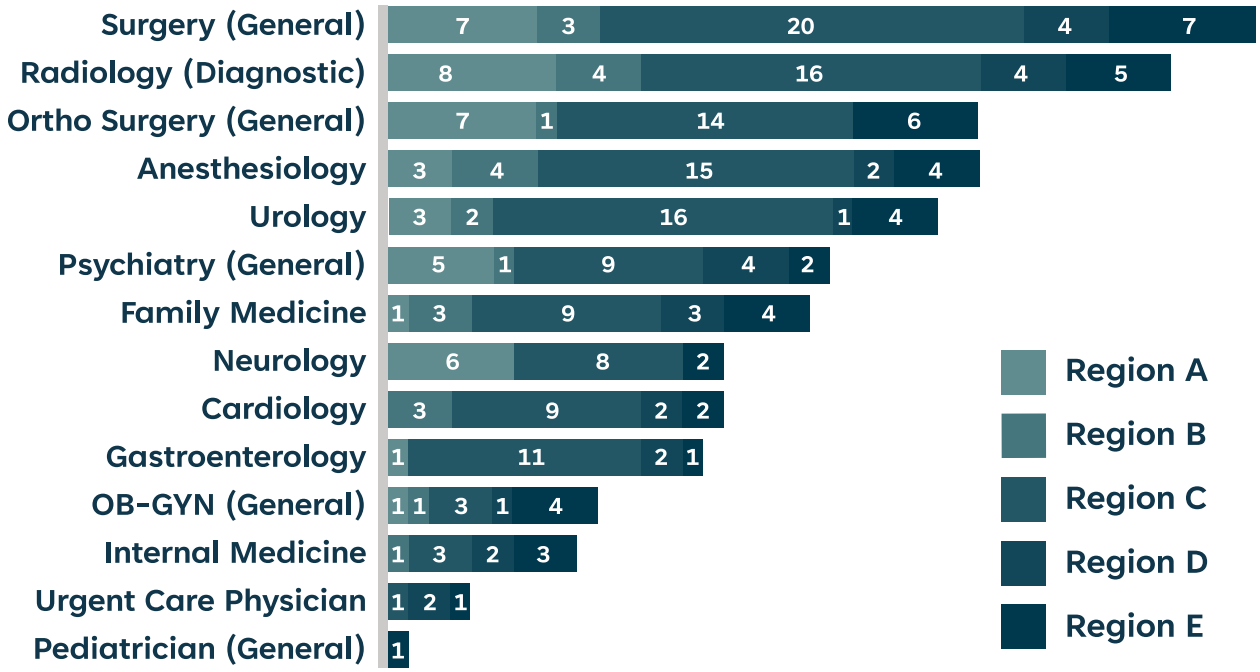

## Independent - Professional Service Agreements



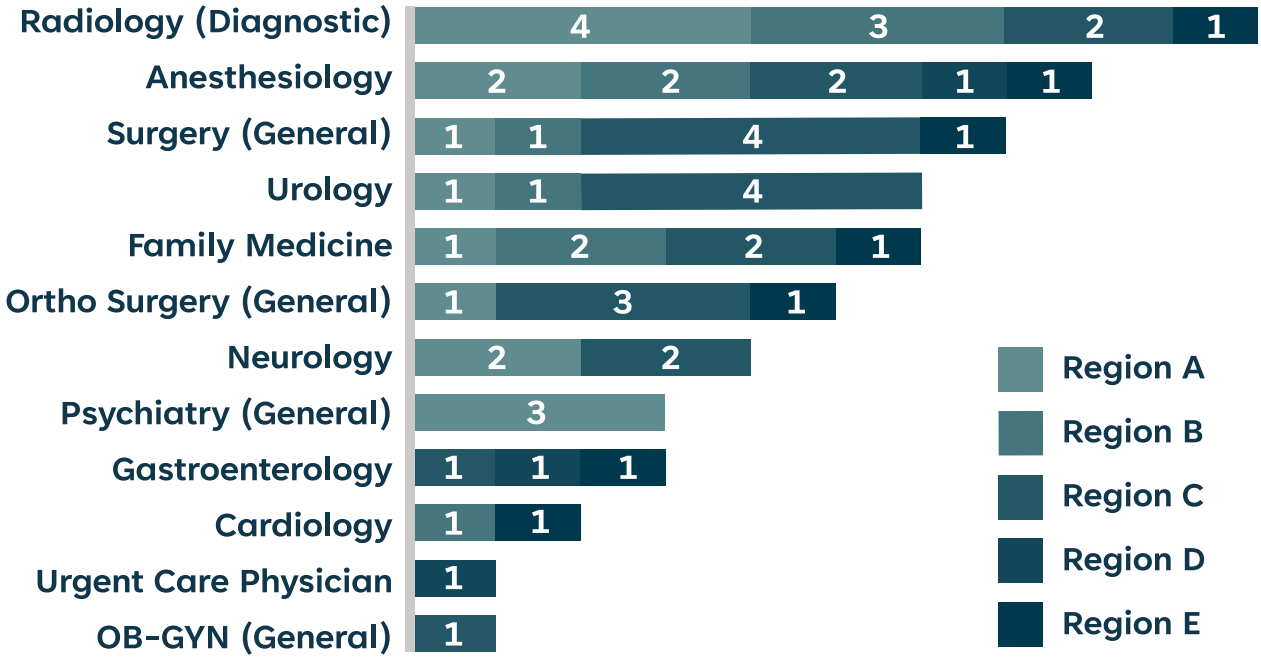

