



The State of Rural Provider
Compensation in 2025:

Rural Physician & Advanced Practice Provider Compensation Survey Results

Table of Contents

3	 	Executive Summary
3	 	Key Takeaways from the 2025 Survey Data
4-5	 	Forces Influencing Compensation
5-7	 	Survey Background
8-13	 	Types of Compensation for Employed Providers
		12-13 Additional Compensation Provided
14-16	 	Primary Care Compensation with & without Obstetrics
17-19	 	Advanced Practice Provider Compensation with & without Obstetrics
20-24	 	Full Practice States vs. Restricted States
24-30	 	Specialty Care Physician Compensation
30-34	 	Best Practices in Building a Rural Provider Compensation Strategy
		31 Compensation Structure: Bridging Alignment & Transparency
		31-32 Compensation Structure: Patient-Facing Hours
		33 Compliance: Physician Fee Schedules & wRVUs
		34 Compliance: Mitigating Risk for Fair Market Value
35	 	The Future of Rural Compensation



Executive Summary

A new report from Stroudwater Associates, the National Rural Health Association (NRHA), and the National Organization of State Offices of Rural Health (NOSORH) highlights the significant variation in provider pay among rural organizations and emphasizes the urgent need for rural healthcare to align provider compensation with the organization's goals and ensure compliance with fair market value (FMV).

Many rural healthcare organizations' current provider compensation strategies are financially unsustainable, aren't consistent with best practices, and raise serious concerns about maintaining compliance. Since 2005, more than 238 rural hospitals have closed or stopped inpatient services.¹ Rural healthcare leaders must step back, consider the big picture, and align provider pay with the changing market and their organization's goals to ensure financial and operational sustainability.

Key Takeaways from the 2025 Survey Data*

- » **Rural hospitals will face a financial sustainability and compliance challenge if they do not address provider pay disparities and overcompensation compared to productivity.**
- » **Rural provider compensation is not tied to incentives for many rural hospitals.**
 - » 43.7% of respondents pay providers a straight salary with no performance or quality incentives; compared to 2024 data, which reported 54.7% for this metric, this suggests that alternative base-plus-incentive models are being adopted.
- » **Compensation variability in primary care is narrowing compared to the 2024 report, driven by increases at the lower end of the salary range—particularly among family medicine physicians without OB.**
 - » While the average family medicine physician without OB's total compensation is less than \$343,000, the survey uncovered a rural spread of \$240,287 to \$465,000 across family medicine providers.
- » **Only 14.1% of organizations surveyed indicated using the current CMS physician fee schedule; nearly 55% of respondents were unsure which physician fee schedule they were using.****
 - » 15.5% of the organizations surveyed were using the 2023 or older CMS physician fee schedule.
- » **Anesthesiologist and CRNA shortages exacerbated compensation growth.**
 - » Both anesthesiologists and CRNAs experienced compensation growth that outpaced inflation; median adjustments from 2024 for anesthesiologists and CRNAs were a 14% increase and an 11% increase, respectively.
- » **Nearly half of the organizations surveyed did not require patient-facing hours.**
 - » 42.4% of organizations do not have a requirement, and 38% of organizations have requirements that do not meet the industry standards.

¹ Merative; as of July 11, 2025

*References to the 2025 survey and report reflect 2024 data, and references to the 2024 report reflect 2023 data

**Key takeaway updated on March 18, 2026



A data-informed compensation strategy that aligns with the organization's goals is the *only way forward* for rural healthcare organizations.

Over 80% of American counties are considered healthcare deserts.

Stroudwater Associates launched the 2025 Rural Provider Compensation Survey in partnership with the National Rural Health Association (NRHA) and the National Organization of State Offices of Rural Health (NOSORH). The 2025 survey reflects rural compensation data from 2024. The third annual report explores in more detail the compensation trends of rural healthcare providers, highlights significant compliance issues related to fair market value (FMV), and emphasizes rising concerns about increasing provider compensation in a financially unsustainable market without ties to organizational performance.

Released in November 2025, the Third Annual Rural Provider Compensation Report provides a path forward for rural healthcare organizations facing supply and demand headwinds made more complicated by escalating compensation demands among providers, the rising cost of operations, higher cost of living in most areas of the country, and the upcoming reduction in reimbursement rates for Medicare/Medicaid, among many other factors.

“As rural hospitals face mounting challenges—from tightening Medicare and Medicaid reimbursement rates to persistent workforce shortages—access to relevant, timely data is more critical than ever,” says Stroudwater Managing Director Jeff Sommer, MPH. “Now in its third year, our report provides rural-specific benchmarks and emerging trends that empower leaders to make informed decisions tailored to the unique realities of rural healthcare.”

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 Individuals living in rural areas, a population with a disproportionate rate of poverty and adverse health outcomes, often must travel long distances to access routine or specialized medical care for chronic or complex conditions.³

Rural health leaders face a significant challenge in attracting and retaining medical staff. To succeed, they must use a compensation strategy that is attuned to market forces and organizational goals—a fundamental tool for recruitment and retention. 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 an insufficient supply of providers to meet that demand lead to higher rates of death, disability, and chronic disease. This has a significant impact on the health of rural Americans compared to their urban counterparts.

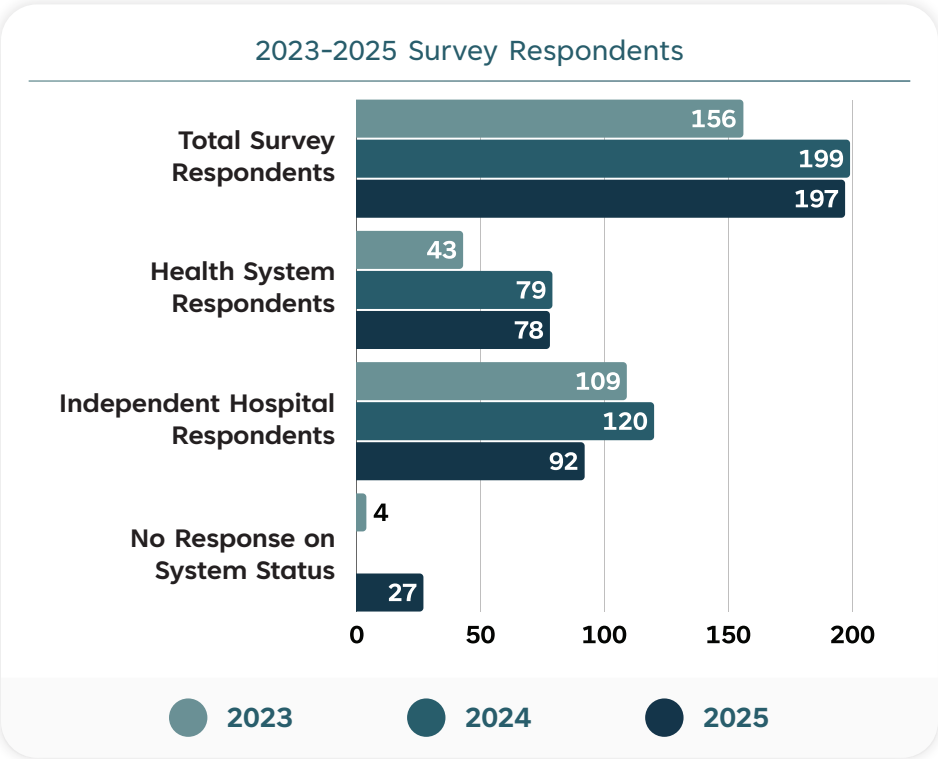
² GoodRX, *Mapping Healthcare Deserts: 80% of the Country Lacks Adequate Access to Healthcare*

³ www.cdc.gov/rural-health/php/about/?CDC_AAref_Val=https://www.cdc.gov/ruralhealth/about.html

⁴ National Conference of State Legislators

While the 2025 report reflects meaningful progress, rural organizations must have a sustainable provider compensation strategy that is aligned with organizational goals and reflects both patient access needs and provider expectations. With continued pressures from reimbursement changes and workforce challenges, now is the time to ensure compensation models are competitive, intentional, and built to last. Without a clear, data-informed approach, organizations risk falling behind in the market and may face financial and legal consequences as well.

With 69% of physician respondents in a recent McKinsey survey⁵ citing compensation as a major factor – if not the main factor – in deciding whether to leave or stay at an organization, it is crucial that rural healthcare organizations focus on developing compensation structures that are financially responsible and sustainable.



“Despite provider compensation being the single most expensive item on the hospital’s profit and loss statements, rural leaders are setting compensation based on provider requests,” says Shad Ritchie, MHA, FACMPE, CRHCP, Senior Consultant at Stroudwater Associates. “Rural leaders must start aligning compensation with incentives that support the organization’s goals to maintain operations. **Data. Strategy. Alignment.** These milestones are the only way forward for rural healthcare leadership to recruit and retain primary care physicians and advanced practice providers and maintain the financial health of the hospital and/or provider practices.”

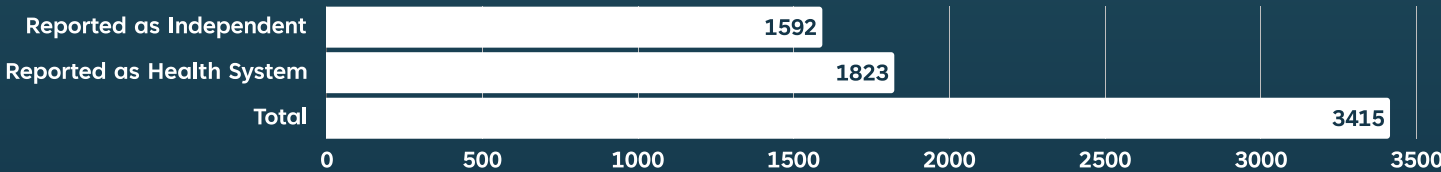
SURVEY BACKGROUND

The 2025 Provider Compensation Survey was issued by Stroudwater Associates in February/March 2025 to provide insight into rural healthcare organizations and promote evidence-based, informed decisions when considering physician and advanced practice provider (APP) compensation.

This year’s survey respondents ranged from independent hospitals with fewer than 10 staffed beds to rural systems with over 150 staffed beds. One independent hospital respondent reported having more than 150 staffed beds.

The 2025 survey represents, at a minimum, the equivalent of approximately 4,697 providers, including employed providers, locums, contracted, and telehealth. As a breakout, the survey represents at a minimum of **3,415 employed providers.**

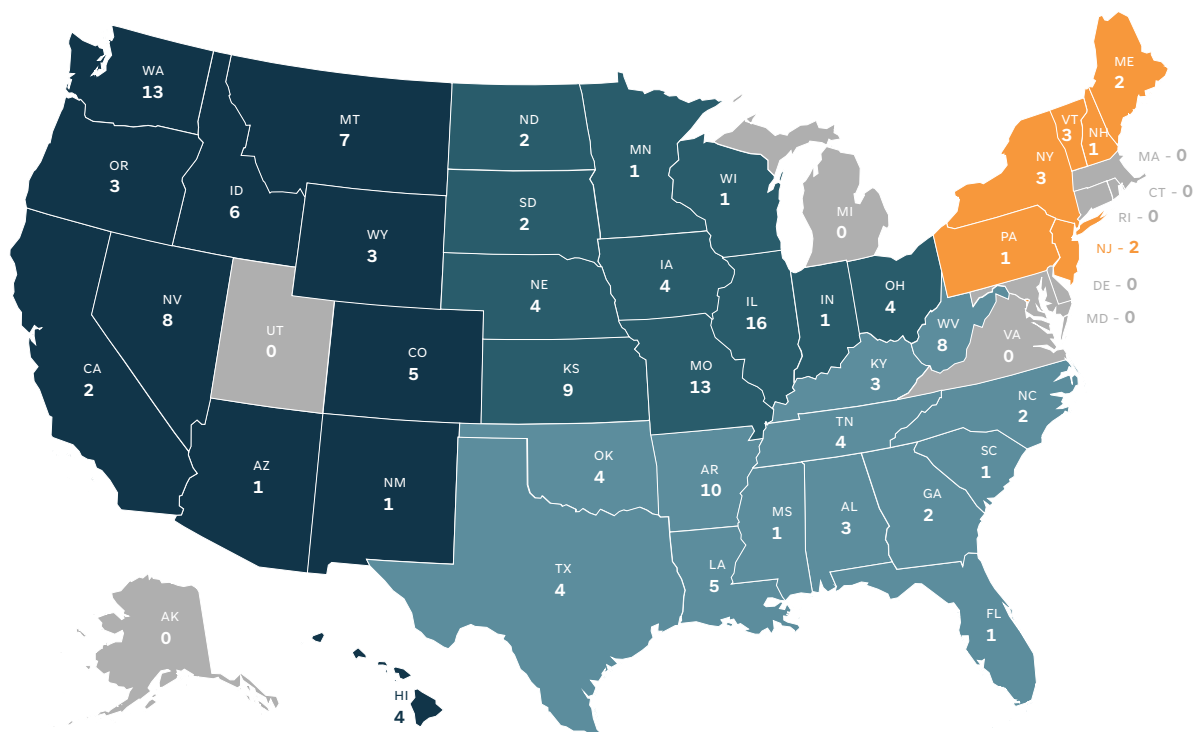
Minimum of Provider FTEs Represented



Respondents represent 41 out of 50 states,
and all five regions had at least one respondent.



2025 Regional Respondents



● Northeast
 ● Midwest
 ● South
 ● West
 ● Did Not Provide

MEASURES

- » **Average Compensation:** The average compensation paid within a calendar year to a specific specialty and provider type.
- » Number of providers by specialty.
- » **Provider Employment Status:** Providers were identified as W-2, Contracted (1099) or locums.

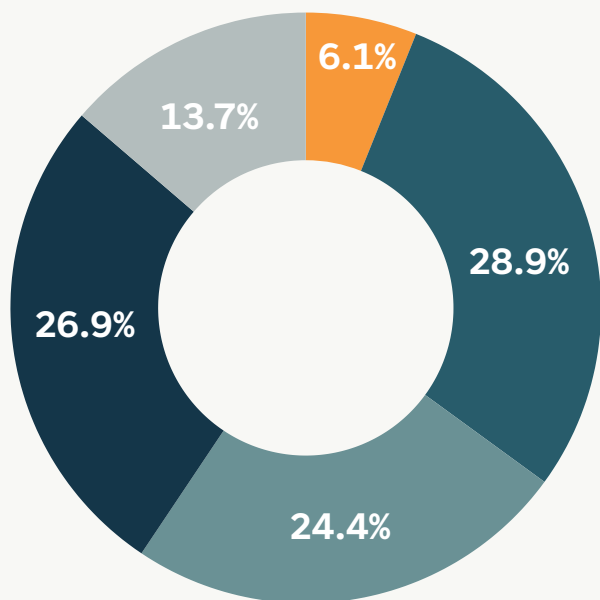
SOURCES

- » Stroudwater Associates 2025 Provider Compensation survey, 197 responses reflective of 41 of 50 states.
- » AANP State Practice Environmental map.
- » Rural Organizations were contacted through NRHA, NOSORH, and individual State Offices of Rural Health.

LIMITATIONS

- » Data is self-reported by organizations without validation and is based on total compensation.
- » For results indicating an “*” the value needs further validation, but additional data is available; N/A indicates insufficient responses for category.

Survey Respondents by Region



REGIONAL INDEX

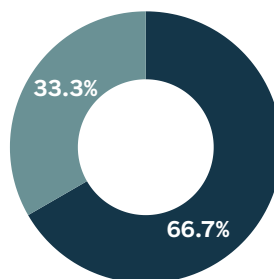
- Northeast
- Midwest
- South
- West
- Did Not Provide

The Midwest accounted for 28.9% of surveys returned.

The South was the only region with a higher percentage of independent respondents.

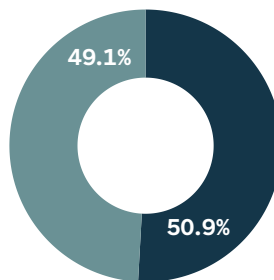
The Northeast has the highest percentage of health system respondents.

