HEALTHCARE REGULATORY ROUND-UP EPISODE #35

Physician Compensation and the Three Rs of Rural Markets — Reality, Recruiting, Regulatory Considerations

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Introductions

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Agenda

1. Realities of Rural Medicine
2. Physician Recruiting in Rural Markets
3. Case Study: Best Practices and Valuation Considerations

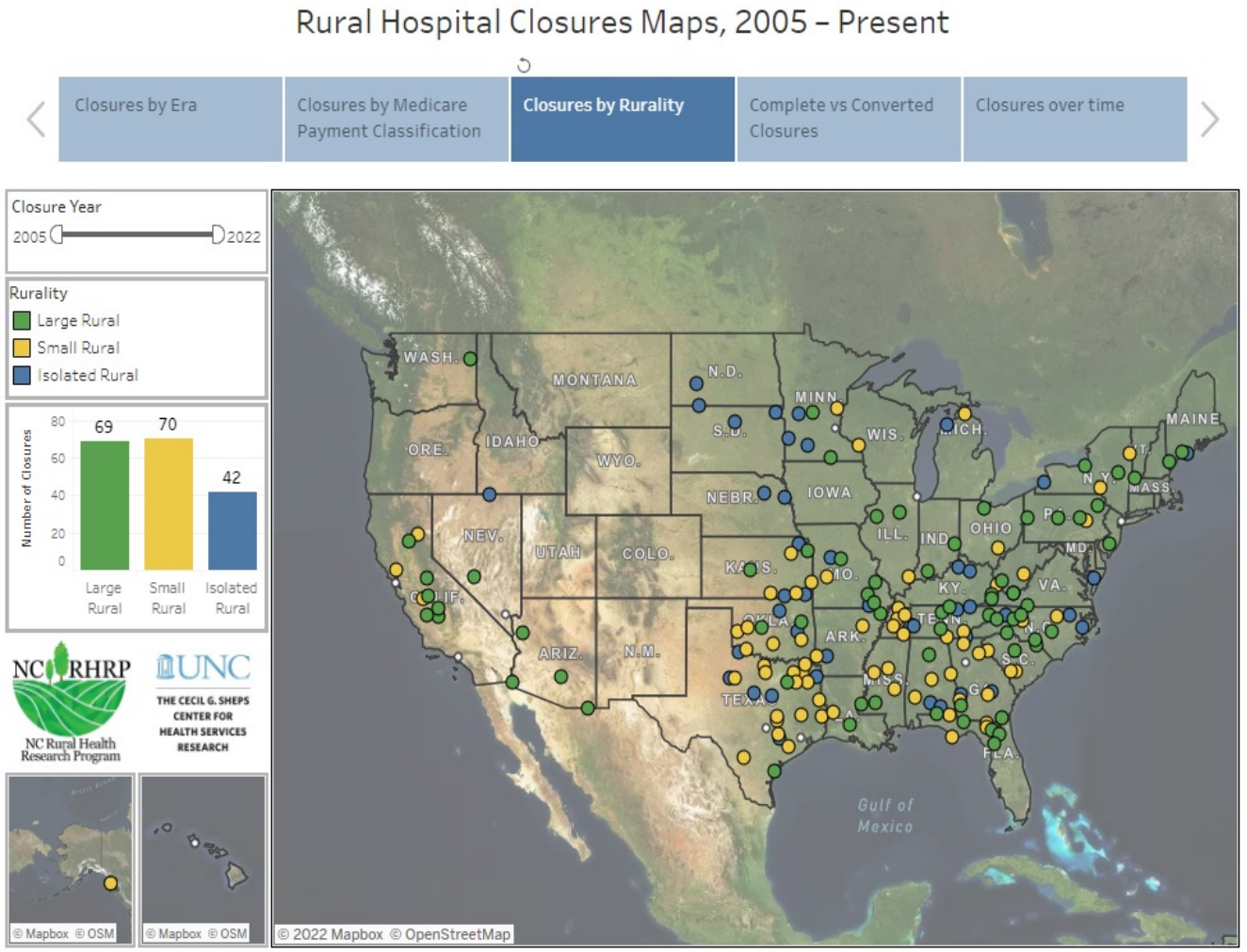
Realities of Rural Medicine

2019: **18** rural hospital closures

2020: **19** rural hospital closures

2021: **2** rural hospital closures

2022: **3** rural hospital closures



Source: https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/, accessed September 1, 2022