## System Affiliation - Professional Service Agreements



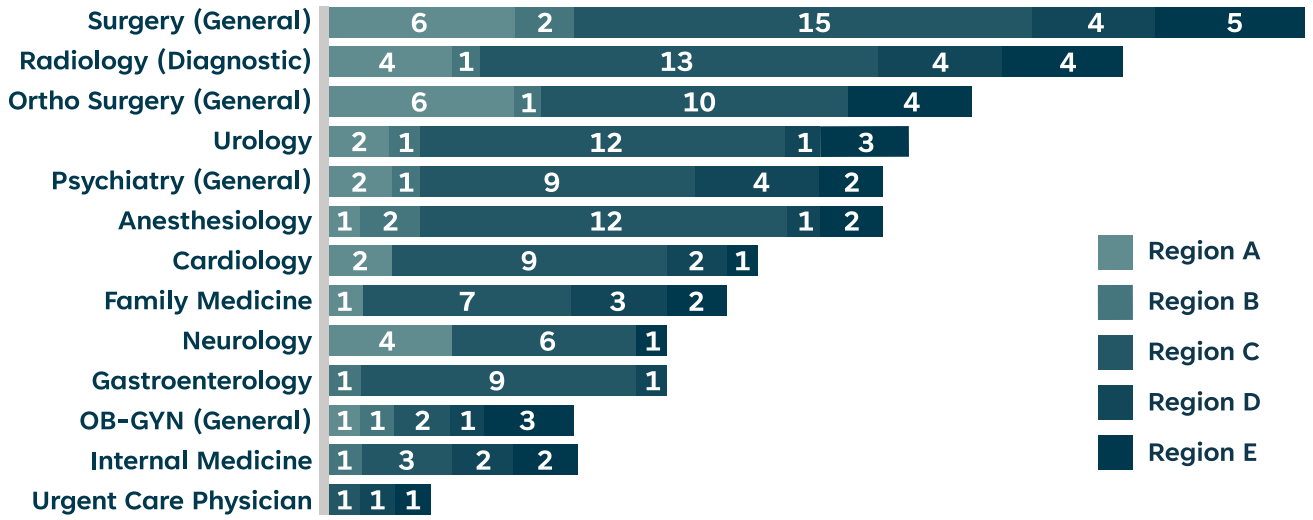
## Professional Service Agreements by Specialty and Region