Independent vs. Health System Survey Responses by Region



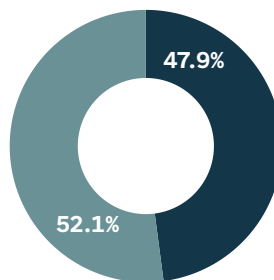
Northeast

Total Number of Responses: 12



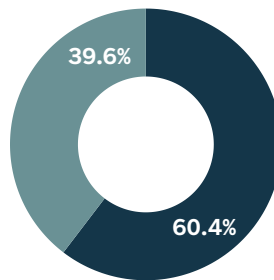
Midwest

Total Number of Responses: 57



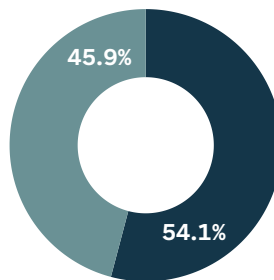
South

Total Number of Responses: 48



West

Total Number of Responses: 53



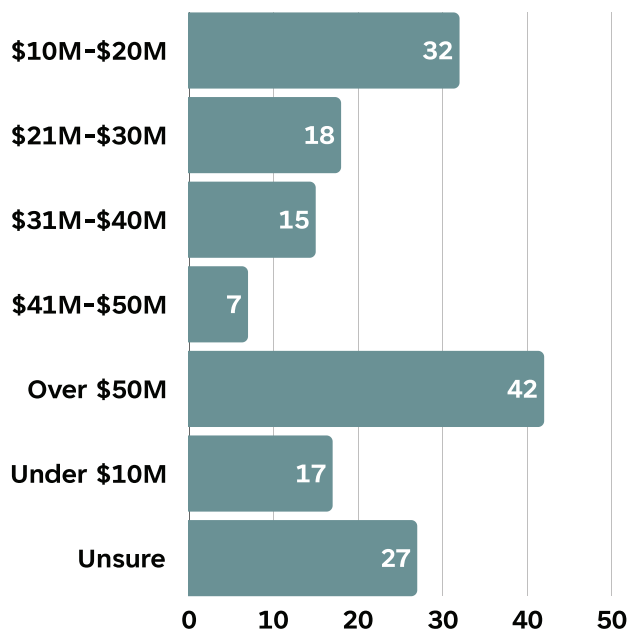
Total

Total Number of Responses: 197

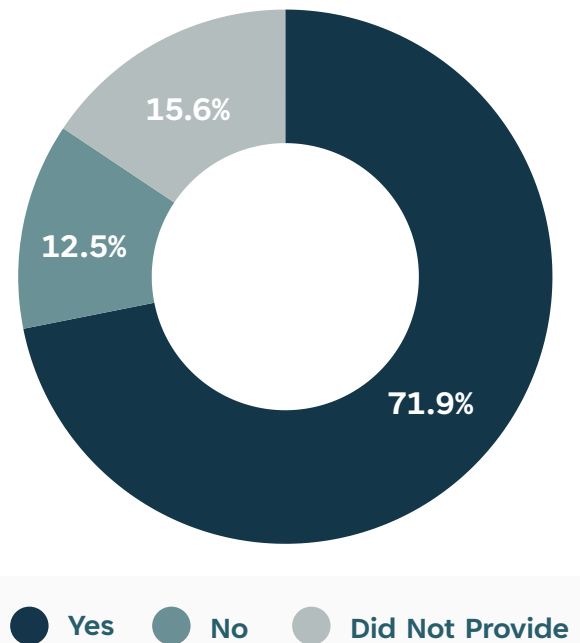
INDEX

- Independent Respondents
- Health System Respondents

Hospital Revenue



Hospital Reported Having an RHC



TYPES OF COMPENSATION FOR EMPLOYED PROVIDERS



Annual Guarantee

- » Starting base salary.
- » Base Compensation - may or may not be readjusted.



Administrative & Other Duties

- » Medical directorships.
- » APP supervision.
- » Call compensation.



Productivity Incentive

% of NPSR or Gross Charges - mostly replaced by:

- » Compensation per work RVU (wRVU).
- » Compensation per visit.
- » Panel size compensation.



Value-Based Compensation

- » Quality incentive.
- » Value-based reimbursement adjusted wRVU.
- » Distributions of ACO dollars.

43.7%

of respondents pay providers entirely on a straight salary, not tied to performance or quality. **Compared to the 2024 data, which reported 54.7%, this indicates that alternative base-plus-incentive models are being implemented.**

Compensation is the remuneration awarded to an employee in exchange for their service or individual contributions to your business. The contributions can be their *time, knowledge, skills, abilities, & commitment* to your company or a project.

“Straight salary is not aligned with best practices. Rural healthcare organizations are under pressure, and hospitals need providers to do more than just show up,” says Stroudwater Senior Advisor and Board Member Carol Alexander, MBA. “With serious headwinds ahead, especially as reimbursement pressures continue to mount, it is critical that compensation strategies reward those who are actively contributing to the organization’s goals. If providers don’t understand those goals and aren’t incentivized to see more patients, adjust how they deliver care, or focus on quality outcomes, the organization will suffer—not from a lack of effort, but from a lack of alignment.”

Comparatively, the most recent data from MGMA⁶ shares that less than 20% of the organizations surveyed – where the respondents are predominantly urban and suburban organizations – pay a straight salary.⁷



“Setting provider compensation at a guaranteed base salary without incentives reduces the opportunity for providers and hospital to jointly align. Provider satisfaction depends on active participation in strategic initiatives that strengthen care delivery and financial stability. The compensation model is more than a payment method,” states Alexander, “it is a way to engage with providers, making them an integral part of the success of the organization by actively setting and achieving goals together.”



There are several benefits of incentive compensation:

- » Endorses multiple types of incentives based on organizational strategy and immediate needs.
- » Creates a mechanism for enhancing provider engagement.
- » Promotes a data-driven culture.
- » Creates bilateral accountability.
- » Encourages healthy competition within a group.
- » Supports pay equity.

There are certain challenges with incentive compensation that have caused some providers to mistrust incentives. Examples include:

- » Overly complicated or unclear incentives.
- » Unreachable incentives.
- » Inaccurate data analytics.
- » Ties to metrics they feel they cannot impact.
- » Clinic operations and/or staffing may not be optimal to allow the provider to achieve higher productivity goals.

“There is an ongoing trend of healthcare organizations defaulting to paying their providers the median salary from a compensation survey. If everyone pays the median – which is potentially not tied to the organization’s goals – then the median becomes the floor,” cautions Alexander.

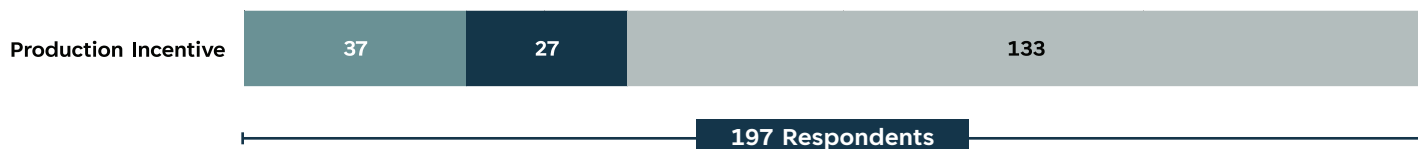
Using work relative value units (wRVUs), which are measurable and set by CMS, is a standardized way to assign productivity credit. wRVU-based models are the most-used incentives to promote patient volume. The downside of a wRVU-based model is that it ties provider compensation to patient volume rather 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 Ritchie. “In today’s environment, compensation must also support recruitment and retention. Financially motivated providers often look for meaningful performance incentives, and disconnecting compensation from organizational goals and overall operational efficiencies undermines long-term sustainability. If your largest line item on the P&L isn’t tied to how your organization generates revenue and delivers value, you’re operating at a disadvantage.”

34%

of respondents provide some form of incentive compensation, **up from 32.1% in the 2024 report.**⁸

Independent vs. Health System Production Incentive



INDEX

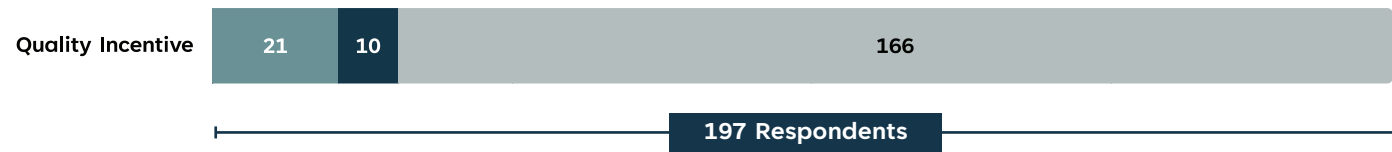
● Independent Respondents ● Health System Respondents ● Did Not Provide



“The transition to value-based care hasn’t been nearly as fast as we anticipated. Many organizations expected value-based reimbursement to fundamentally reshape provider compensation, but that shift has been slow,” says Ritchie. “While quality incentives saw a slight uptick in 2025, they remain low overall. During and after the pandemic, providers were frustrated with quality-based pay because the data was unreliable—patients were sicker, care had been delayed, and metrics like satisfaction scores didn’t reflect the reality on the ground. As a result, many organizations backed away from quality incentives. Now, as quality starts to re-emerge as part of the compensation mix, it’s still a relatively small component. But even a modest incentive tied to quality can signal that outcomes matter and help engage providers in meaningful ways. The hope is that this alignment will ultimately lead to improved results for both patients and organizations.”

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.”⁹ Tying a percentage of provider compensation to quality data ensures that rural organizations and providers are accountable for the quality of care they provide and are aligned with the industry’s transition to population health.

Independent vs. Health System Quality Incentive



INDEX

- Independent Respondents
- Health System Respondents
- Did Not Provide

“Health systems generally have more resources to track and report quality data, so it would be reasonable to expect them to lead in offering quality incentives. Surprisingly, our survey found that independent hospitals are nearly twice as likely to provide such incentives,” notes Ritchie.

To implement meaningful quality-driven compensation, the metrics must have provider input and be evaluated annually. The quality incentive program is designed to reward progress, not to maintain existing standards.

22.8%

of independent hospitals provide quality incentives; **this is an improvement from 16.7% in the 2024 report.**¹⁰

12.8%

of health systems provide quality incentives; **this is an improvement from 7.6% in the 2024 report.**¹⁰



⁹ Centers for Medicare & Medicaid Services: <https://www.cms.gov/medicare/quality/measures#:~:text=Quality%20measures%20are%20tools%20that,quality%20goals%20for%20health%20care>
¹⁰ The State of Rural Provider Compensation in 2024 Report | Stroudwater | December 2024

Additional Compensation Provided

Rural organizations started offering new types of compensation during the pandemic to better meet their providers’ changing needs. That change has had a lasting effect, shaping how providers view their pay and what they value most. A new generation of physicians is entering the workforce, bringing different expectations about their careers. They are placing more importance on flexibility, work-life balance, and meaningful work. To tackle recruitment and retention issues, rural organizations are adopting more creative and personalized incentives. These incentives are increasingly customized to match each provider’s priorities, which explains the variations in the types of incentives offered year after year.

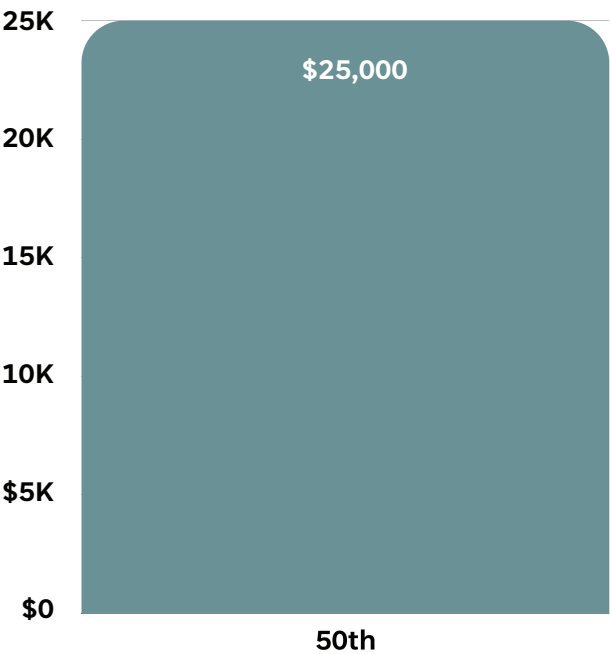
For physicians:

- » 38 respondents reported they currently provide student loan repayments, with respondents averaging \$54,708.33 in loan repayments.
» This is a **decrease** from 54 respondents in 2024.
- » 63 respondents provide sign-on bonuses, with respondents averaging \$35,000 in bonuses.
» This is a **slight decrease** from 68 respondents in 2024.
- » 58 respondents provide medical directorships, with respondents averaging \$28,846 in stipends.
» This is a **slight increase** from 57 respondents in 2024.

For advanced practice providers:

- » 36 respondents reported they currently provide student loan repayments, with respondents averaging \$39,875 in loan repayments.
- » 41 respondents reported sign-on bonuses, with respondents averaging \$18,785 in bonuses.
- » 7 respondents provide medical directorships, with respondents averaging \$24,500 in stipends.
*This was not reported in 2024; therefore, there is no current trend data.

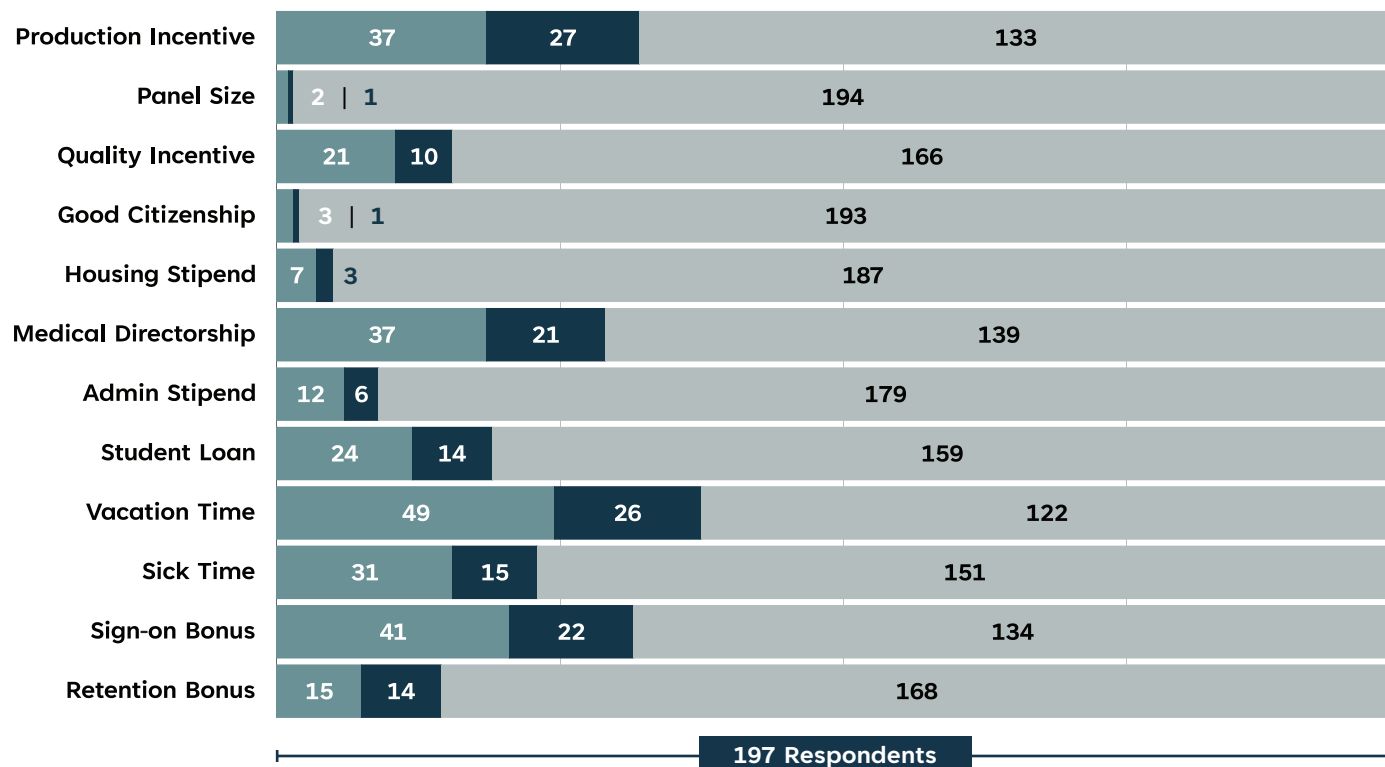
Medical Directorships Compensation:
Physicians