Realities of Rural Medicine, *continued*

Population Loss

Rural areas are losing population

Often (not always) elderly and low income

Need

Rural market population:

$\frac{1}{5}$ of United States population

Rural Market Physicians:

$^{1}/_{10}$ of United States physicians

Bypass Behavior

Rural residents seek care in places other than their local hospital

Sources: https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures-archive/rural-hospital-closures/, accessed September 1, 2022; Keeping Physicians in Rural Healthcare, by Merritt Hawkins (July 23, 2018), and Federal Office of Rural Health Policy

Realities of Rural Medicine, *continued*

Healthcare Delivery Changes

Participation in value-based reimbursement

Large health system referral patterns

Regulatory Changes

Impact to hospital margins

State Medicaid expansion
(reduce uncompensated care)

Medicare payment policy

Sources: https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures-archive/rural-hospital-closures/, accessed September 1, 2022; Keeping Physicians in Rural Healthcare, by Merritt Hawkins (July 23, 2018)

Realities of Rural Medicine, *continued*

Technology

Expense

Outpatient vs. inpatient delivery

Talent

Recruitment difficulties

Market resources

Sources: https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures-archive/rural-hospital-closures/, accessed September 1, 2022; Keeping Physicians in Rural Healthcare, by Merritt Hawkins (July 23, 2018)

Rural Medicine Done Right

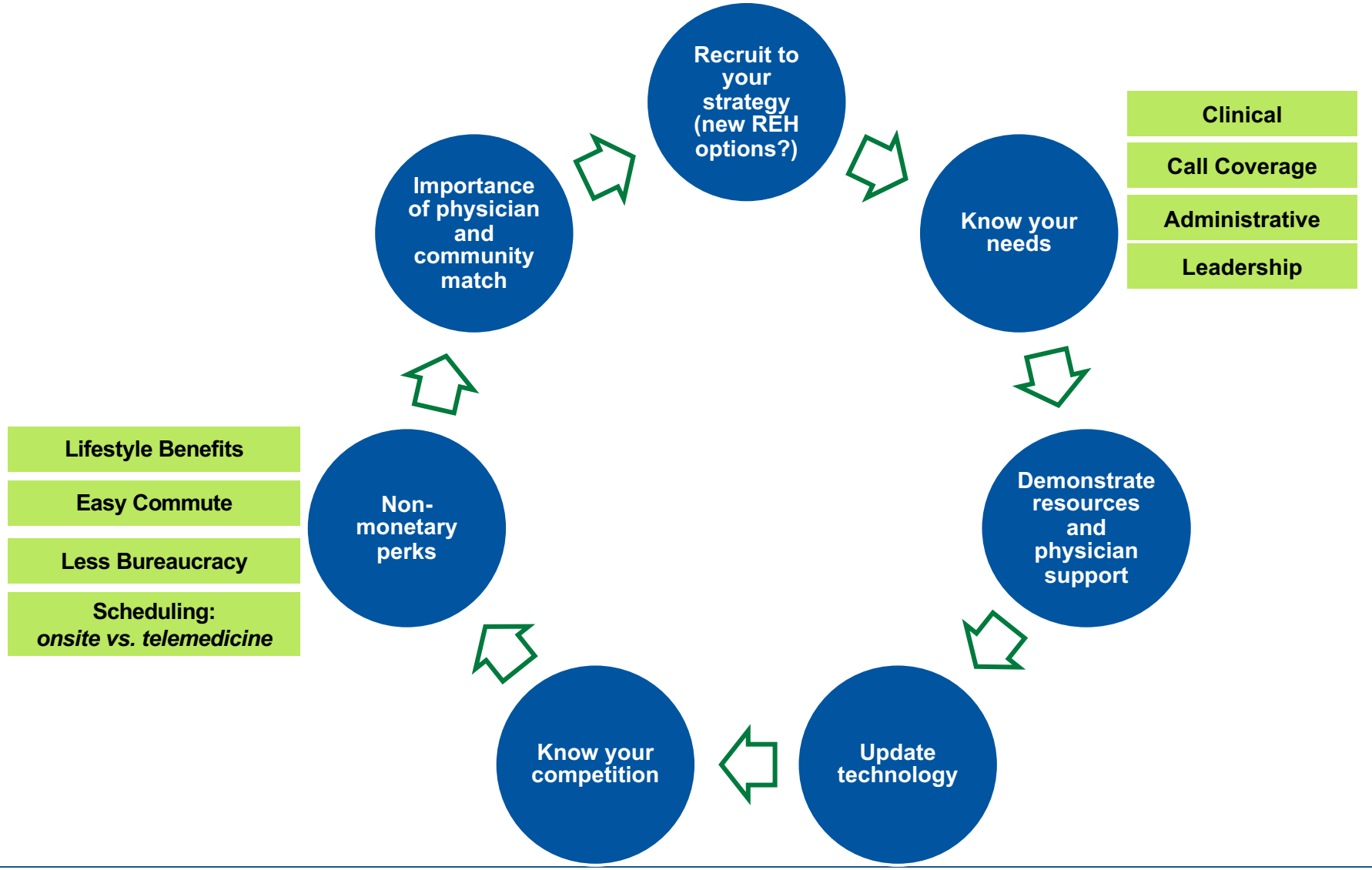
Meeting community, patient, and provider needs

