OREGON OFFICE of RURAL HEALTH
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Rural Health Conference
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OPPORTUNITY Just knock.
OHSU

Integrating Incentives in Rural Provider Compensation

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STROUDWATER

INTEGRATING INCENTIVES IN RURAL PROVIDER COMPENSATION

OREGON RURAL HEALTH CONFERENCE

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October 3, 2025

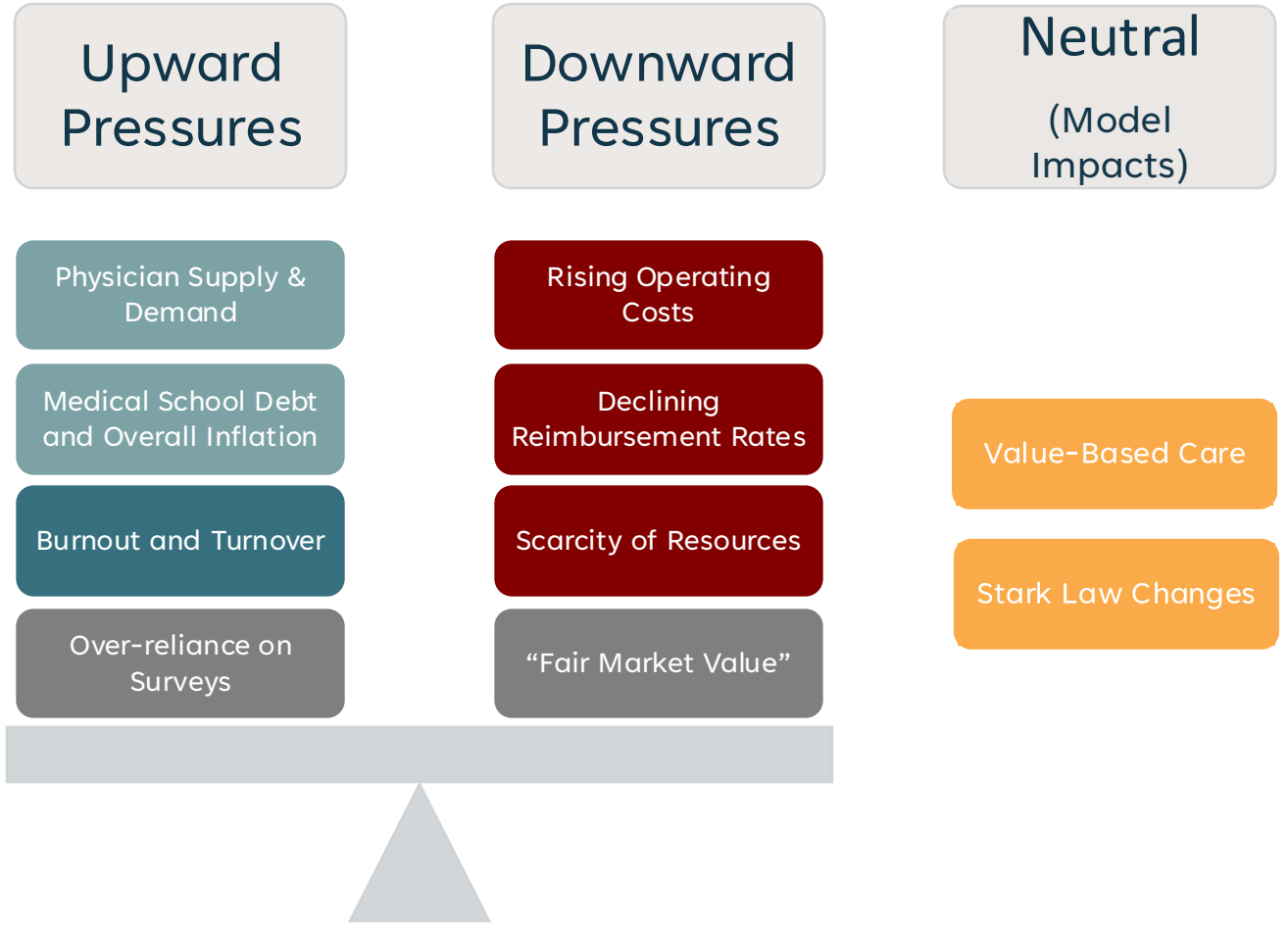
AGENDA

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

CURRENT COMPENSATION MARKET

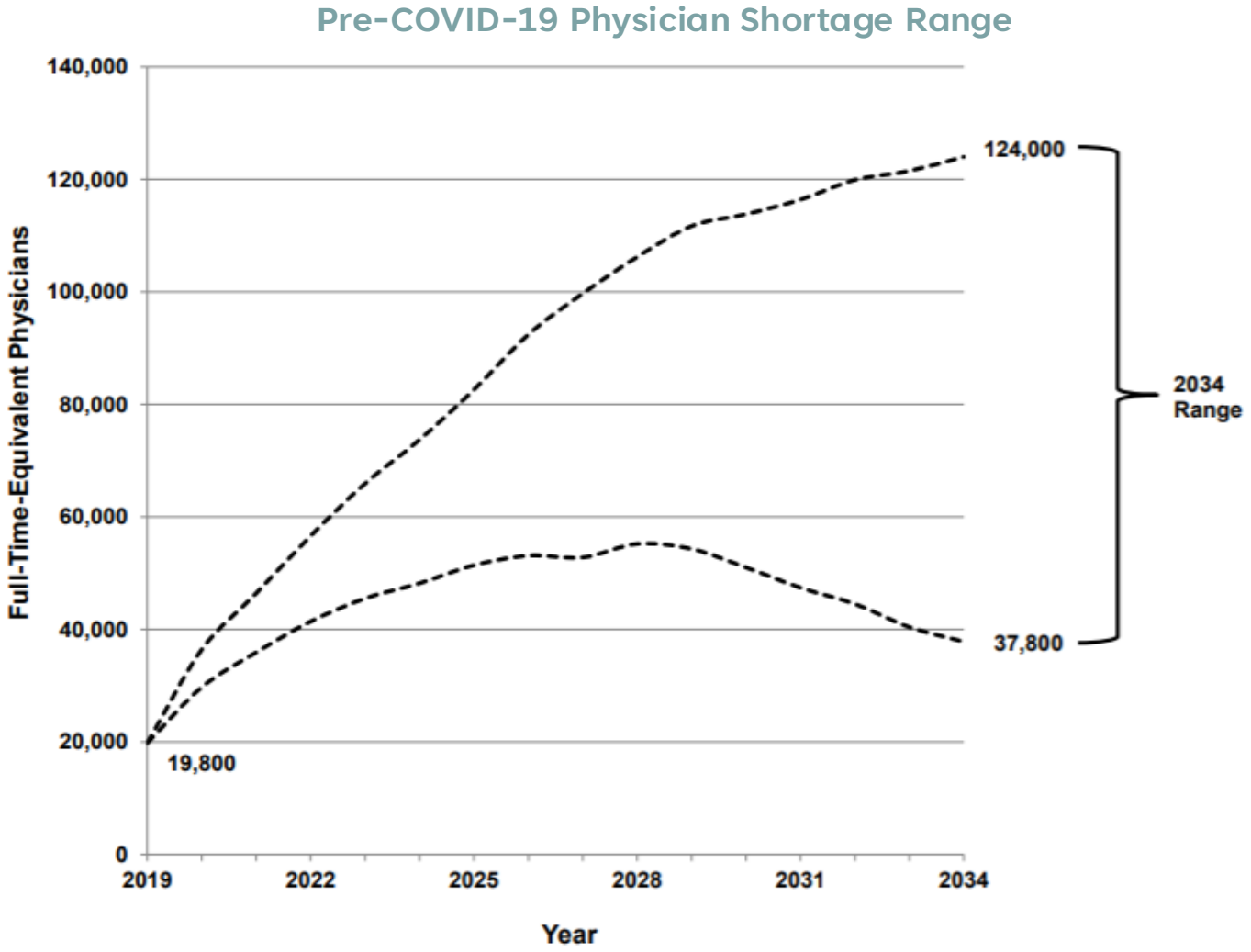
FORCES INFLUENCING COMPENSATION

- Provider supply (shortages) and demand (increasing need), rising costs (healthcare and personal), regulatory changes, etc. all 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



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
- Health disparities have long existed, affecting minority groups, rural residents, and the uninsured, who often face significant barriers to care. If these populations were to access healthcare at rates similar to those with fewer obstacles, the United States would face a physician shortage ranging from **102,400 to 180,400**.
- This underscores existing pressures on the physician workforce, which has experienced consequences in several key areas:
  - **Training**: Disruptions in medical education and residency programs.
  - **Regulation**: Changes to professional licensure and reimbursement policies.
  - **Practice**: The rapid adoption of telehealth and fluctuations in patient appointments.
  - **Workforce Exits**: An increase in providers leaving the profession.