Medical Directorships Compensation:
APPs



Additional Incentives for MDs: Independent vs. Health System



INDEX

● Independent Respondents
 ● Health System Respondents
 ● Did Not Provide

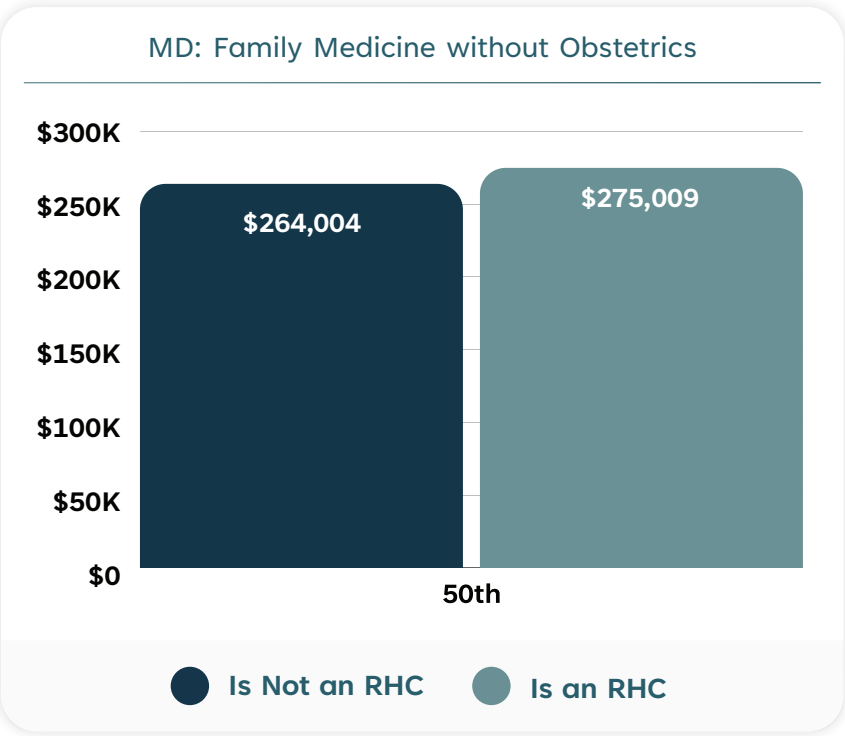
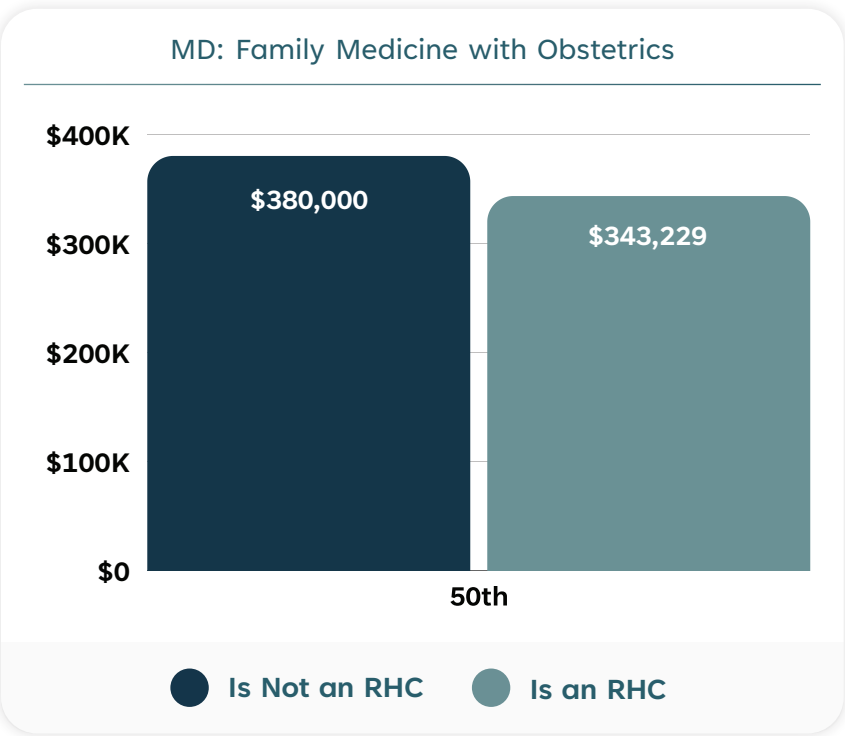
Organizations also indicated other types of compensation:

- | | | |
|-----------------------------------|--------------------------|--|
| Percentage of Collections | Retention Bonuses | Student Loan Assistance/Repayment |
| Productivity Bonuses | Housing Stipends | Extra Shift Compensation |
| Quality & Outcome Bonuses | Call Pay | Medical Director Stipend |
| Citizenship or Behavioral Bonuses | Weekend Pay | Continuing Medical Education Allowance |
| Signing Bonuses | Holiday Pay Differential | Weekend Coverage Compensation |

PRIMARY CARE COMPENSATION WITH & WITHOUT OBSTETRICS

The 2025 survey data shows a notable increase in rural primary care compensation, driven primarily by growth at the lower end of the salary range. While median compensation has increased slightly, the more important trend is the narrowing gap across the compensation spectrum. This upward movement is consistent for primary care providers both with and without OB, suggesting that organizations are responding to market pressures by raising baseline pay rather than significantly altering top-end compensation.

The survey revealed interesting data regarding primary care for rural:



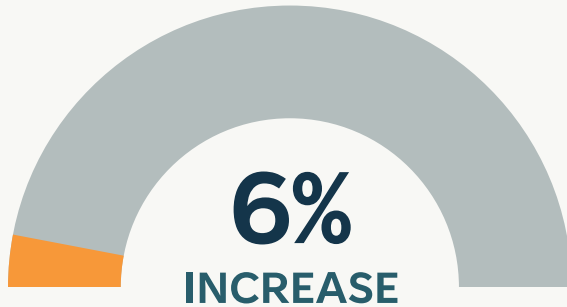
Median compensation for family medicine with OB increased slightly, rising to \$343,229 from \$322,341 in the 2024 report. The gap between organizations with Rural Health Clinics (RHCs) and those without has also narrowed. In the 2024 report, the difference in median compensation was nearly \$100,000; in the 2025 report, it is now under \$40,000.

“Rural healthcare providers face a unique challenge: a scarcity of specialists, particularly in women’s health and OB/GYN. This puts the onus on primary care physicians to fill the gaps, often acting as generalists with specialist-level capabilities. Consequently, family medicine doctors in rural settings frequently handle deliveries, C-sections, and heavy on-call schedules. Given this demanding scope of practice, it makes sense that they are compensated at a higher rate. To ensure both fairness and regulatory compliance, a fair market value analysis is crucial. This analysis will provide the clear justification needed to pay these physicians a higher premium, which is a fitting reflection of the critical, multi-faceted services they provide to their communities,” notes Alexander.

For family medicine providers without OB, the median compensation is \$275,000. When comparing organizations without RHCs to one another, providers with OB have a median compensation of approximately \$380,000, while those without OB have a median compensation of about \$264,000. Compared to 2024, when the variance between these two groups was far wider, the 2025 data reflects a narrowing difference and a compensation structure that more closely aligns with the level of services being delivered.

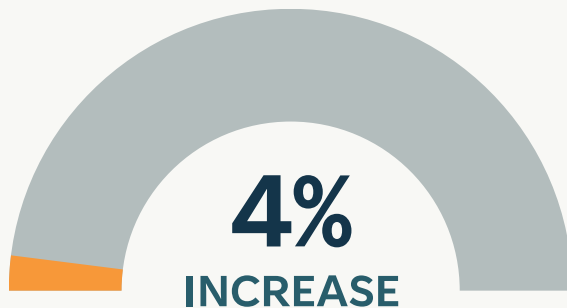
MDs: Family Medicine with & without
Obstetrics Compensation Difference between
the 2024 & 2025 Reports

With OB



50th percentile

Without OB



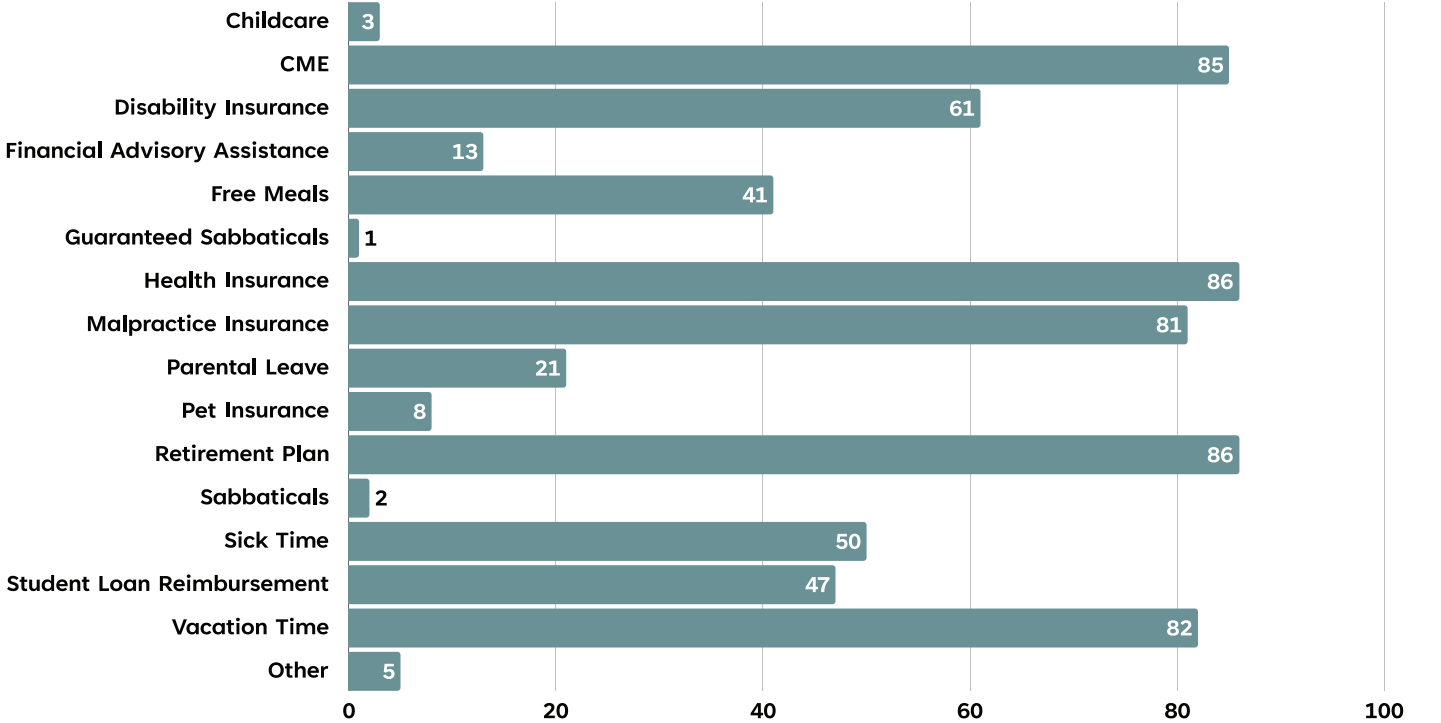
50th percentile

“It’s encouraging to see that compensation is becoming more closely tied to the services providers are delivering,” says Alexander. “When family medicine physicians who offer OB services are compensated at a level that reflects the complexity and scope of their work, it signals progress toward greater alignment and fairness in rural provider compensation.”



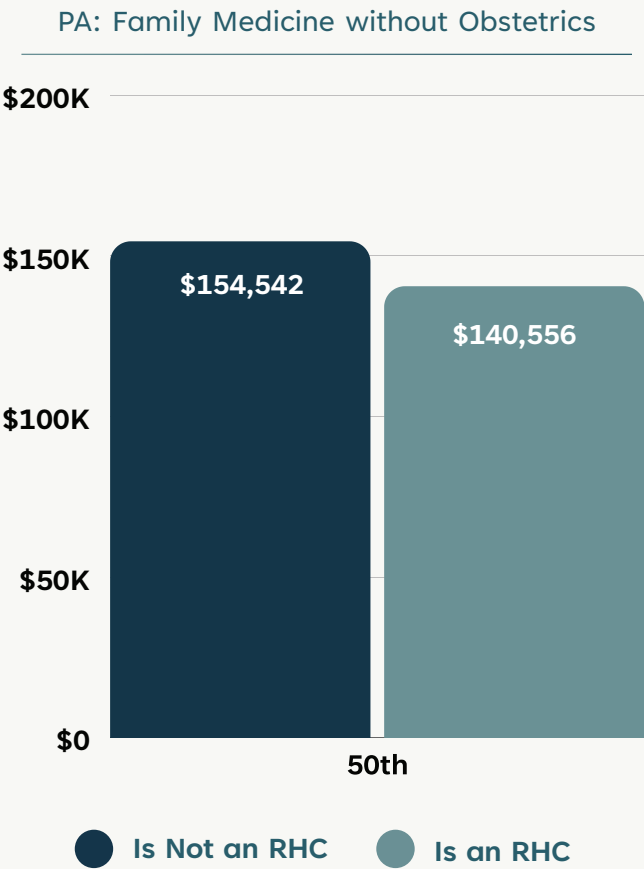
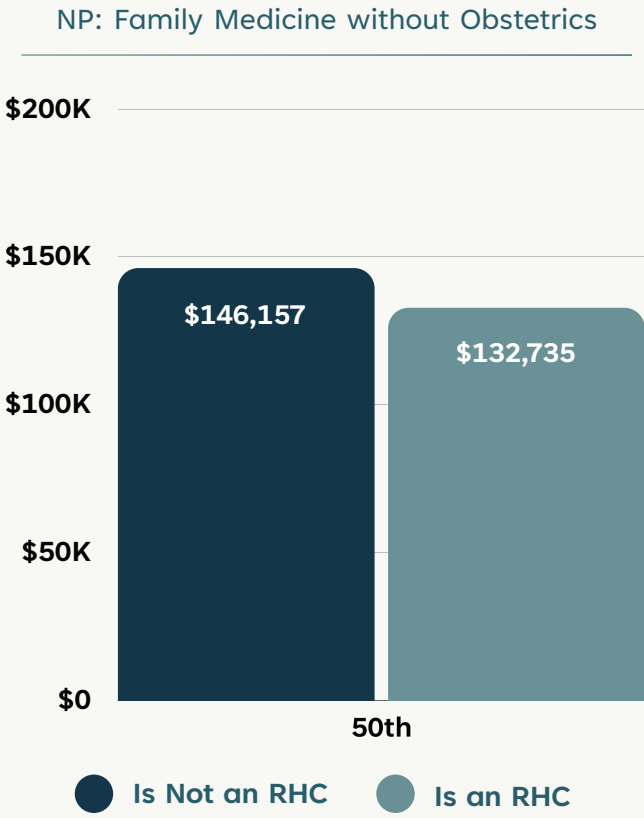
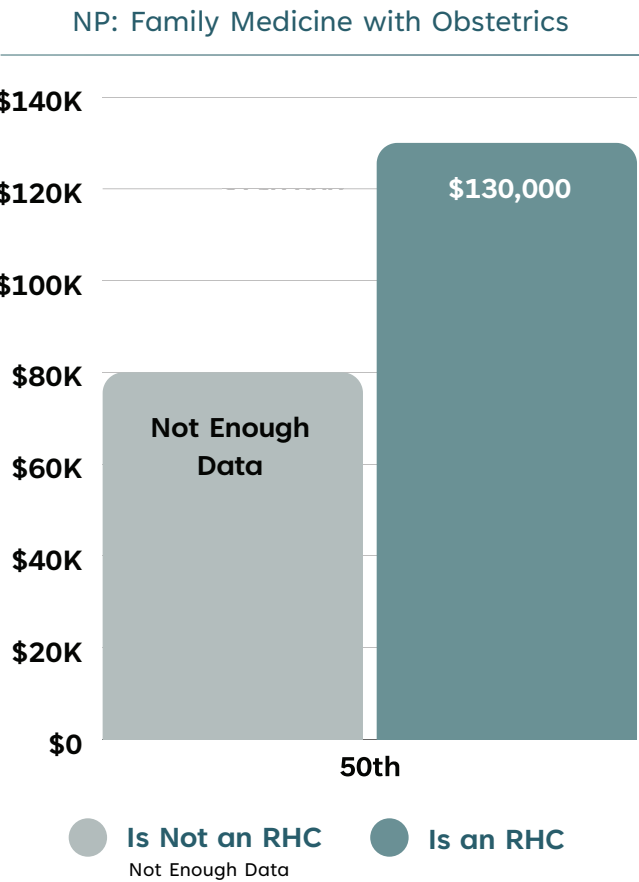
A provider’s compensation should **always** be tied to the services they actually deliver.