How can rural health providers develop a range of inpatient and outpatient procedures?

Services ranging from prevention, to intervention, to rehabilitation

How can rural health providers best meet community needs with limited resources?

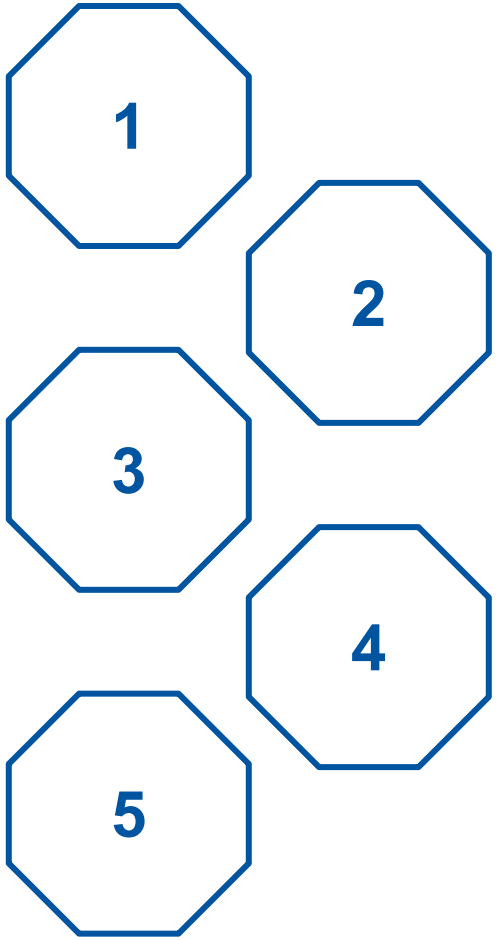
Physician Recruiting in Rural Markets



Physician Recruiting in Rural Markets

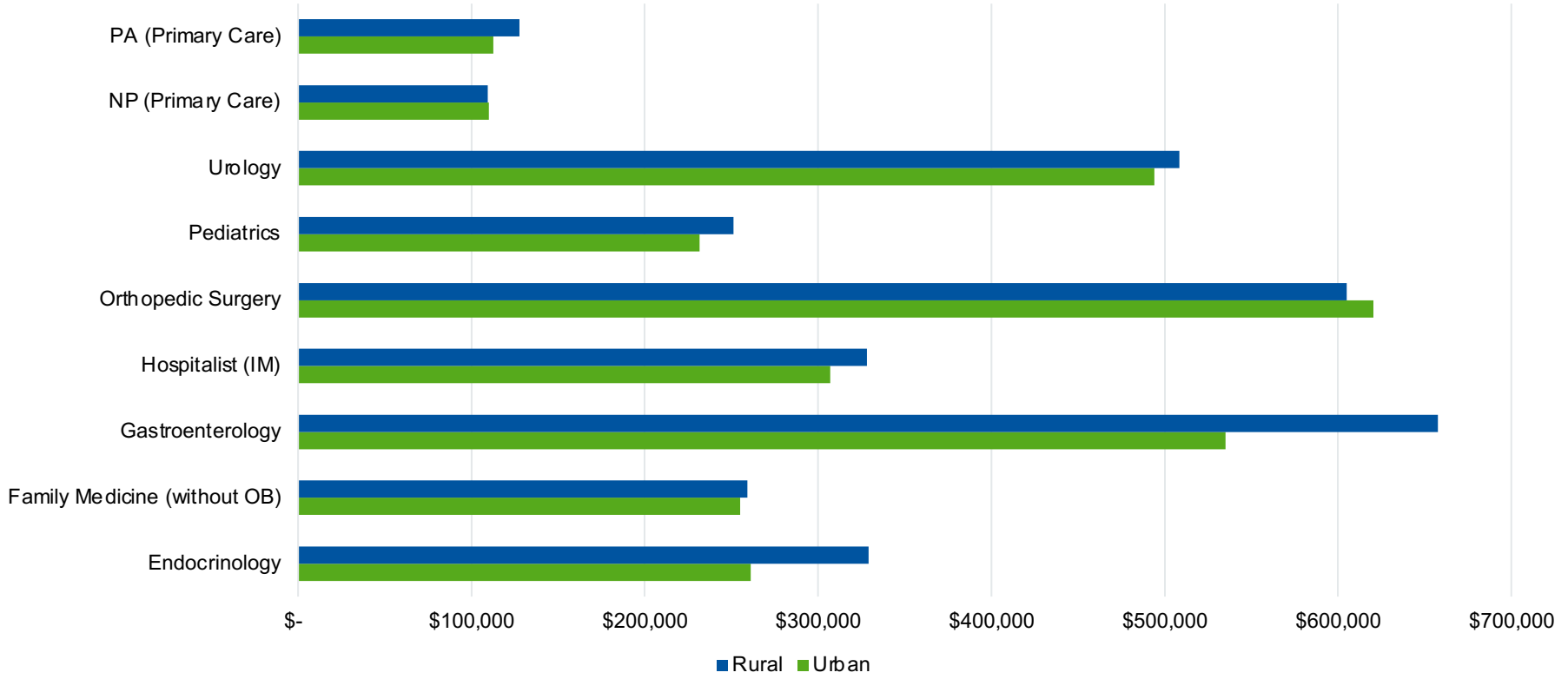
Best Practices

1. Use community needs assessment
2. Incorporate classes lead by physicians and other professionals to educate the community on living a healthy lifestyle (e.g., nutrition, importance of sleep, etc.)
3. Recruit physicians with ties to the specific rural area
4. Form partnerships with local medical schools
5. Consider stipends during residency