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

STATE OF PHYSICIAN SUPPLY & DEMAND IN OREGON

- By 2030, Oregon is projected to be short 1,726 physicians
  - Primary care alone is projected to be short 1,174 providers to maintain status quo (i.e., to meet demand as population ages and expands); also, the need for PCPs is expected to grow by 38% by 2030 in Oregon
- Given that Oregon is at ~145 to 150 PCPs/100,000, which is somewhat above many other states but still with gaps, especially in rural or underserved areas, a target might reasonably be:
  - **Around 160–200 PCPs per 100,000 people** as a state-wide goal over the next decade, to accommodate population aging, greater chronic disease, access equity, etc.
  - In 2013, it was reported that approximately 30.8% of rural PCPs in Oregon were near retirement age. Nationally, the % of physicians that are age 60 or older is 33.7%.
  - Oregon has about 145 to 150 primary care physicians per 100,000 residents. That puts Oregon around 24th among all U.S. states.
  - All 36 counties in Oregon contain at least one health professional shortage area (HPSA) designation (i.e., geographic, population, or facility-based HPSA)
    - This means that while a county may have some areas with sufficient providers, at least a portion of every county in Oregon experiences a shortage in some healthcare discipline (primary care, dental, or mental health)

Press Release | Oregon GME Consortium
States with the Largest Projected PCP Shortages
US primary care physician workforce per 100,000 capita - Becker's Hospital Review | Healthcare News & Analysis
The Aging of Rural Primary Care Physicians | The Daily Yonder
A data-based look at America's physicians and medical students, state-by-state | AAMC

INDUSTRY TRENDS IN PROVIDER COMPENSATION

COMPENSATION STRATEGY

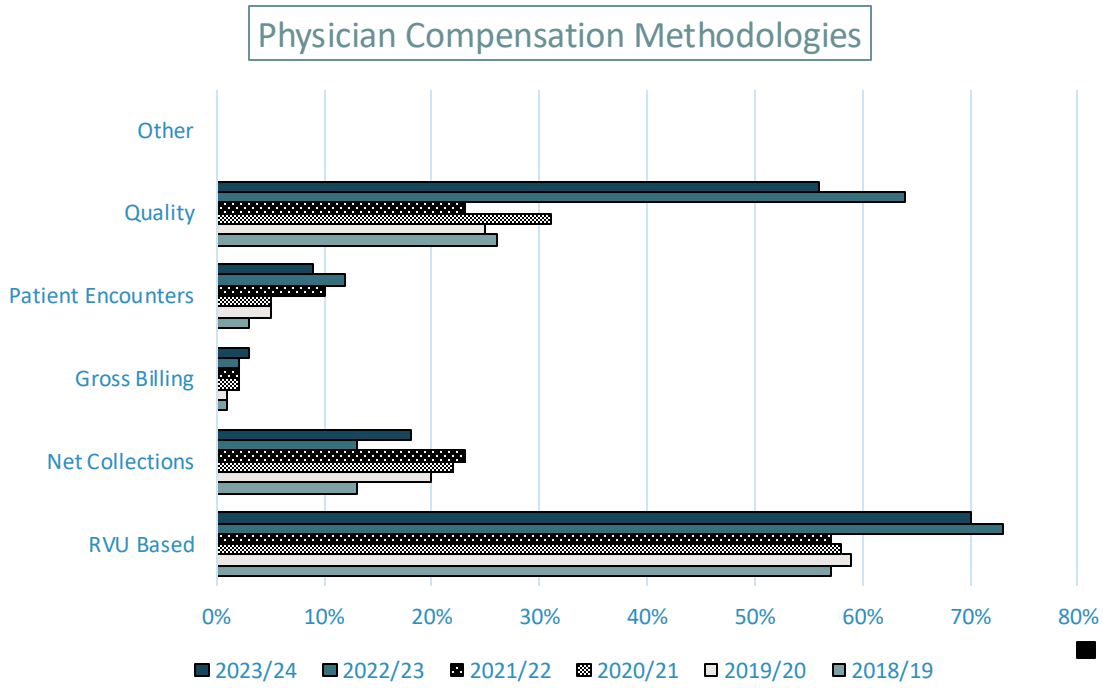
- A significant number of healthcare organizations, particularly those in rural areas, are **actively developing provider compensation strategies** that are directly aligned with their mission and strategic goals. This includes implementing a sustainable framework for long-term provider recruitment and retention, recognizing that well-structured incentives are crucial for fostering provider longevity within the organization.