Additional Benefits: Physicians

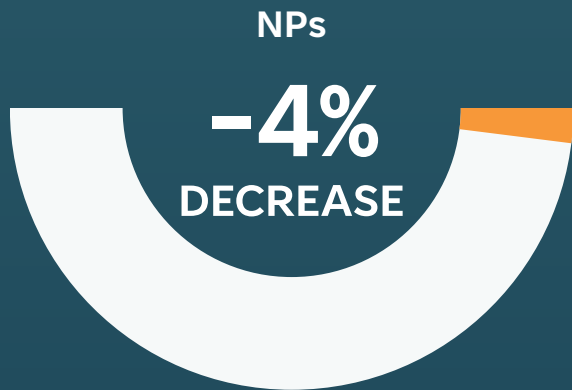


ADVANCED PRACTICE PROVIDER COMPENSATION WITH & WITHOUT OBSTETRICS

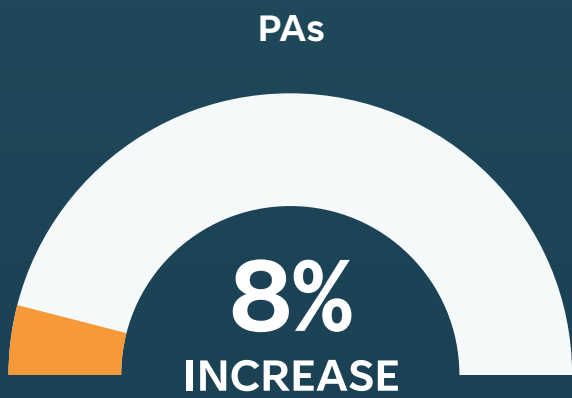
Most family medicine nurse practitioners (NPs) continue to earn less than \$135,000 per year, regardless of OB responsibilities. However, this year’s data highlights several notable shifts. NPs without OB responsibilities reported higher median compensation than those with OB, a trend worth watching as roles continue to evolve. Among NPs with OB, compensation at the lower end declined sharply—down 20% at the 10th percentile—while the 90th percentile rose 59%, suggesting growing variability. In RHC settings specifically, reported compensation for NPs with OB ranged from \$80,000 to \$309,000, underscoring the significant pay gap that can exist within a single role. Meanwhile, NPs without OB saw modest gains across most percentiles, except for the top end. Physician assistants (PAs) continued to outpace NPs in both OB and non-OB roles, reinforcing the persistent pay differential across advanced practice providers.



NPs & PAs: Family Medicine *with*
Obstetrics Compensation Difference
between 2024 & 2025 Reports

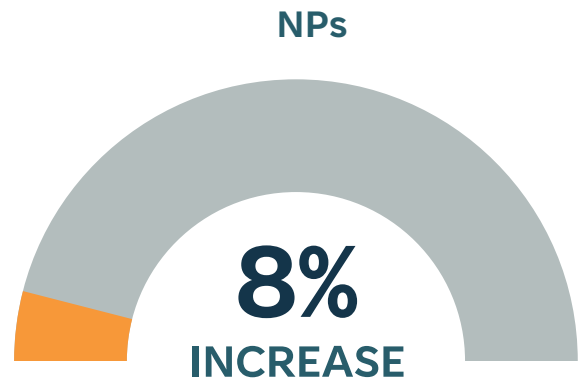


50th percentile

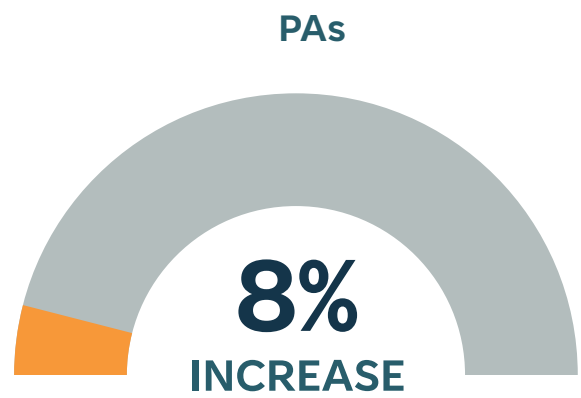


50th percentile

NPs & PAs: Family Medicine *without*
Obstetrics Compensation Difference
between 2024 & 2025 Reports

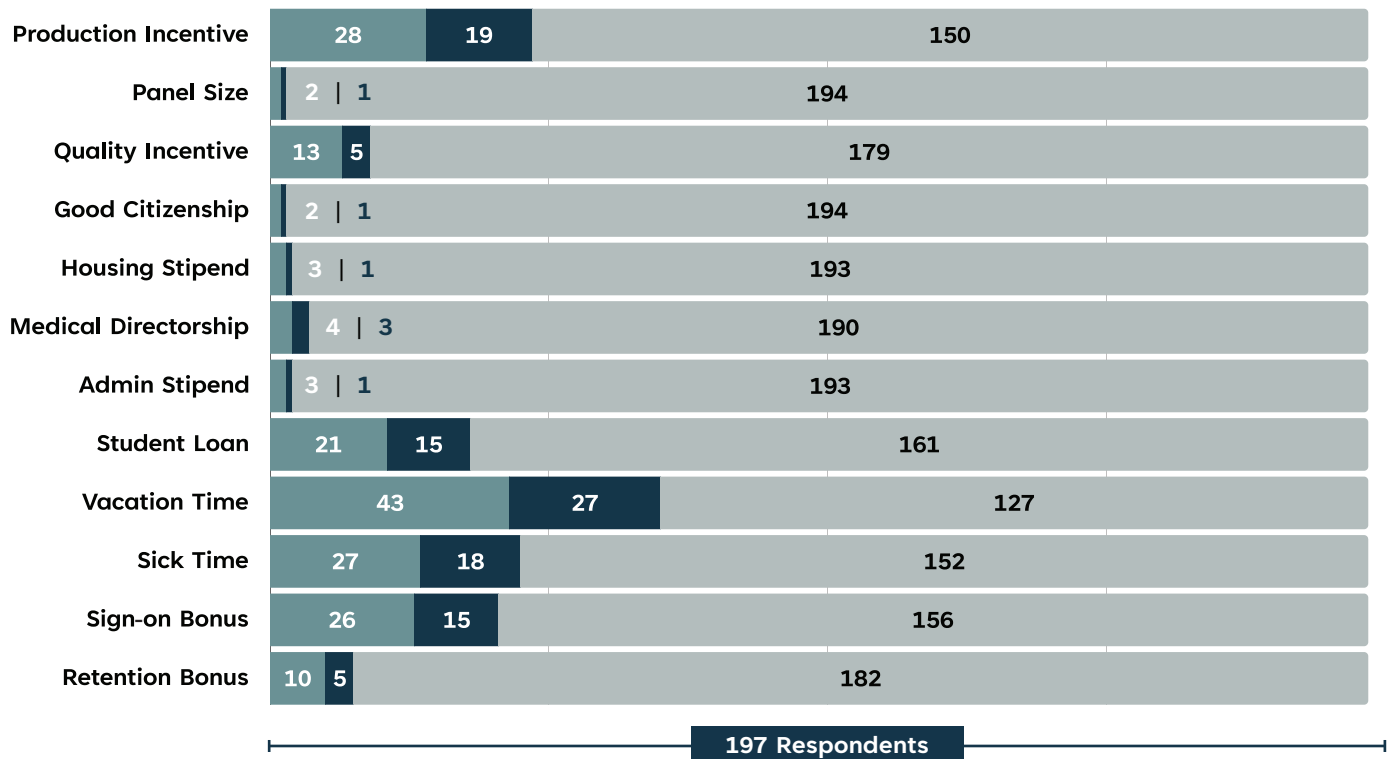


50th percentile



50th percentile

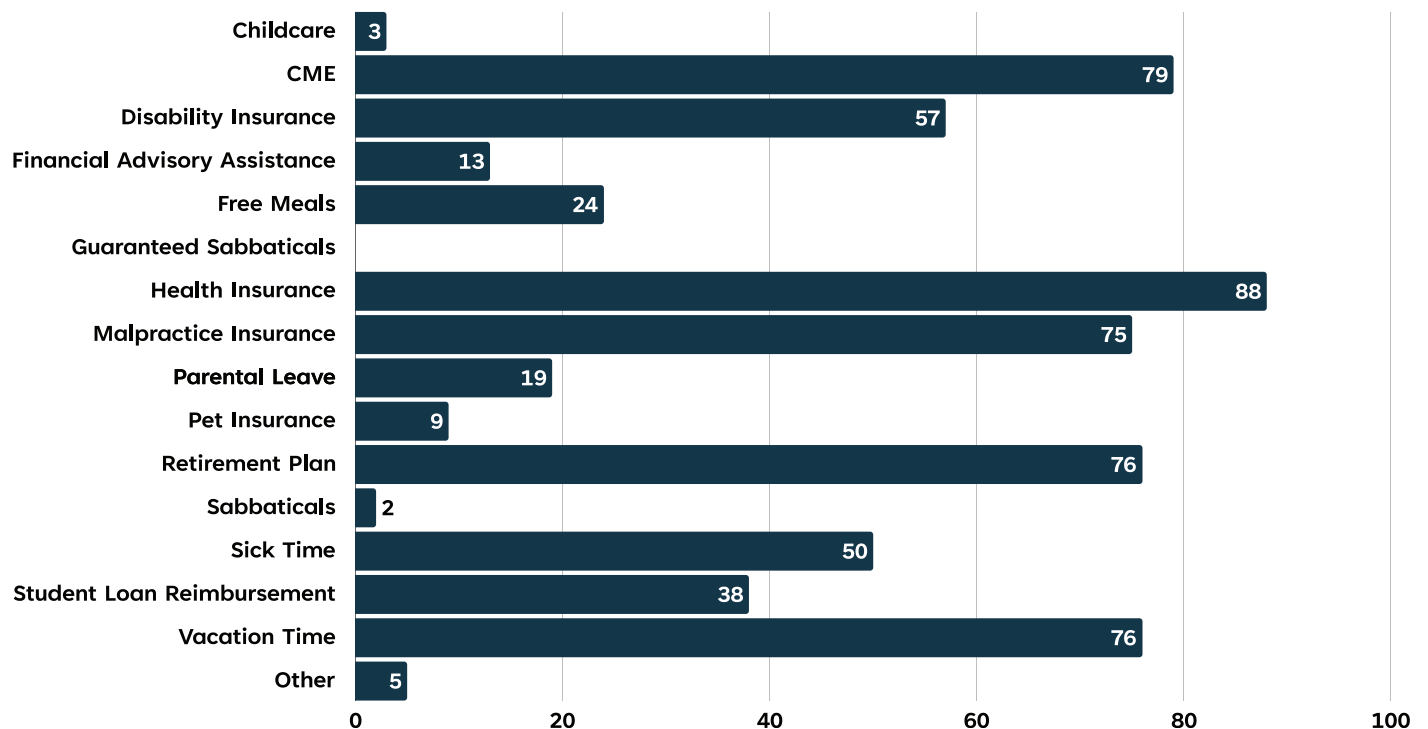
Additional Incentives for APPs: Independent vs. Health System



INDEX

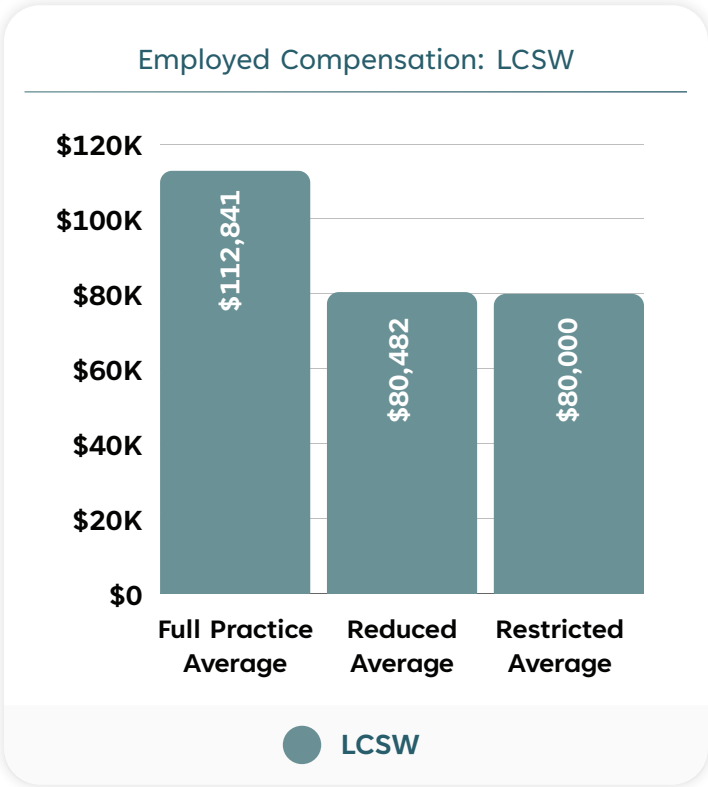
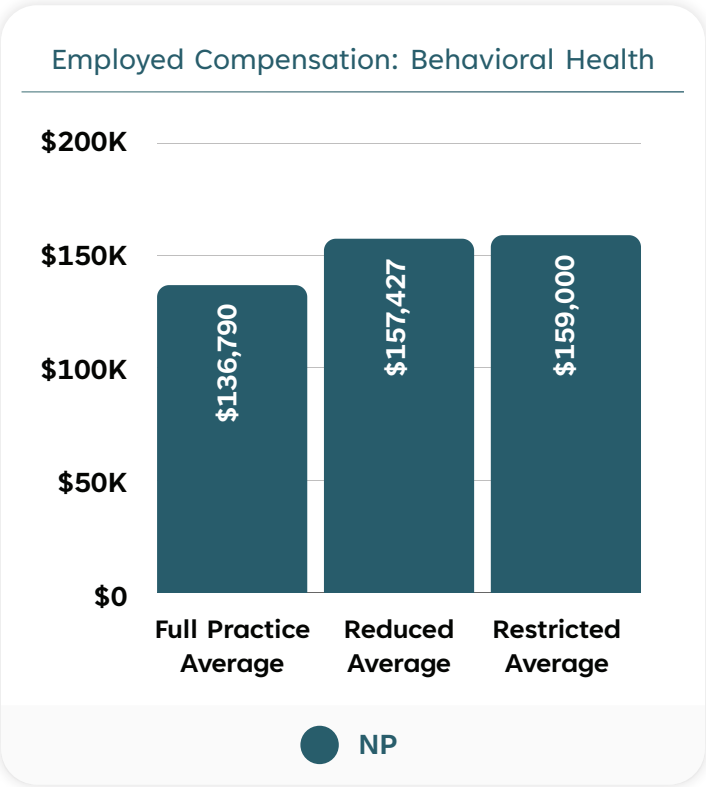
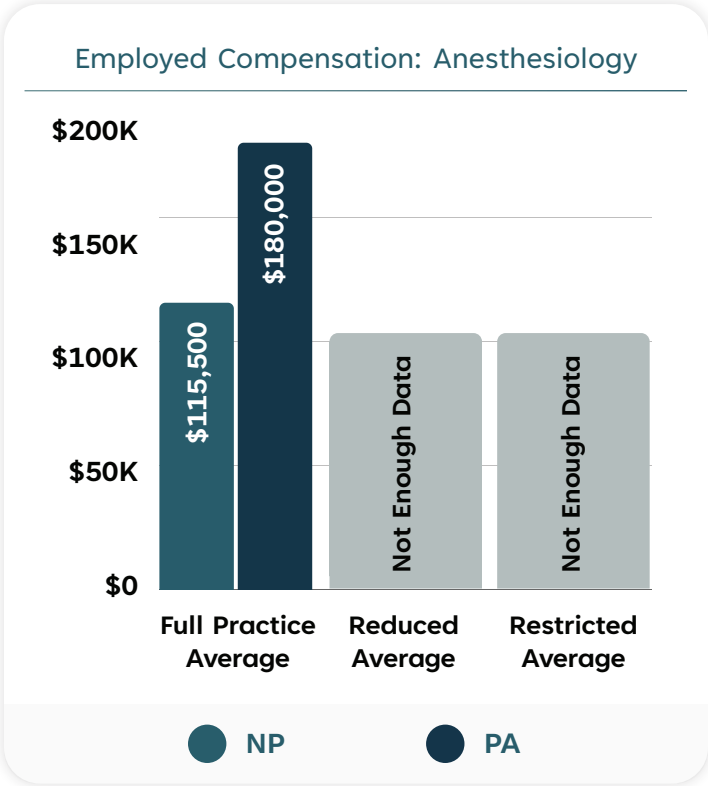
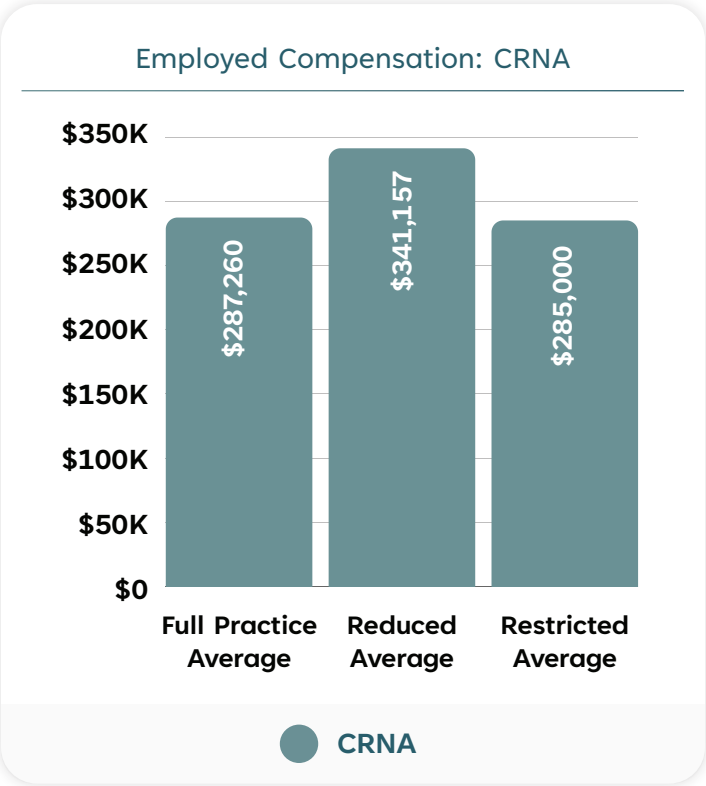