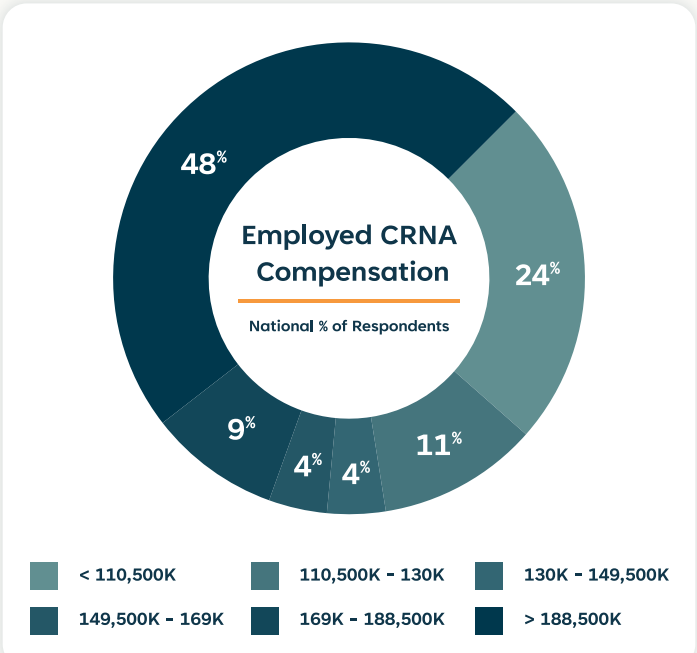

## System Professional Service Agreements by Specialty

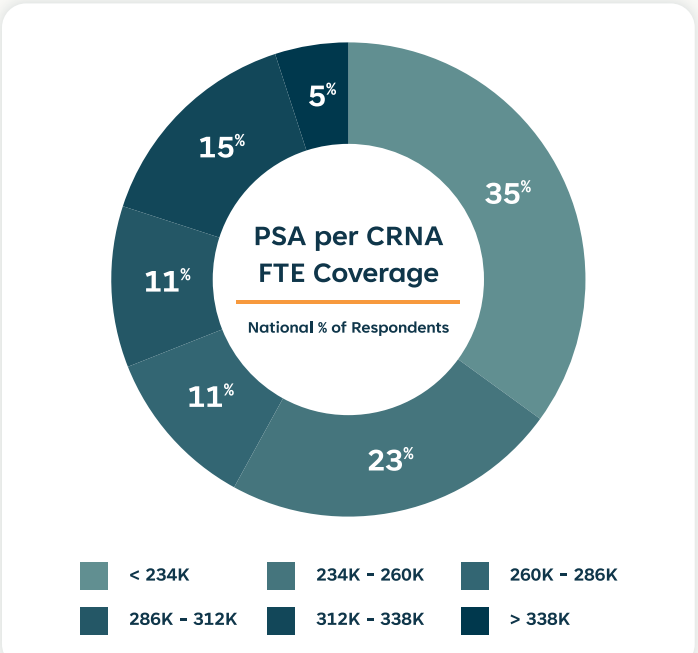


## Independent Professional Service Agreements by Specialty




The survey results illuminated compensation trends for specialty providers that may be contributing to the rising costs of providing care, with CRNA compensation as a prime example. “In rural, we want CRNA data for anesthesiology so we can understand what we should pay for CRNAs,” explains Greenway. “They used to make salaries of $150K, but now with incentive compensation, extra call pay and increased salaries, over half make over $180K. Some sources even have CRNA total comp exceeding $215K. Interestingly, CRNAs are not in short supply. While we can recruit and retain CRNAs, their compensation has jumped significantly which means running an OR is getting more and more expensive.” Taking a closer look at the compensation trends for specialty providers and the driving forces behind them may reveal opportunities for rural providers to recruit and retain more effectively while controlling costs.



## RETHINKING PROVIDER COMPENSATION AND BEST PRACTICES IN RURAL

The results of Stroudwater and NRHA's first Annual Rural Provider Compensation Survey exposed some key opportunities for rural providers.

**As rural organizations look to the future, several areas could benefit especially from strategic review, including:**

Compensation Structure

Compliance

Alignment

### **Compensation Structure:** Bridging Alignment & Transparency

"Providers want to be able to accurately understand and calculate their compensation, but many rural providers, unless their compensation is 100% base salary, do not understand how their compensation is calculated and, in many instances, don't understand how it's tied to the organization's goals," states Greenway. "When it comes to building alignment, transparency is critical. Organizations should be clear about the reasoning behind any incentive compensation. This must be combined with providing a simple formula for providers to calculate their incentive compensation based on reliable data that is timely and accessible. Providers want confidence in their compensation. Organizations can build that confidence by offering flexibility for new providers and being clear about expectations before having more than 10% of compensation put into incentives. Even after an initial period, in rural organizations, providers overall expect 80-85% of their total cash compensation target to be fixed or guaranteed."

The remaining portion of provider compensation should be tied to performance—specifically, the achievement and/or surpassing of minimum wRVUs, quality, and engagement/citizenship. Incentive compensation can then be tailored for providers who excel beyond these minimum standards, allowing high performers the opportunity to earn more than their total cash compensation target.