- In the current healthcare landscape, many organizations are operating with minimal or negative margins. Consequently, a growing number of these organizations are utilizing a comprehensive **Provider Needs Assessment** to strategically balance provider supply with patient demand.

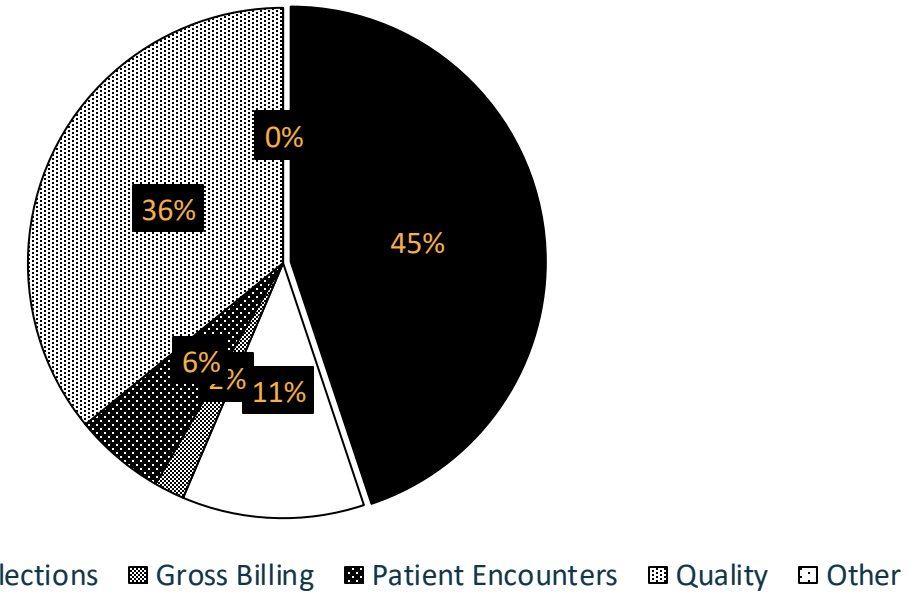
- Lastly, many healthcare organizations are focused on **refining their employment agreements to incorporate standardized language across all providers**. By aligning their agreements with industry best practices, CEOs can ensure greater transparency and equity, which is especially vital for leaders who have inherited a workforce with a wide range of disparate and individually negotiated terms and conditions.

INDUSTRY TRENDS IN COMPENSATION METHODOLOGY

- Majority of physicians are compensated based on a salary plus bonus (such as 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/

CALL COMPENSATION

- Factors that need to be considered:
  - 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
- Excess call comp can be appropriate
- 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 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

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”
- 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 FMV opinions typically review	“Benefits” What FMV opinions should also consider
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)

NON-TRADITIONAL INCENTIVES

Rural healthcare organizations are increasingly moving beyond traditional salary and loan repayment programs to offer a suite of innovative incentives. These incentives are designed to address the unique challenges of rural practice, such as professional isolation and limited social opportunities, and to make these roles more appealing to a broader range of providers.

PROFESSIONAL AND CAREER DEVELOPMENT

Mentorship Programs and Peer Support:

- Rural providers often lack the immediate access to specialists and colleagues that is common in urban settings. Innovative programs are pairing new providers with experienced mentors, either in-person or via telehealth, to offer clinical support, career guidance, and a sense of community.

Leadership Opportunities:

- Rural settings often allow providers to take on a broader scope of practice and leadership roles earlier in their careers. Organizations are formalizing this by offering clear leadership tracks and administrative roles, which can be highly appealing to ambitious providers.

Academic and Research Opportunities:

- Some rural organizations are forging partnerships with nearby universities and medical schools to offer providers the chance to teach or participate in research. This helps combat professional isolation and provides a way for providers to stay connected to the academic world.