Additional Benefits: APPs

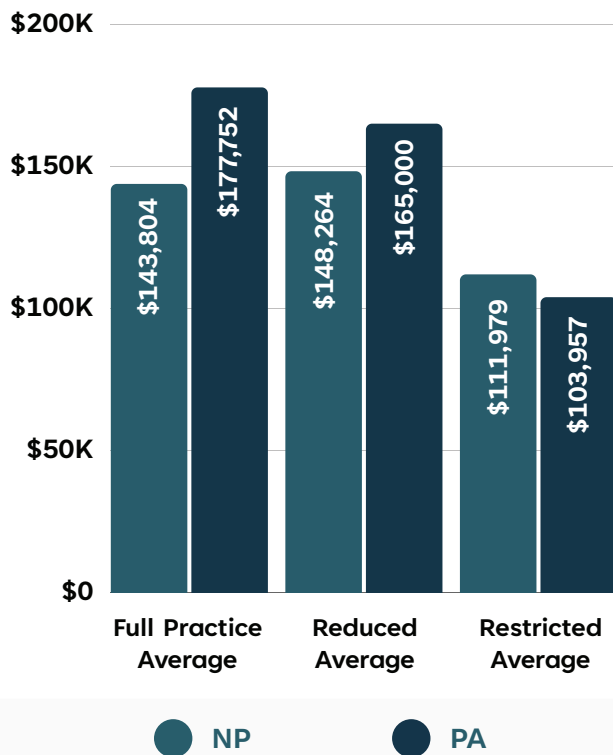


FULL PRACTICE STATES VS. RESTRICTED STATES

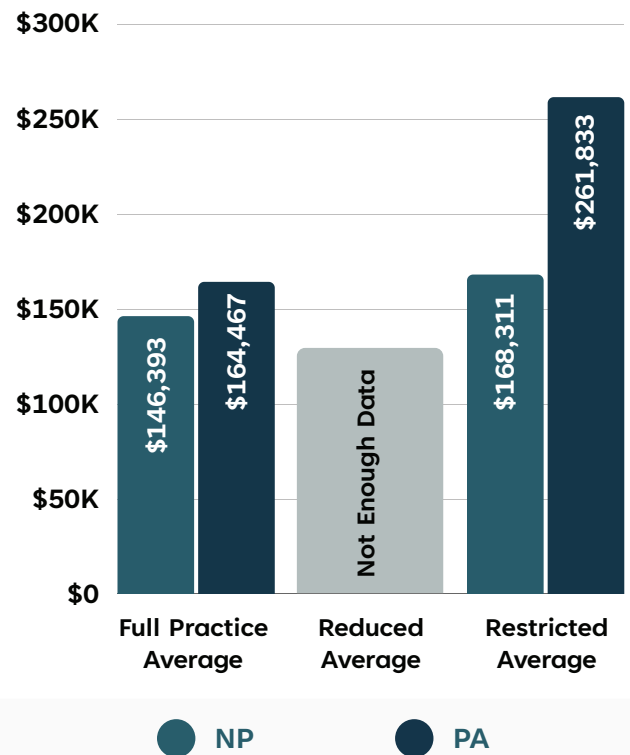
Historically, the belief was that APPs in full practice states received higher compensation because they do not require physician supervision and can practice to the full scope of their license. However, the data does not fully support this belief – the survey shows a wide variation in compensation across state licensure.



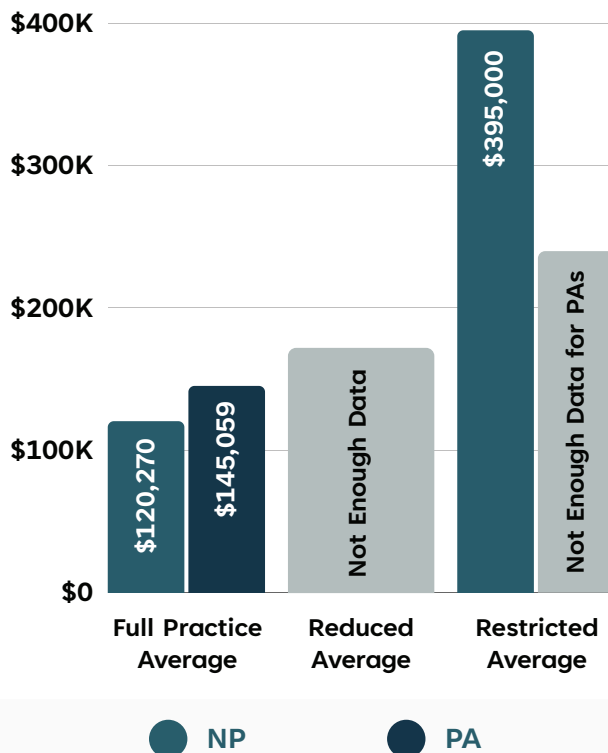
Employed Compensation: Cardiology



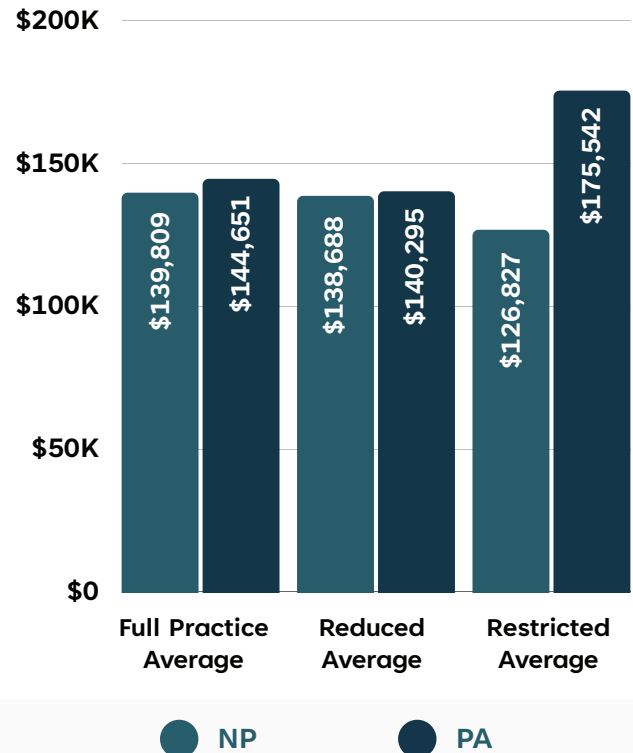
Employed Compensation: ER



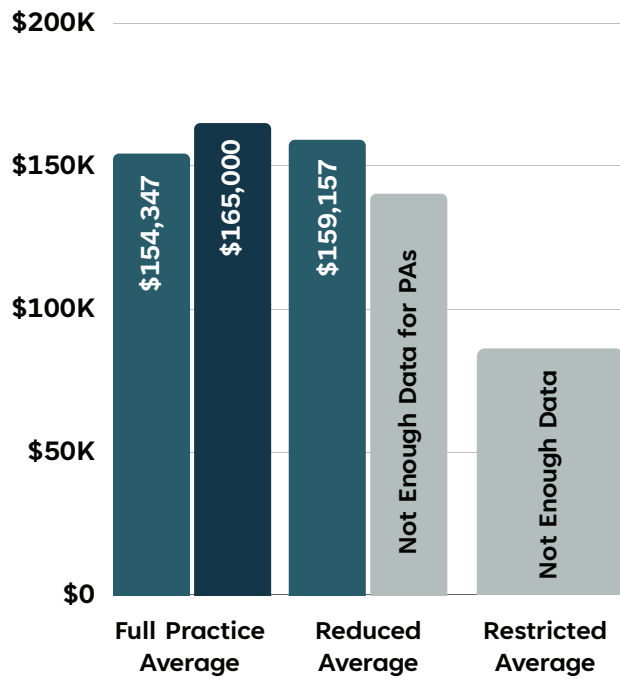
Employed Compensation: Family Medicine w/ OB