Levelset – Rural vs. Urban Data

Median Compensation

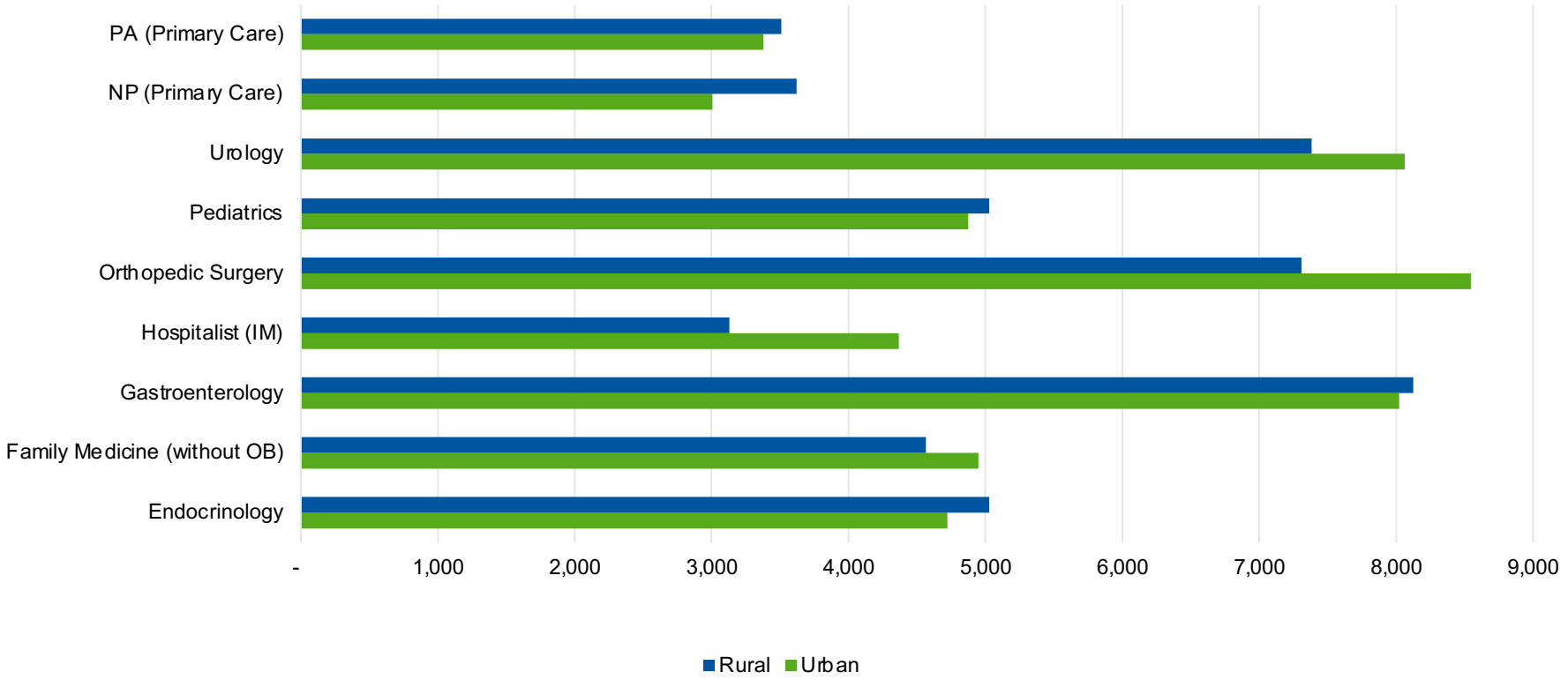


	Endocrinology	Family Medicine (without OB)	Gastroenterology	Hospitalist (IM)	Orthopedic Surgery	Pediatrics	Urology	NP (Primary Care)	PA (Primary Care)
Rural	$ 329,139	$ 259,292	$ 657,784	$ 328,256	$ 605,127	$ 251,343	$ 508,572	$ 109,341	$ 127,634
Urban	$ 261,208	$ 254,943	$ 535,230	$ 307,173	$ 620,551	$ 231,644	$ 494,078	$ 110,053	$ 112,532

Source: Medical Group Management Association 2020 DataDive Provider Compensation Survey