Above all, the compensation structure should be sustainable and align with the organization's strategic goals and market expectations. A strategic compensation structure will support the hospital in recruiting and retaining high-quality providers to meet organizational and community needs.

## **Compliance:** Mitigating Risk for Fair Market Value

The survey results underscored a major concern for independent rural hospitals: the widespread variance in total compensation for providers could be an underlying compliance risk.

> "The variance in the data shows me that independent hospitals do not have an overall compensation strategy, and they have not evaluated their compensation packages from a regulatory perspective. It immediately raises red flags for potential noncompliance with Fair Market Value, STARK law, and Anti-Kickback regulations," notes Greenway.

To maintain compliance, rural hospitals should evaluate Fair Market Value (FMV) each time a new agreement is put in place or every two years. "Rural hospitals now have the data to compare compensation against what other rural organizations in their region are paying providers, but I urge leadership to do more than just look at a dollar amount because incentives are important. To maintain compliance, organizations need to evaluate the market level for the services provided," says Greenway.

Rural organizations must have a comprehensive understanding of the prevailing market conditions, the specific services being offered, the requirements of providers, patient accessibility, and economic trends that are directly relevant to the particular entity or provider contract under consideration.

## **Independents vs. Systems:** Aligning Specialist Access Across the System

For health systems with rural affiliates, the First Annual Rural Provider Compensation Survey clarifies that indeed, compensation in rural organizations is different. While many systems might believe that they are following best practices (strategic, templated, aligned, contracts accessible) they are likely not evaluating the specific needs of their rural organizations as compared to the larger organization.

Health systems can also create a competitive advantage by evaluating their PSAs with specialists and aligning compensation to enhance access to care among their rural affiliates, tying compensation to achieving specific goals within their rural affiliates. This may mean evaluating how incentives at the larger organization could impact healthcare quality and access at rural affiliates. For example, a specialist with compensation primarily tied to productivity may be less inclined to spend two days a month at a low-volume rural affiliate that does not generate the productivity compensation possible at the primary tertiary or urban hospital. If systems with rural affiliates want to ensure rural strategy is accomplished, an examination of how compensation can impact the viability of a strategy is essential.

## THE FUTURE OF RURAL COMPENSATION

There is a grave sense of urgency in rural organizations to overhaul how compensation is calculated. With more than 104 rural hospital closures since 2005,[9] the rural healthcare landscape is plagued by staffing challenges, health disparities, and shrinking margins. Taking a step back, rural leaders must acknowledge that if 56% of organizations are using a base salary for their providers, those organizations have not aligned their compensation strategy with the overall success of the organization.

To achieve this strategic alignment, physician and advanced practice provider compensation plans must be financially sustainable and reward providers for meeting and exceeding clinical and nonclinical goals. Furthermore, the plans must align with overall growth goals for rural healthcare organizations.

> "Rural healthcare organizations are being called on to evaluate the relationship between productivity, quality, and compensation and they simply haven't had all the tools and data points to make that happen," says Greenway. "Misalignment can put organizations at risk of either losing providers, overpaying for them, or being non-compliant. Coverage or other immediate needs may call for variances outside of this, but should be the exception, not the rule."

**Structured and strategic compensation plans can strengthen provider and organization alignment, benefiting all parties through:**


As part of our commitment to supporting, sustaining, and amplifying the impact of rural and community healthcare, Stroudwater will continue to conduct and distribute rural compensation data to rural organizations at no cost to the organizations. The next Rural Provider Compensation Survey will open in January 2024 in partnership with the National Rural Health Association (NRHA) and the National Office of the State Offices of Rural Health (NOSORH). The 2024 survey has been updated based on feedback from organizations to provide more comprehensive data, better statistics, and compensation details, and to grow overall response rates. More specific regional data will be available as response rates grow, which can greatly assist organizations in meeting FMV compliance requirements, and more importantly, ensure rural organizations can stay competitive in provider recruitment. Stroudwater is dedicated to ensuring that rural hospitals have accurate data and insightful analysis to make informed decisions critical to a thriving healthcare organization.

**To learn more about provider compensation and strategy, connect with the Stroudwater team.**

[9] Rural Hospitals in crisis mode. Becker's Hospital Review.