Employed Compensation: Family Medicine w/o OB

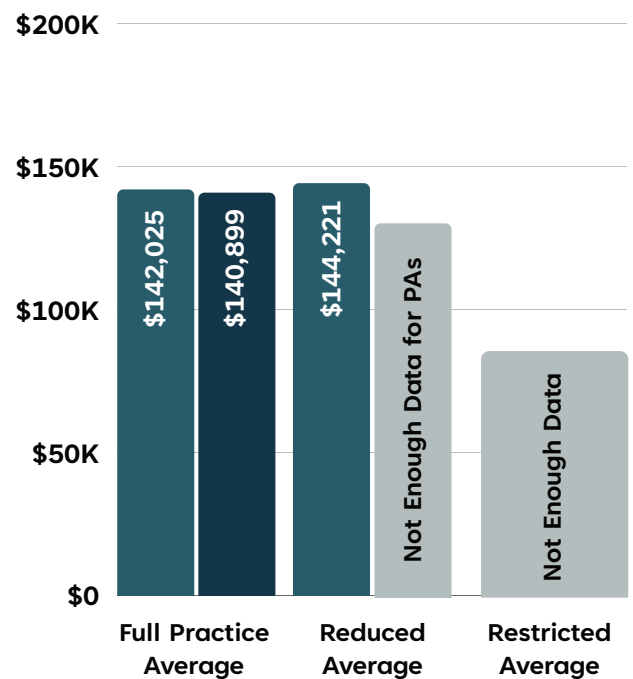


Employed Compensation: Gastroenterology



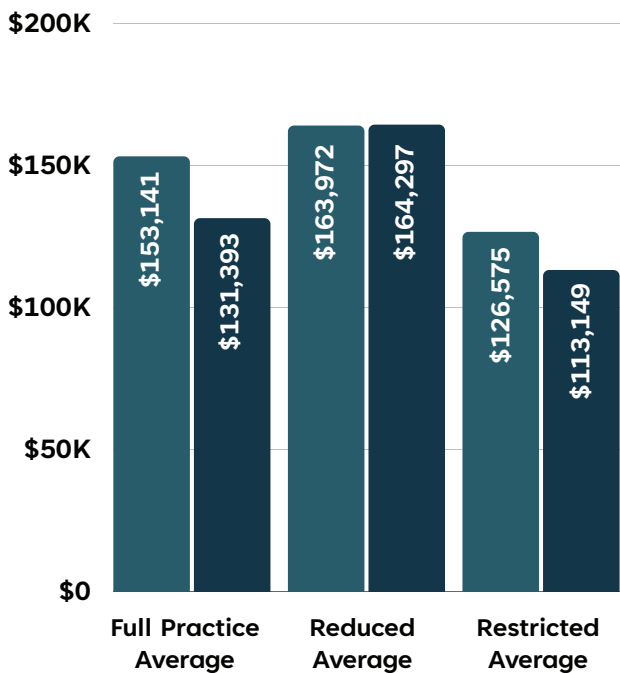
NP PA

Employed Compensation: General Surgery



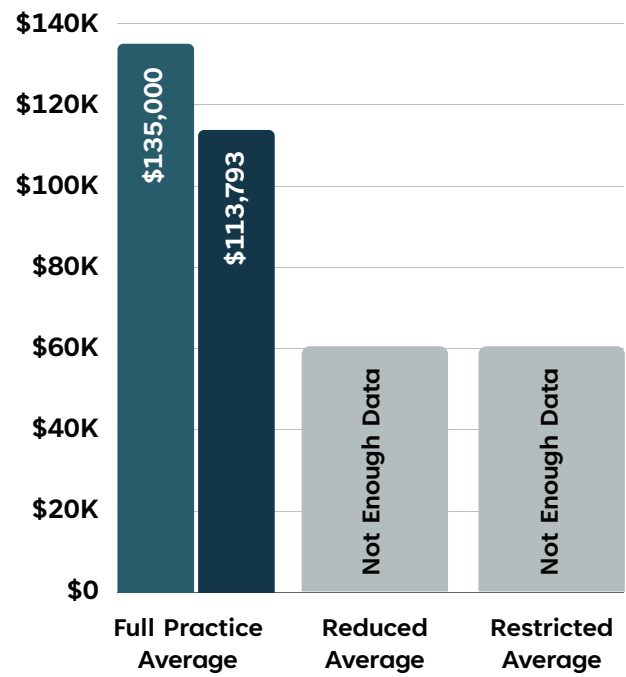
NP PA

Employed Compensation: Hospitalist



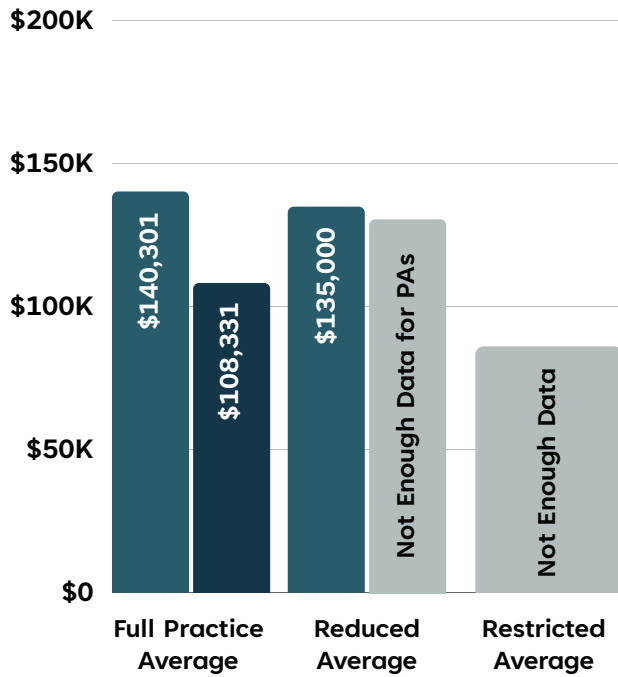
NP PA

Employed Compensation: Neurology



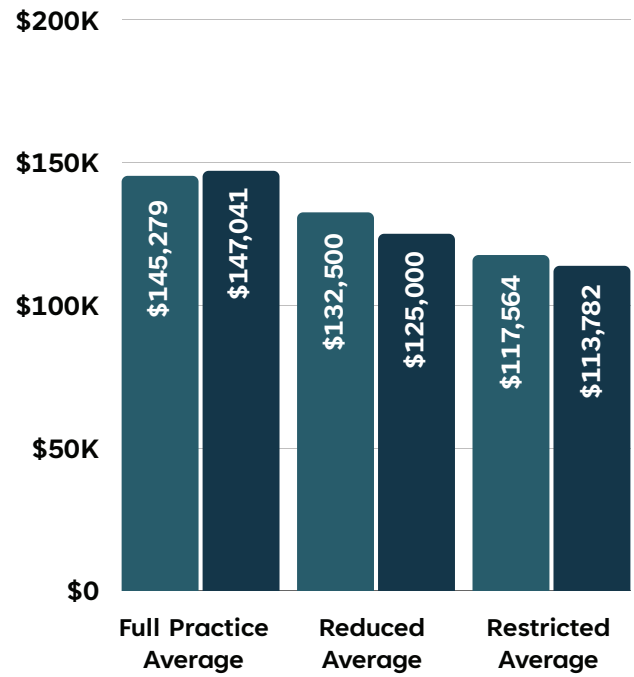
NP PA

Employed Compensation: OBGYN



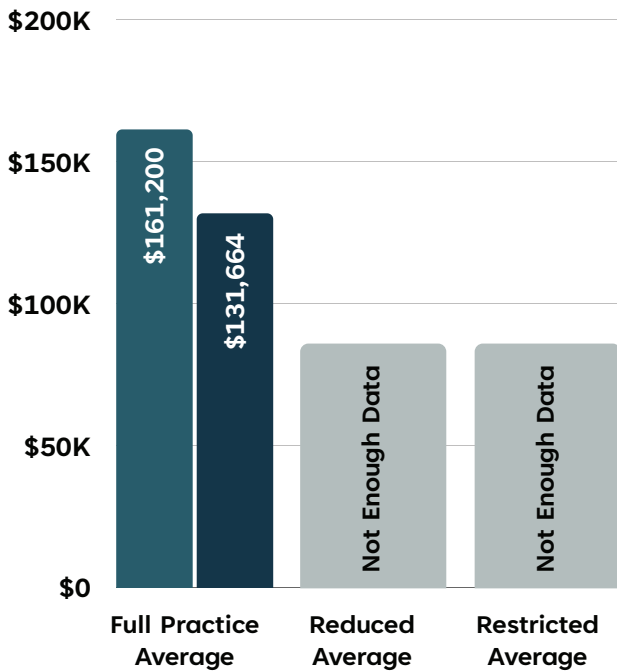
NP PA

Employed Compensation: Orthopedics



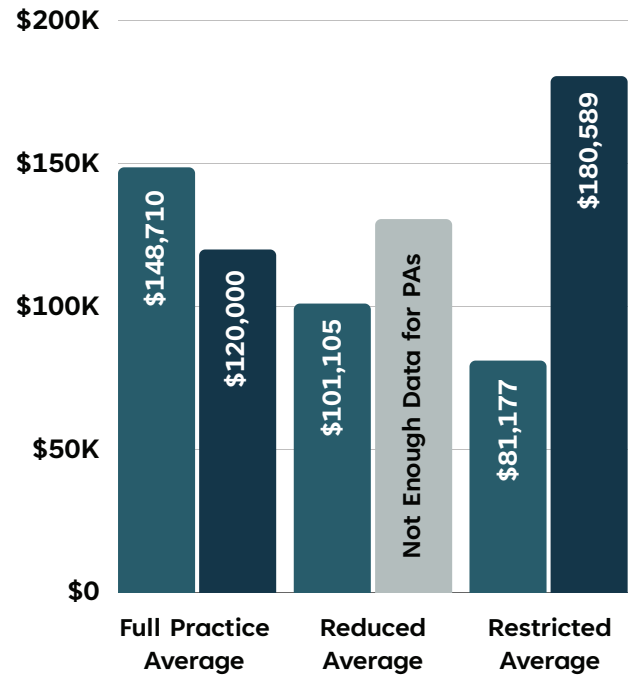
NP PA

Employed Compensation: Radiologists



NP PA

Employed Compensation: Urology



NP PA



“The variance in compensation for physicians and APPs is another example of how compensation is not tied to the organization’s goals, objectives, or even services provided,” states Ritchie. “In several instances, we see reduced and even restricted states paying more than full practice states. It defies best practices and logically can only be rooted in having to pay more to incentivize clinicians to work in less-than-desirable scenarios where they will not utilize the scope of their training.”

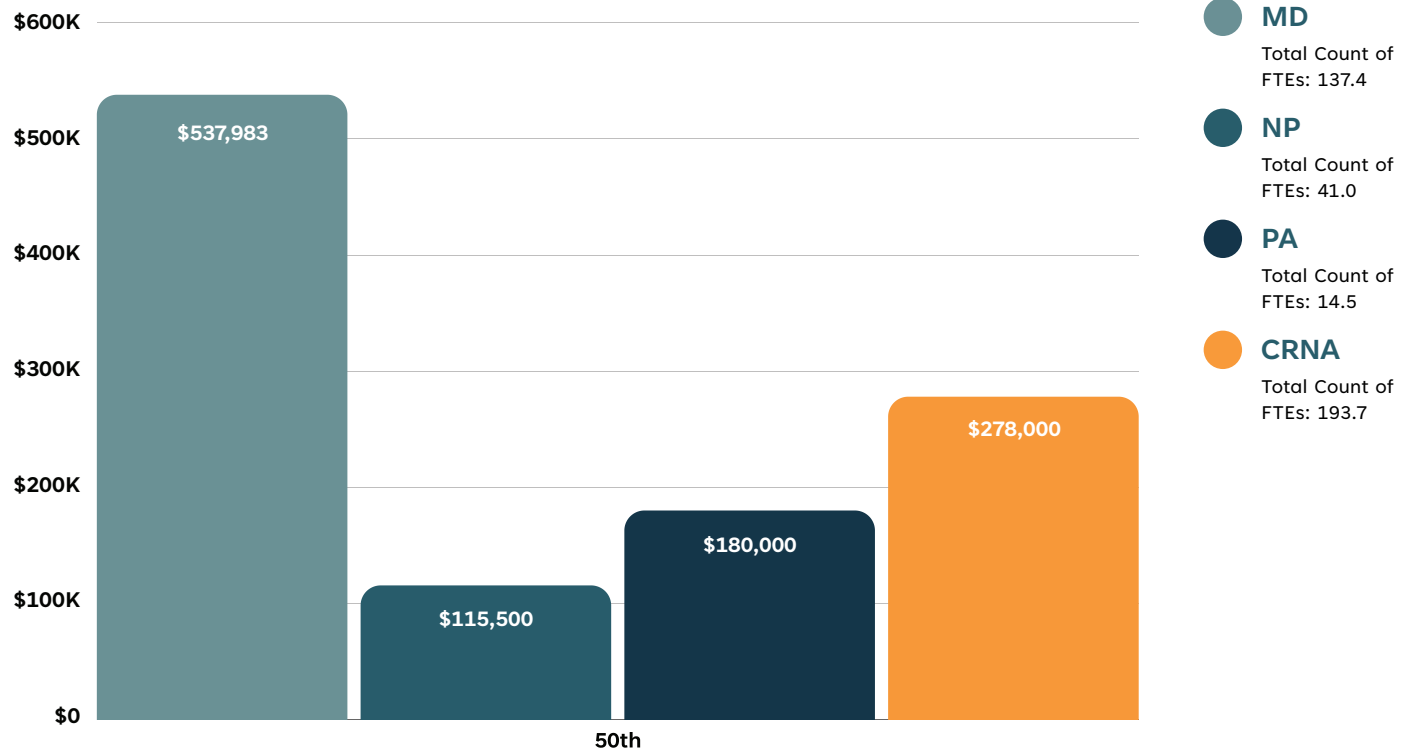
SPECIALTY CARE PHYSICIAN COMPENSATION

Specialist compensation continues to climb, with anesthesiologists and CRNAs both seeing double-digit median increases from 2024 to 2025. This trend is fueled in part by America’s aging population and growing demand for surgical and procedural care; it is particularly challenging for independent rural hospitals that lack the financial leverage and coverage models of larger systems. While market pressures persist, hospitals are increasingly compelled to reassess their staffing strategies for specialty care. Paying one specialist a high salary with additional call coverage is, in some cases, more financially sustainable than recruiting and supporting a full roster of providers. The shift reflects not only budget realities but also the operational demands tied to ER call coverage, patient transfers, and retention.

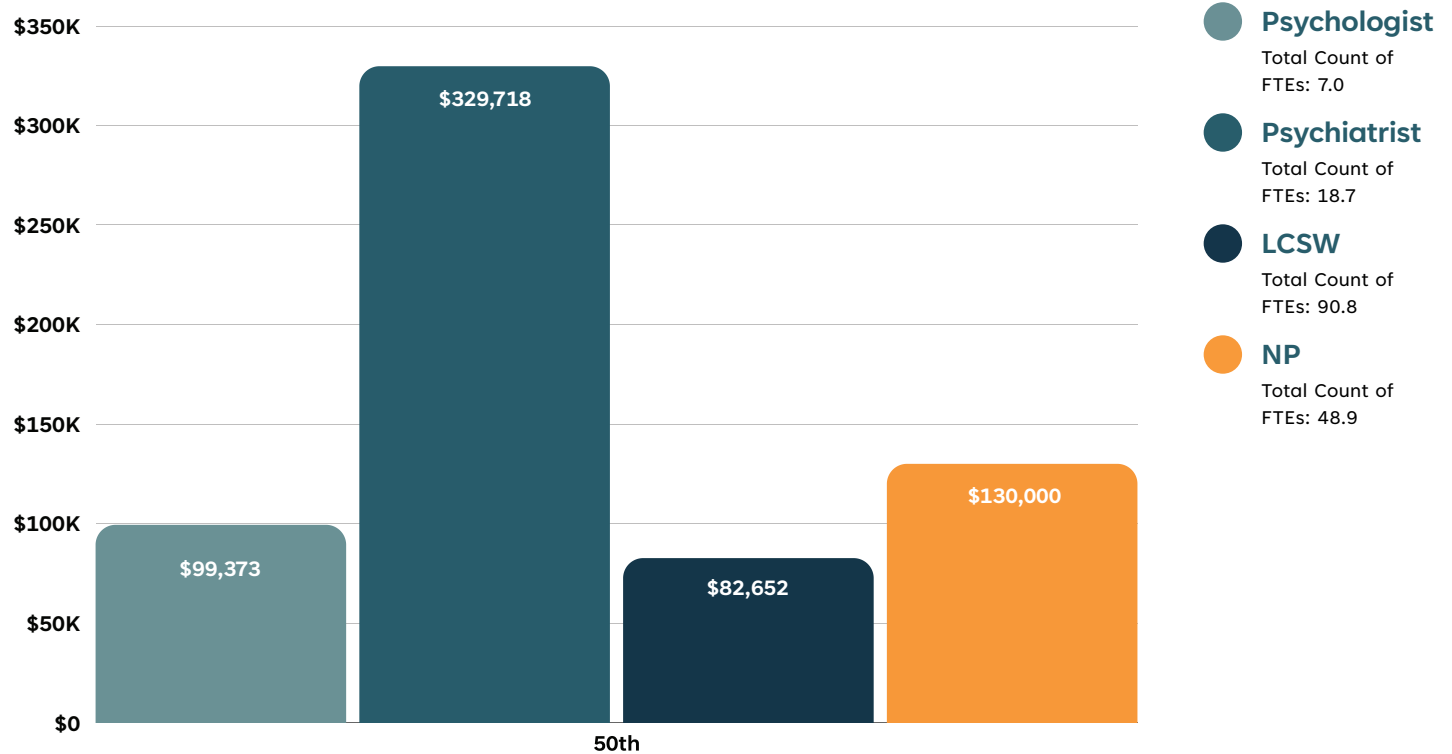
“We continue to see significant growth in specialist compensation, particularly in anesthesia,” says Ritchie. “But what’s becoming more common is the decision to pay one specialist—say an orthopedic surgeon—upwards of \$900,000 with heavy call compensation, rather than hiring three separate orthopods. It may seem surprising, but for some hospitals, this model is more sustainable. Still, any time we see individual providers earning close to or above seven figures in these markets, it raises important questions around fair market value and long-term risk. Having only one specialist in the community can also cause major issues if the provider leaves the organization. This will create a void in care for the community and force the organization to seek locums coverage, which is expensive, and will definitely impact the financial performance of the clinic and hospital.”

Anesthesiologists
& CRNAs are
seeing **double-digit**
median increases
from 2024 to 2025.

Specialist Compensation: Anesthesiology & CRNA



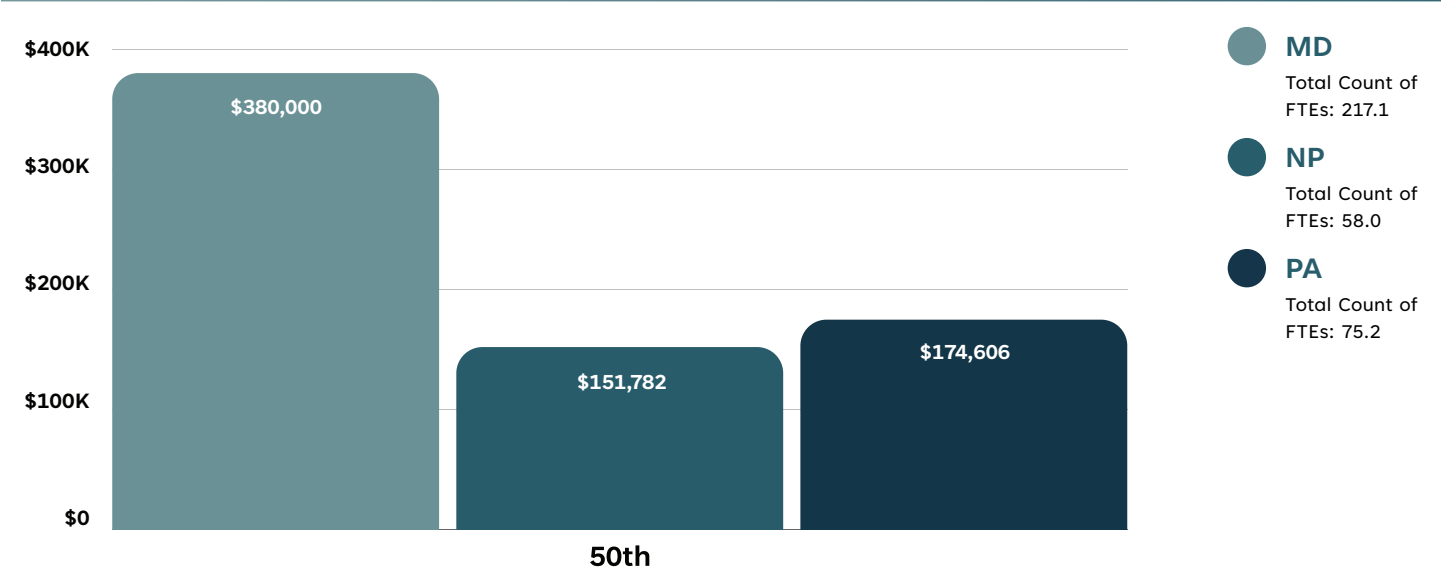
Specialist Compensation: Behavioral Health