LIFESTYLE AND QUALITY OF LIFE INCENTIVES

Flexible Scheduling and Reduced Workload:

- Rural practices are recognizing the importance of work-life balance. They are offering more flexible scheduling options, reduced on-call responsibilities, and part-time or fractional employment models to prevent burnout and make the job more sustainable.

Community Integration Support:

- To help providers and their families acclimate, organizations are offering more than just relocation assistance. This can include assistance with spousal employment, help finding quality schools and childcare, and introductions to local community groups and social clubs.

Housing Assistance:

- Beyond a simple relocation stipend, some organizations are offering low-interest home loans, housing stipends, or temporary subsidized housing to ease the financial burden of moving and setting up a new life.

TECHNOLOGY AND OPERATIONAL SUPPORT

Advanced Telehealth Infrastructure:

- To combat professional isolation and enhance patient care, many rural health systems are investing in robust telehealth platforms. This allows providers to connect with specialists for consults, participate in continuing medical education (CME), and even mentor other providers, all from their rural location.

Integrated Care Teams:

- Creating a team-based care model where providers work at the top of their licenses and are supported by advanced practice providers, nurses, and other staff helps to reduce the daily administrative burden on physicians and mitigate burnout.

Technology to Improve Efficiency:

- Rural organizations are leveraging technology, such as optimized EHRs and other digital tools, to streamline clerical and clinical workflows. This helps reduce administrative tasks, increases productivity, and allows providers to focus more on patient care.

WHY DO INCENTIVES MATTER?

WHY PROVIDER COMPENSATION INCENTIVES MATTER

Attraction and Retention of Talent:

- Incentives such as student loan repayment, sign-on bonuses, and relocation stipends are crucial for attracting providers to rural areas and retaining them. This directly addresses the significant provider shortages and professional challenges often found in these communities.

Alignment of Goals and Driving Efficiency:

- Incentives link a provider's compensation to the organization's strategic objectives. This can include metrics for productivity (wRVUs), quality of care, and patient satisfaction, ensuring providers are motivated to deliver high-value, efficient care.

Ensuring Financial Sustainability:

- As provider compensation is a major expense, a well-designed incentive plan is vital for a practice's financial health. Tying pay to performance helps a practice manage its labor costs and ensures that compensation is aligned with revenue generation and quality goals, a critical factor for rural healthcare's survival.