Levelset – Rural vs. Urban Data

Median wRVU Productivity

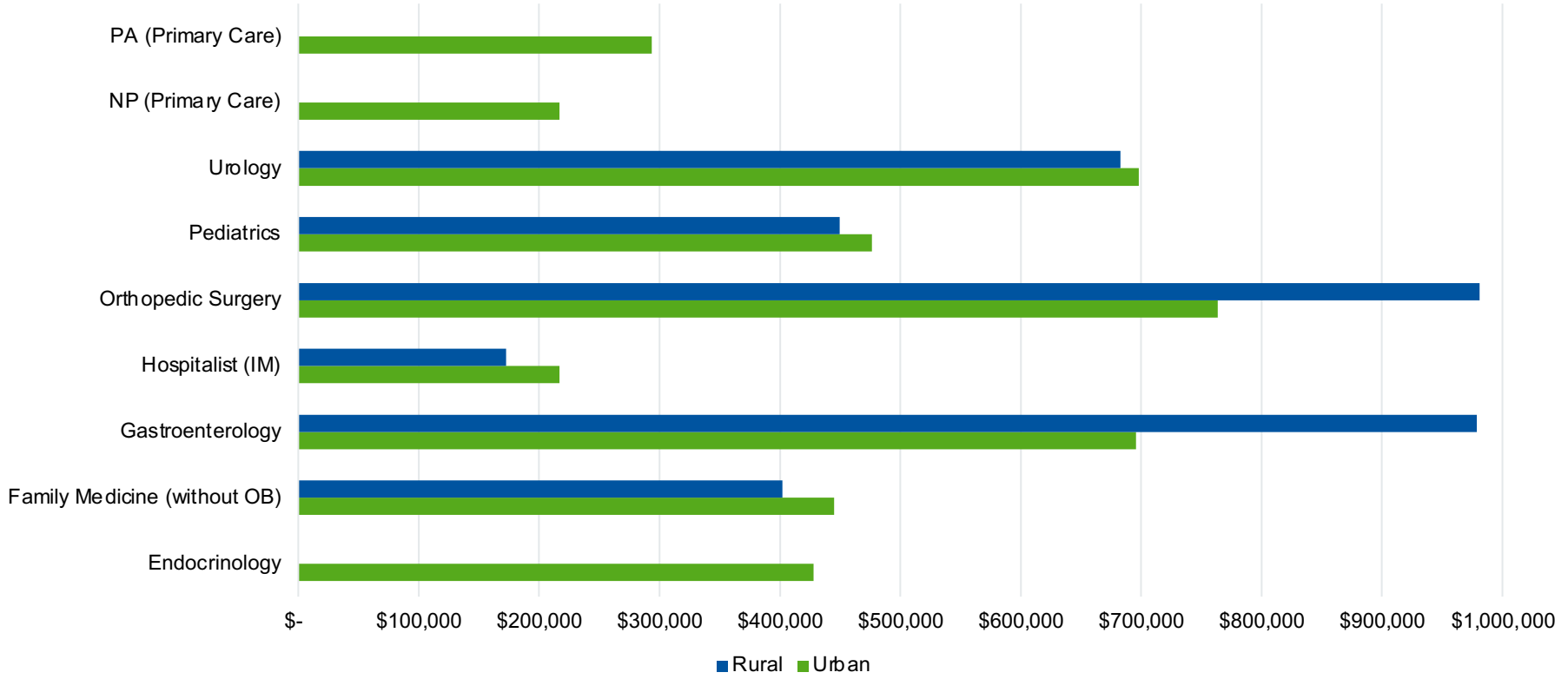


	Endocrinology	Family Medicine (without OB)	Gastroenterology	Hospitalist (IM)	Orthopedic Surgery	Pediatrics	Urology	NP (Primary Care)	PA (Primary Care)
Rural	5,029	4,567	8,126	3,129	7,307	5,026	7,381	3,620	3,511
Urban	4,722	4,949	8,023	4,366	8,548	4,875	8,064	3,005	3,377

Source: Medical Group Management Association 2020 DataDive Provider Compensation Survey

Levelset – Rural vs. Urban Data

Median Professional Collections



	Endocrinology	Family Medicine (without OB)	Gastroenterology	Hospitalist (IM)	Orthopedic Surgery	Pediatrics	Urology	NP (Primary Care)	PA (Primary Care)
Rural	ISD	$ 402,258	$ 978,601	$ 172,460	$ 980,919	$ 449,791	$ 682,577	ISD	ISD
Urban	$ 427,705	$ 445,061	$ 695,833	$ 216,927	$ 763,628	$ 476,624	$ 698,070	$ 217,010	$ 293,788

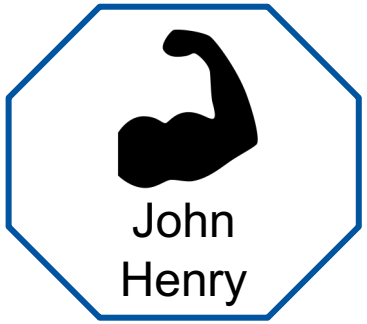
Source: Medical Group Management Association 2020 DataDive Provider Compensation Survey

Rural Provider Compensation Legends

Rural compensation is not *always* higher than urban compensation. It is not the "windfall" that new providers may expect.

When rural compensation is significantly higher than urban compensation, the organization has demonstrated a significant need and can easily demonstrate commercial reasonableness.

Rural providers can be very productive.



Case Study

What happens when…

The need is demonstrated?

The physician specialty is in very low supply and very high demand?

The physician's productivity is anticipated to be low?

Case Study: Best Practices

Document -

1. The legitimate business purpose
2. How the physician is key to organizational strategy
3. Reference physician needs assessment
4. National physician supply and demand
5. Do not hide the anticipated physician practice loss

   Budget for it, explain it, and compare it.

Case Study: Best Practices

Document -

6

Community Benefit

Services to self-pay patients, quality of care concerns mitigated by physician, and the nearest facility providing the services

8

Recruitment Attempts

Including the number of attempts, the compensation offered and the related structure, and why possible recruiting attempts failed

7

The best alternative

9

Facility and other investments made to support the physician's program/specialty

(e.g., major equipment purchased, renovations made, etc.)

10

How the arrangement will be monitored

Case Study: Best Practices

Design compensation carefully

1. Know the physician's historical compensation
2. Understand projected productivity
3. Understand projected professional collections
4. Consider call coverage burden and intensity
5. Consider administrative responsibilities

   (e.g., as a physician of one in a specialty)

Case Study: Best Practices

Design compensation carefully

6. APP collaboration

8. Sign-on bonuses

7. Telemedicine opportunities

9. Transition costs

   (e.g., travel, housing, etc.)