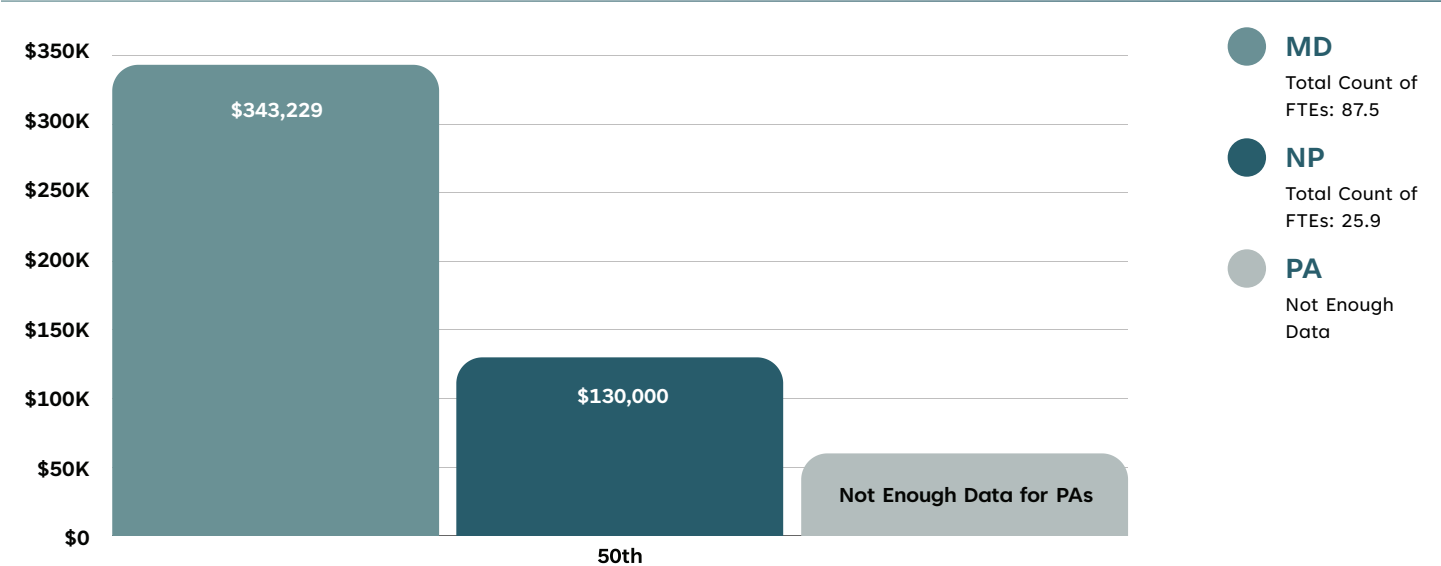
Specialist Compensation: Cardiology



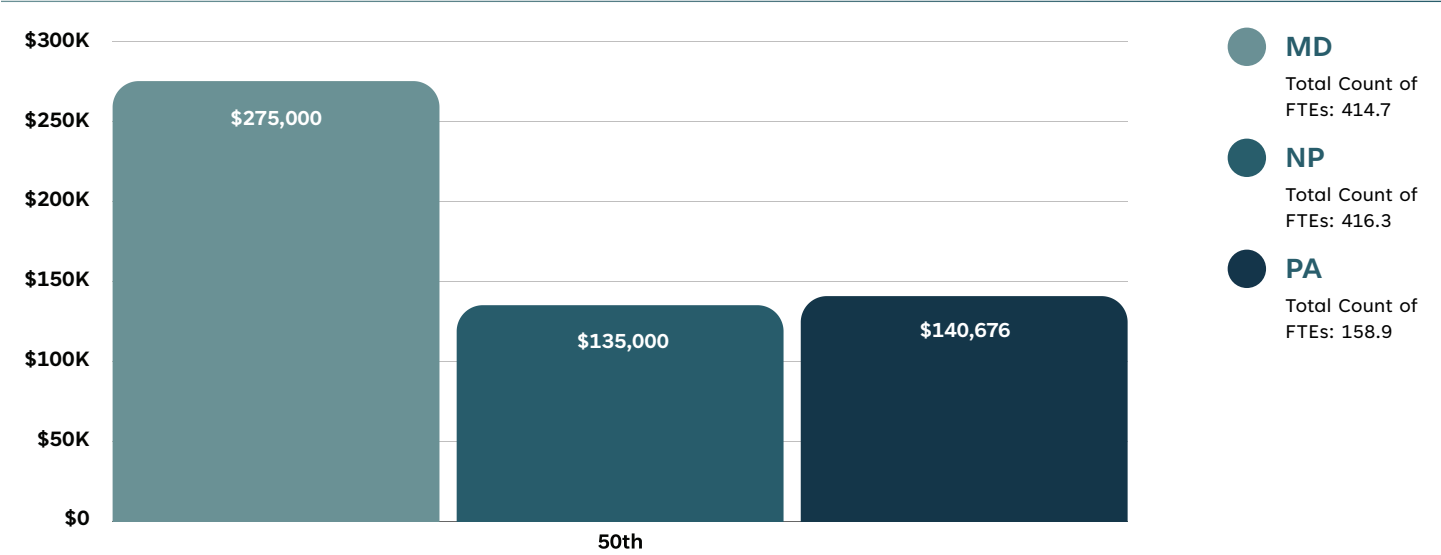
Specialist Compensation: ER



Specialist Compensation: Family Medicine with OB



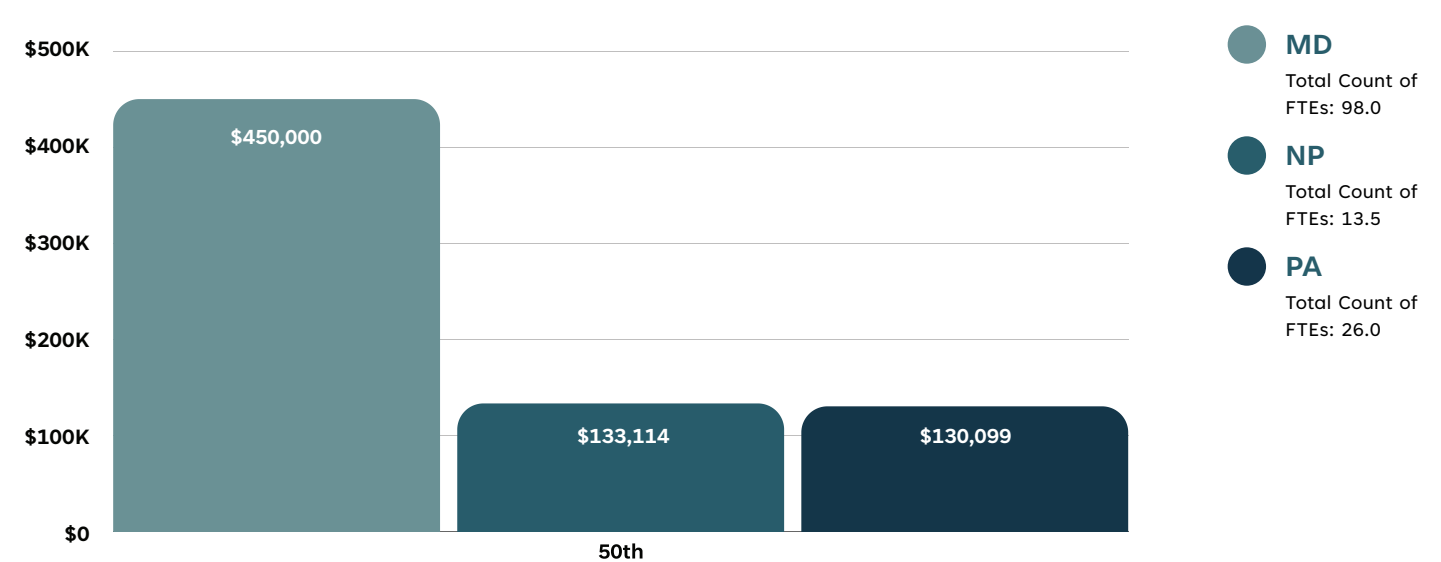
Specialist Compensation: Family Medicine without OB



Specialist Compensation: Gastroenterology



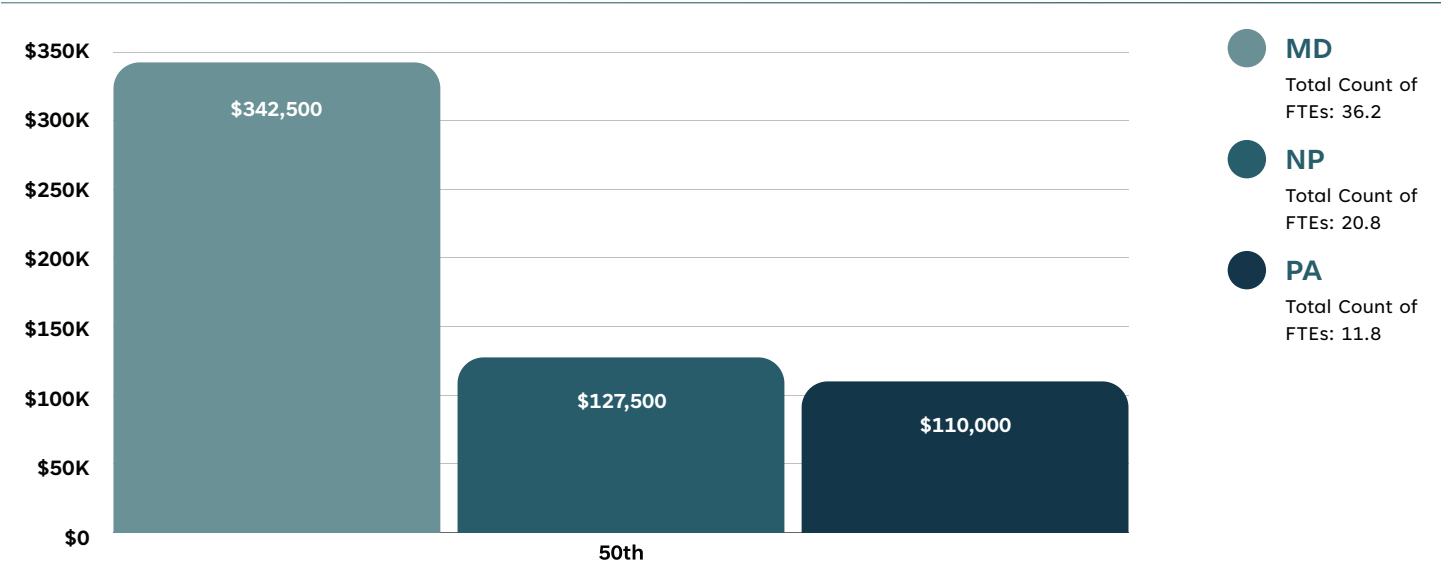
Specialist Compensation: General Surgery



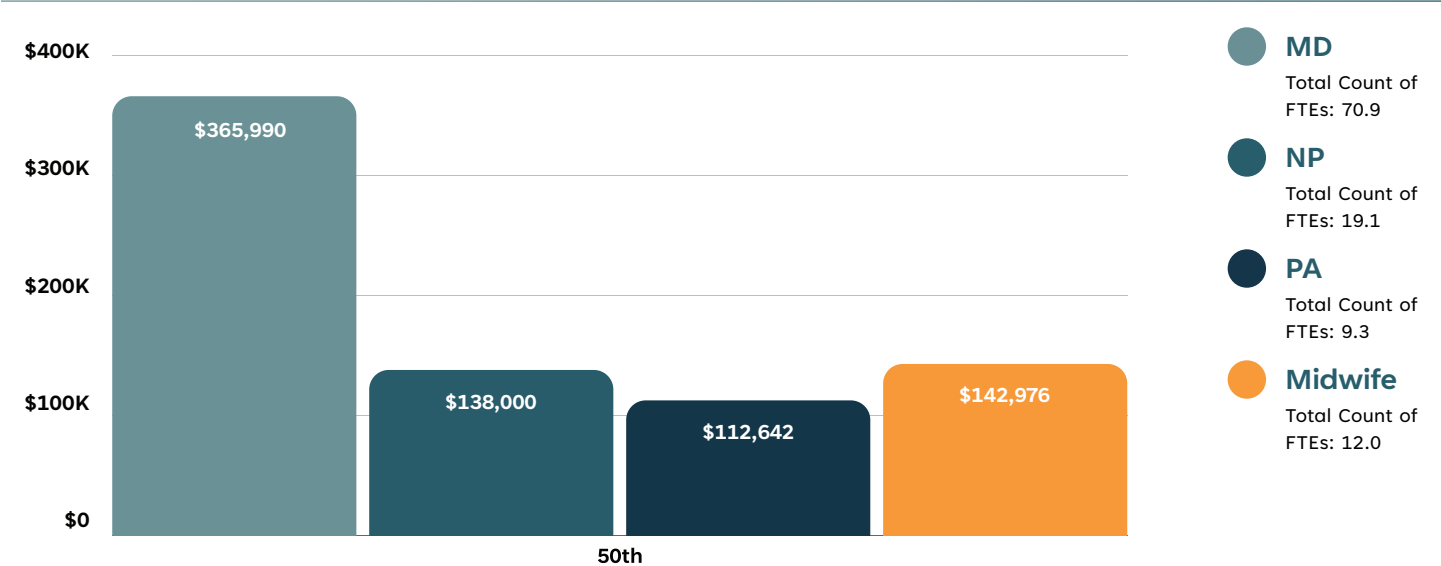
Specialist Compensation: Hospitalist



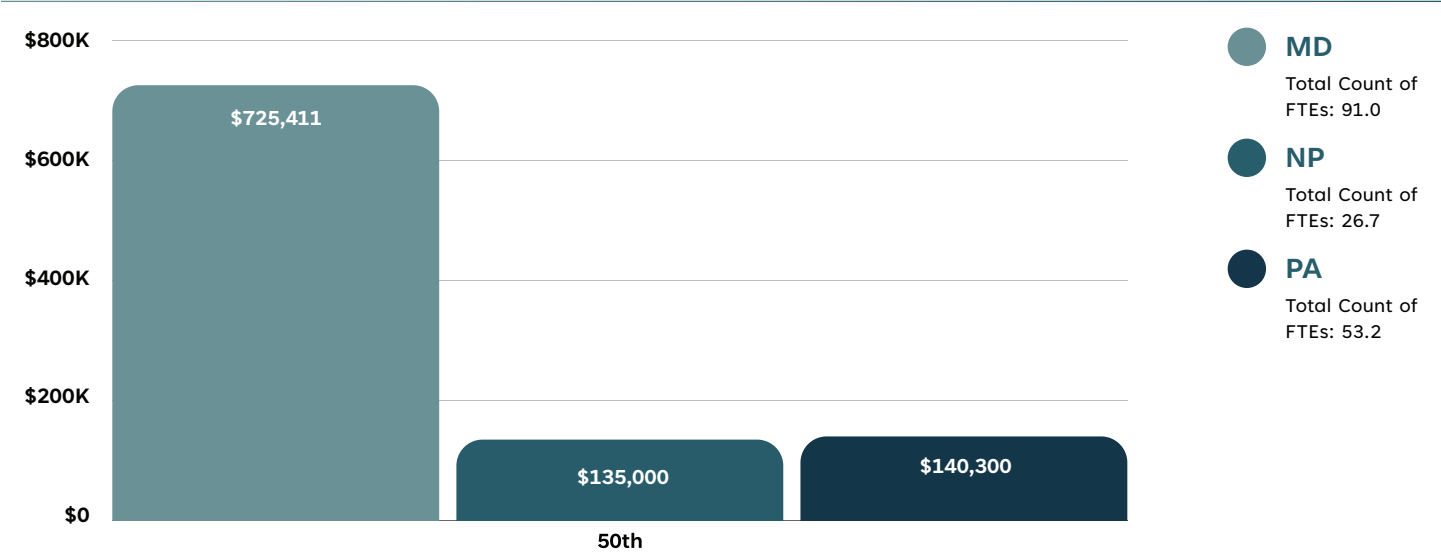
Specialist Compensation: Neurology



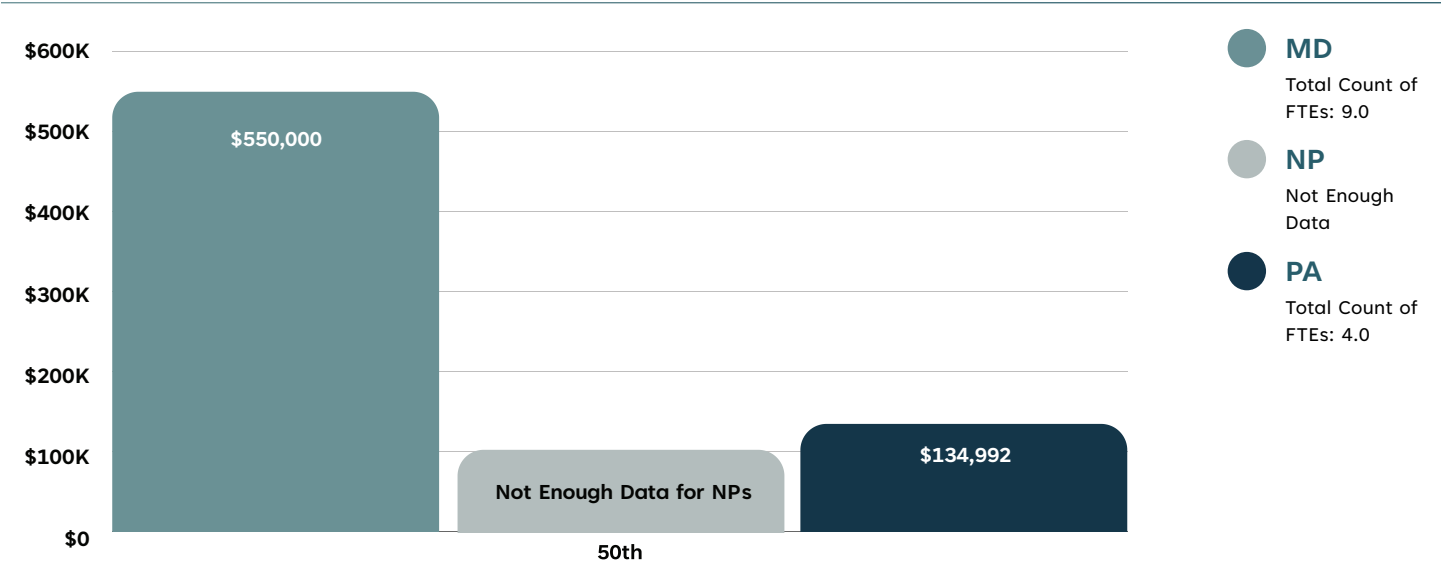
Specialist Compensation: OBGYN



Specialist Compensation: Orthopedics



Specialist Compensation: Radiology



Specialist Compensation: Urology



Amount of Compensation Growth between 2024 & 2025 for Anesthesiology & CRNA

Anesthesiology



50th percentile

CRNA



50th percentile



“To secure CRNAs, rural markets are leveraging a comprehensive strategy that goes far beyond a high salary. They’re offering a package that reflects the immense demand and geographic challenges, with some offers exceeding \$300,000 annually. This includes substantial sign-on and retention bonuses, robust student loan repayment programs, and elevated hourly rates. These incentives are necessary to attract and retain talent, ensuring that essential surgical and obstetric care can be provided to communities in areas where CRNAs are the sole anesthesia providers. However, all organizations, including rural areas, need to ensure that the compensation for these individuals is within FMV for compliance purposes,” says Ritchie.