“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

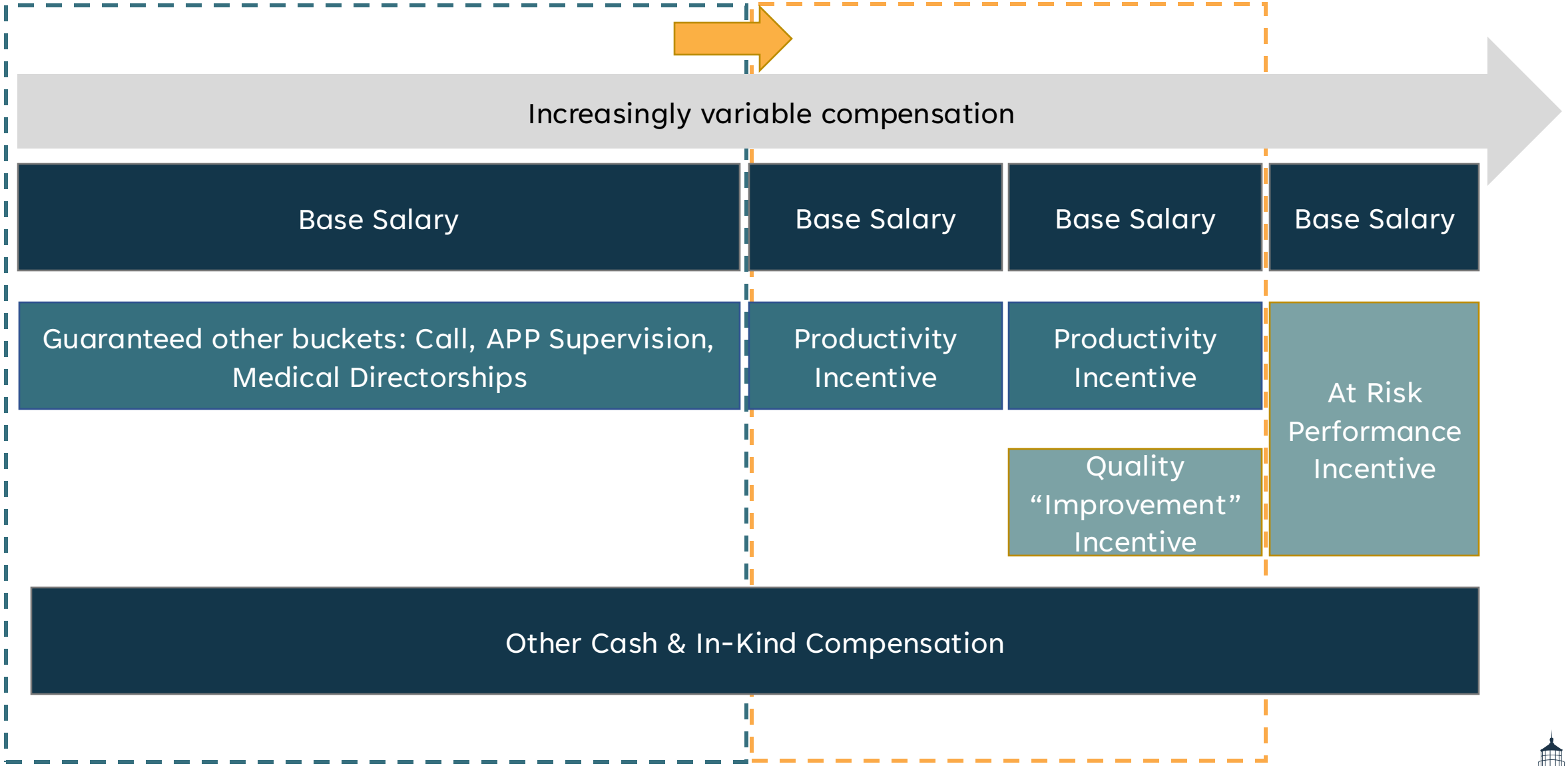
Stroudwater's 2nd Annual Rural Provider Compensation Survey co-sponsored by NRHA and NoSORH indicates that 54.7% of rural hospitals DO NOT pay providers incentive compensation

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 lack of information regarding what they could control.

CURRENT STATUS OF COMPENSATION IN RURAL



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

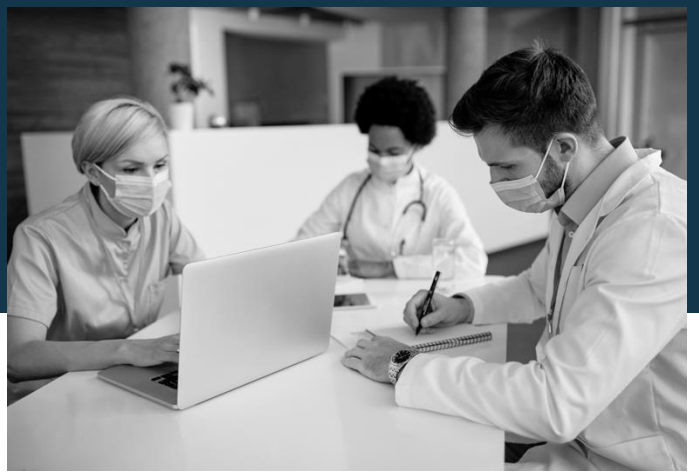
- Unclear or overly complicated incentives
- Unreachable incentives
- Requires data analytics
- Providers feel it impacts the quality of their care – wRVUs are a distraction
- What do you do if it doesn’t change behavior?

COMPLIANCE REQUIREMENTS

RELEVANCE OF PROVIDER CONTRACTS

Provider remuneration expense is significant & increasing

Provider remuneration is highly regulated



Pace of change is significant

Many organizations find their provider alignment & compensation is 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 judgements 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 judgements, the 2nd highest number of settlements and judgements in a single year. Of the more than $2.9 billion in False Claims Act settlements and judgements 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

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
- 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