10. Flexible schedules and minimum work standards

Alternative Arrangements

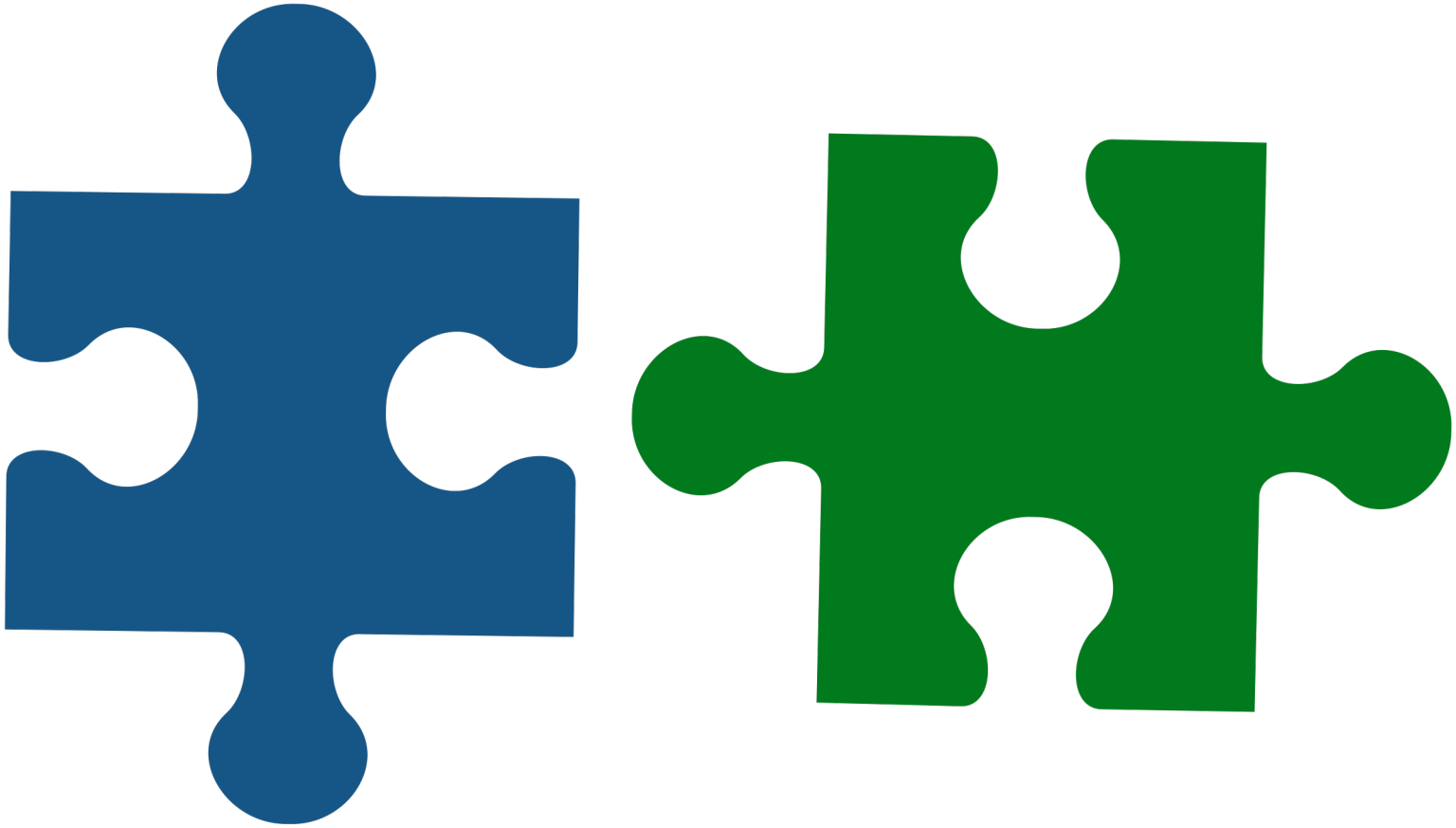
Physician “sharing” arrangements

- Your physicians with others
- Others’ physicians with you

Part-time coverage models via independent contractors

- Local
- National

How Can We HELP?



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