BEST PRACTICES IN BUILDING A RURAL PROVIDER COMPENSATION STRATEGY

The results of the Third Annual Rural Compensation Survey underscored the financial and operational vulnerabilities of rural organizations and exposed compliance concerns related to FMV and Stark/anti-kickback. As rural organizations plan for the future, several areas could benefit from strategic review, including:



Compensation Structure



Compliance



Alignment



Compensation Structure: Bridging Alignment & Transparency

“Providers expect transparency around their compensation. They want to be able to accurately understand and calculate their compensation, but unless their compensation is 100% base salary, they do not understand how their compensation is calculated and, in many instances, don’t understand how it’s tied to the organization’s goals. Even at 100% base salary, providers are starting to question the basis of their compensation – they want to know where they stand compared to their peers,” states Alexander. “When it comes to building alignment, transparency is critical. Organizations should be clear about the reasoning behind any compensation, incentive or guaranteed. 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 and to understand how to make more or what other things, such as flexibility, may cost them. 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. For any compensation strategy design to work, providers must also have trust in their administration, knowing that the new system is designed fairly and implemented with their best interests in mind.”

The remaining part of provider compensation should be linked to performance—specifically, meeting or exceeding minimum wRVUs, quality, and engagement/citizenship. Incentive pay can then be customized for providers who perform above these minimum standards, giving high achievers the chance to earn more than their total cash compensation target.

Above all, the compensation structure should be financially feasible and sustainable, aligning 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.



Compensation Structure: Patient-Facing Hours

As a best practice, provider contracts should specify the number of hours of patient-facing time required per 1.0 FTE provider. However, the 2025 data reveals that 42.4% of surveyed organizations do not have any formal requirement, and another 38% report expectations that fall below industry standards. Only 18 organizations indicated a threshold of 36 or more patient-facing hours per week—the benchmark most used to define a 1.0 FTE physician.

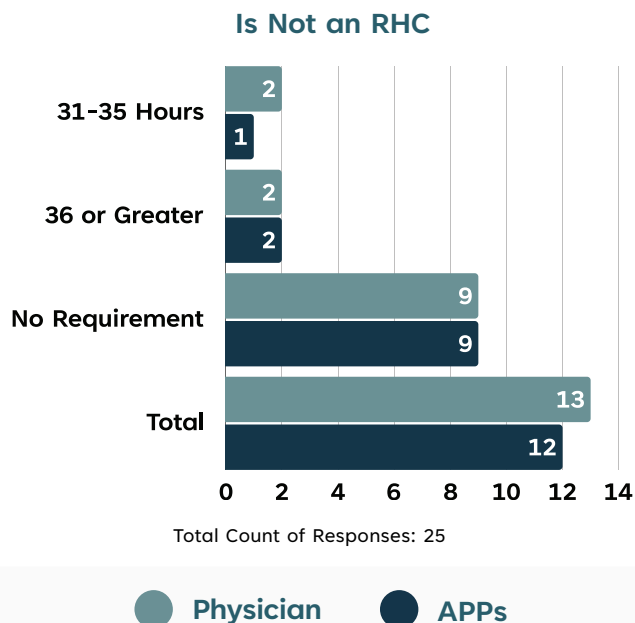
This lack of standardization creates risk across multiple areas. Without clear expectations, organizations face compliance challenges, potential pay equity concerns, and significant retention issues. If compensation is not aligned with productivity or patient demand, internal disparities arise and recruiting inefficiencies increase.

“Defining a 1.0 Full-Time Equivalent (FTE) is essential for building a robust and equitable healthcare provider compensation plan. This metric serves as a standardized baseline for a full-time workload, which allows for fair and consistent compensation across all providers, regardless of their specific work schedules. It provides a clear, defensible basis for pro-rating salaries for part-time providers and ensures that compensation is directly proportional to the expected work output. Without this fundamental definition, an organization risks creating a confusing and inconsistent pay structure, leading to disputes and employee dissatisfaction. Beyond fairness, a clear FTE definition is critical for legal compliance and sound financial management. It provides the necessary transparency for meeting regulatory requirements, such as those related to the Stark Law and the Anti-Kickback Statute, which scrutinize provider compensation to ensure it’s at fair market value. From a business perspective, the FTE metric is a powerful tool for budgeting and operational planning. It allows leaders to accurately forecast labor costs, measure provider productivity against a consistent benchmark, and make informed staffing decisions based on the actual capacity of their workforce. By establishing a 1.0 FTE, an organization can create a compensation system that is not only transparent and fair but also legally compliant and financially sustainable,” says Ritchie.

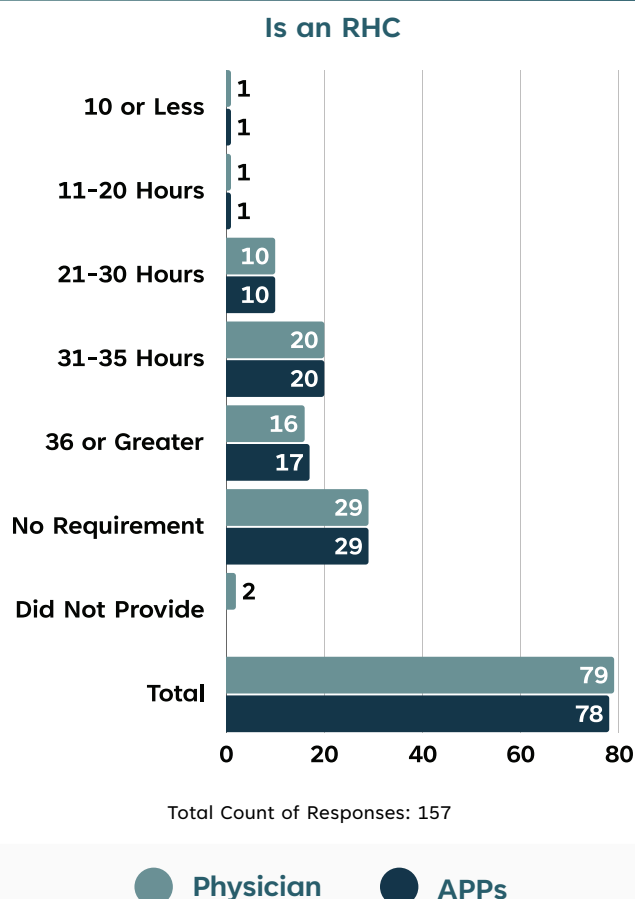
Rural organizations face pressure to balance flexibility with access, but failing to define a 1.0 FTE makes it harder to staff appropriately. In today’s environment of provider shortages and increasing wait times, few organizations can afford to be overstaffed or underutilized. Establishing clear, enforceable expectations for patient-facing hours is crucial to improving alignment, sustaining access, and supporting long-term financial stability.

“Most respondents require at least 30 hours of patient-facing time,” notes Ritchie. “However, nearly half of those surveyed do not have a set requirement, which is extremely concerning given that many organizations surveyed relied on pure base salary, and providers should be incentivized to see more patients due to serious patient access concerns amongst rural hospitals.”

Patient Facing Hours: Physicians vs. APPs



Patient Facing Hours: Physicians vs. APPs





Compliance: Physician Fee Schedules & wRVUs

In December 2020, CMS issued a major overhaul to the physician fee schedule, significantly increasing the value of evaluation and management services to better reflect the time, cognitive effort, and documentation burden involved—especially for primary care physicians. These changes were intended to modernize the measurement of productivity and to close long-standing gaps in how services are valued following the COVID-19 pandemic.

Despite these changes being in place for several years, widespread confusion and inconsistency persist. Only 14.1% of organizations surveyed for this report indicated that they were utilizing the most recent physician fee schedule, and more than half of respondents were unsure which version they were using.** Additionally, more than half of respondents were unsure which version they were using. This raises serious red flags not just from a FMV and compliance standpoint, but also in terms of operational risk and provider trust.

“A lot of organizations are avoiding the difficult decision of updating their physician fee schedules or determining if they should use wRVUs at all,” says Ritchie. “But the problem is twofold: straight salary is not aligned with compensation best practices, and without calculating wRVUs, you lose an objective measure of the services being provided.”

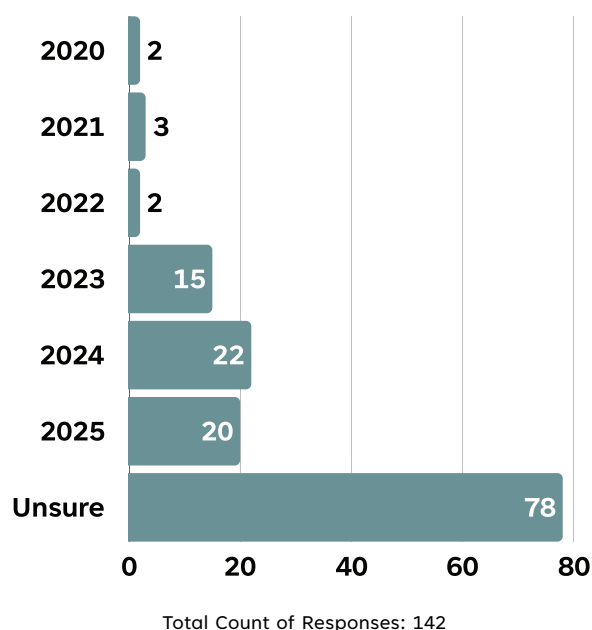
Even in cost-based reimbursement environments, organizations must benchmark compensation against the relevant year of the fee schedule and adjust for inflation, if not using wRVUs. Without that diligence, there is a high risk of either underpaying providers—potentially impacting retention—or overpaying them based on outdated productivity assumptions, which exposes the organization to both financial and regulatory risk.

Part of the issue stems from a lack of internal ownership or visibility into billing systems—particularly for organizations that rely on outsourced billing partners. While these third-party vendors typically know which physician fee schedule they are utilizing, hospital leadership often does not, leading to disconnects between compensation models and actual productivity. In some cases, organizations are incrementally adjusting outdated schedules rather than adopting the current one, or using multiple wRVU systems without accurately reconciling them.

This issue also affects alignment with providers, particularly when trust in the underlying data breaks down. When physicians do not understand how their compensation is being calculated—or worse, suspect the data is inaccurate—they can lose confidence in the organization. This mistrust can lead to disputes over performance-based incentives, especially if bonuses are unexpectedly withheld or adjusted. On the other hand, some providers may later discover that they have been underpaid for extended periods, leading to frustration and demands for retroactive corrections. Without transparent data practices and clear communication, these issues can quickly escalate into broader concerns around fairness, retention, and compliance.

Ultimately, organizations that fail to invest in clean data, clearly defined fee schedules, and transparent communication with providers are at risk of undermining both compliance and the physician relationship. **As productivity-based models gain traction again, these gaps will only widen if left unaddressed.**

Yearly Count of wRVU Fee Schedule**



** Updated on March 18, 2026



Compliance: Mitigating Risk for Fair Market Value

Over the last few years, rural organizations have become increasingly concerned about compliance and with just cause: the Department of Justice is paying more attention to rural hospitals and cracking down on FMV at not just large, for-profit health systems, but also smaller rural hospitals like CAHs.

To maintain compliance, rural hospitals should evaluate FMV each time a new agreement is implemented or every two years thereafter. “Rural hospitals now have the data to compare compensation against what other rural organizations in their region are paying providers, but a compensation survey is not FMV. Many organizations present a survey when asked about their FMV data and believe that if they do not go above the max salary on the survey, they are complying. That couldn’t be further from the truth. To maintain compliance, organizations need to evaluate the market level for the services provided,” cautions Ritchie. “There are three approaches that one must consider with FMV, which are the market, income, and cost approaches. If any organization is concerned that they are at risk related to provider compensation and FMV, they should reach out to experts in that field to provide recommendations and opinions.”

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.

“If your organization commits to setting a strong compensation strategy that aligns with the organizational strategy, you shouldn’t have to redo the strategy. You can have the compensation committee come back together every two to three years to evaluate how the strategy is working, if there are any changes to consider, and if anything needs to be adjusted,” shares Alexander. “Once a strong foundation is set, most organizations need to make small tweaks every couple of years rather than full overhauls.”

When determining FMV for provider services, hospitals should consider the following:



Specialty & Subspecialty



Community Needs & Benefits



Training & Experience



Compensation Methodology & Amount



Duties & Responsibilities



Recruiting Timeline



Benchmark Comparison

To maintain best practice, FMV opinions must be documented in the physician’s contract, especially if compensation exceeds the 70th percentile of the benchmark and/or the compensation-to-productivity variance **exceeds 10%.**



“We know that recruitment for rural organizations is challenging, but when determining FMV, it’s important to understand that you may need to exceed the national average to increase compensation due to ‘recruitment difficulties’. Before the pandemic, **the national average to recruit a primary care physician was 260 days – now, it’s 366.** If you’re increasing compensation because of recruitment, it’s critical to know these averages and how your organization compares,” notes Ritchie.



THE FUTURE OF RURAL COMPENSATION

There is a growing sense of urgency among rural organizations to overhaul the way they calculate compensation. With more than 238 rural hospitals closing or ceasing inpatient services since 2005¹¹ and Medicaid cuts looming, the rural healthcare landscape is plagued by staffing challenges, health disparities, and shrinking margins. Considering the big picture, rural leaders must acknowledge that if 43.7% of organizations are using solely a base salary model for their providers, those organizations have not aligned their compensation strategy with the organization's overall success.

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 organizations face serious financial stability risks if they don't take a hard look at their provider compensation strategy,” cautions Alexander. “There simply isn't enough money in the system to sustain rising compensation costs without a clear understanding of provider productivity, patient volumes, and patient access needs. Without greater transparency and alignment, the financial outcomes are not sustainable.”

Structured and strategic compensation plans can enhance alignment between providers and organizations, benefiting all parties through:



“Rural healthcare organizations have the difficult task of creating an equitable provider compensation model that not only drives productivity and quality but is also competitive enough to attract and retain providers,” says Alexander. “Occasionally, unique circumstances arise that require creative compensation arrangements that will resolve coverage issues. These compensation arrangements should be the exception, not the rule, and should be based on data-driven fair market analysis that will meet the organization's compliance criteria.”

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. The next Rural Provider Compensation Survey will open in January 2026 in partnership with the National Rural Health Association (NRHA) and the National Office of the State Offices of Rural Health (NOSORH). More specific regional data will become available as response rates increase, which can greatly assist organizations in meeting FMV compliance requirements and, more importantly, ensure that rural organizations can stay competitive in provider recruitment. Stroudwater is committed to ensuring that rural hospitals have access to accurate data and insightful analysis, enabling them to make informed decisions critical to a thriving healthcare organization.



To learn more about provider compensation and strategy, contact the Stroudwater team.

¹¹Merative; as of July 11, 2025



STROUDWATER

The State of Rural Provider Compensation in 2025:
**Rural Physician & Advanced Practice Provider
Compensation Survey Results**

PUBLISHED 2025 | STROUDWATER.COM



As rural hospitals face mounting challenges—from tightening Medicare and Medicaid reimbursement rates to persistent workforce shortages—access to relevant, timely data is more critical than ever. Now in its third year, our report provides rural-specific benchmarks and emerging trends that empower leaders to make informed decisions tailored to the unique realities of rural healthcare.

Jeff Sommer, MPH
Stroudwater Managing Director