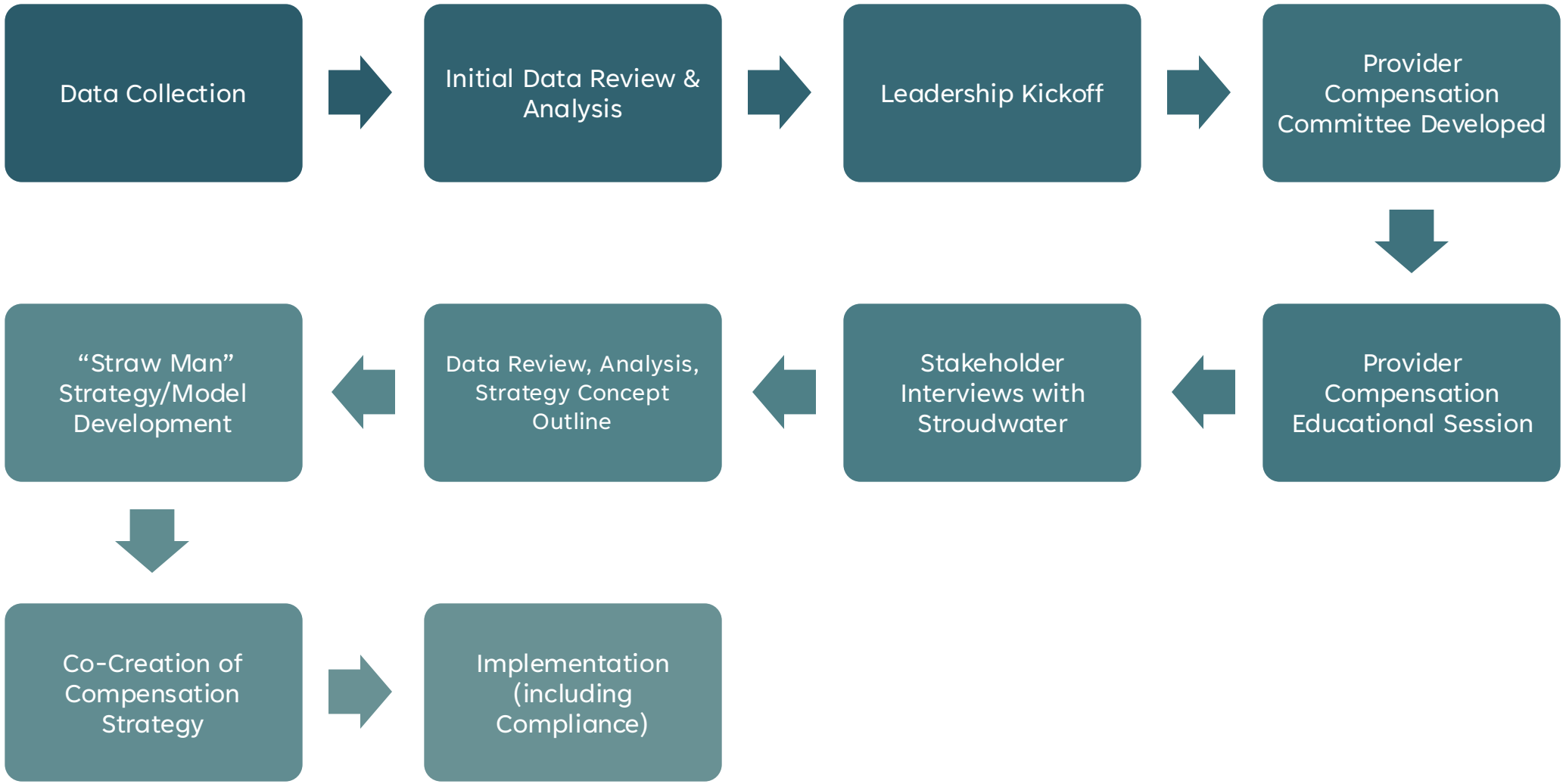
There are two buttons I never like to hit: that’s panic and snooze.

-Ted Lasso

ENGAGEMENT OVERVIEW

- Midwest Hospital wanted to adopt a new compensation strategy and model that would achieve the following:
  - Aligns with Hospital's overarching strategy;
  - Addresses specialty-specific considerations to employ CRNA providers;
  - Competitively and fairly compensates providers for their work while balancing organizational needs;
  - Incorporates productivity incentives that reward high performers;
  - Considers the organization's total remuneration, including compensation and benefits;
  - Addresses provider expectations and demands;
  - **Aligns with industry best practices and compliance requirements**; and
  - Enhances 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

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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