Volume 17, No. 3 • May 2020

New research and expert opinions in the area of hospital and health system governance.

E-Briefings

What Boards Need to Know About Evolving Provider Needs Assessments

By Tynan Kugler, Principal, PYA, P.C.

Hospitals should continuously validate their recruitment and physician affiliation strategies—for both workforce planning and regulatory compliance purposes. It's a research-intensive process in which the centerpiece has long been the provider needs assessment (PNA).

It is important to note that a PNA is different from a community health needs assessment (CHNA), which tax-exempt hospitals are required to complete under Section 501(r) of the Affordable Care Act. A CHNA may address provider need as one component, but it also encompasses socioeconomic data and other health indicators.

For many years, a PNA was a straightforward process that, when used for physician recruitment, identified the hospital's Stark-law-defined service area and compared demand for medical services by specialty to the supply of physicians. But PNAs are rapidly evolving to play an expanding and dynamic role not only in conjunction with an organization's strategic planning and recruitment efforts, but also in both fair market value and commercial reasonableness assessments.

Moreover, "modern" PNAs should better reflect service area supply to include community-specific nuances, such as physician retirement age by specialty and use of advanced practice providers. They also should incorporate enhanced methodologies for determining demand, since not all communities are making the shift from volume to value in the same way or at the same speed.

This article explores what board members need to know about the widening scope of PNAs in order to better oversee the efforts of their hospitals' compliance and recruiting initiatives.

Why PNAs Are Growing More Complex

From the outset, a PNA must take

Key Board Takeaways

- PNAs are growing more complex because of significant population and demographic shifts. Ensure your medical staff provider roster is current and complete including all provider practice locations and ages.
- PNAs are becoming more complicated because communities are transitioning to value-based care at different speeds and in different ways. Identify where along the continuum the organization is in its transition from fee-for-service to value-based care.
- Demographic shifts and value-based care transitions have a significant impact on the determination of provider supply and demand. Evaluate the average patient panel size seen by primary care physicians to assess the impact on provider supply.
- PNAs are now playing an expanding and dynamic role in both fair market value assessments and commercial reasonableness opinions. Be prepared to provide your current PNA, or an applicable portion thereof, as part of information requested for these reviews.
- The influx of advanced practice providers, such as nurse practitioners and physician assistants, adds to the complexity of determining provider needs. Assess how different physician specialties in your community utilize advance practice providers in their clinical practices to guide the impact on provider supply adjustments.

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into account population shifts and physician shortages by service area.

For example, the state of West Virginia has lost 3.5 percent of its population in just the last seven years. Illinois's population has declined for six straight years—and it's the only Midwest state that didn't experience population growth in 2019. And, the population of beautiful Hawaii has inexplicably declined for three years in a row.

Meanwhile, the states experiencing the greatest physician shortages are in the upper Mountain States (Idaho, Wyoming, and Utah) and the southern region between Texas/Oklahoma and Alabama. In Mississippi, there are only 186 physicians per 100,000 people, whereas in Massachusetts there are 443 physicians per 100,000 residents. *Board Vitals* reported that the top five shortage-driven recruiting challenges are in psychiatry, emergency medicine, hospitalist medicine, endocrinology, and rheumatology.[1]

In addition, the prevalence of chronic health conditions isn't spread evenly across the U.S. Cases of chronic obstructive pulmonary disease (COPD) are significantly higher in the Southeast and Appalachian states, while New England leads the nation in reported cases of asthma.

Although the PNA methodology continues to evolve, one point remains the same: the need to pay keen attention to the impact that population shifts, physician supply, and local health conditions have on the community served.

New Perspectives on Physician Supply and Demand

Rapidly shifting demographics play a significant role in provider supply and demand. Over the next decade, the number of Americans under the age of 18 is projected to grow by just 3 percent, while the number of people over 65 will grow by about 50 percent. Clearly, the demand for pediatricians will not keep pace with the demand for physicians in fields such as cardiology, neurology, urology, etc. According to Kaiser Family Foundation studies, many states in the U.S. already have a 55-plus population of 30 percent or more.[2] Correspondingly, 27 percent of U.S. physicians are age 55 or older and are rapidly nearing retirement.

The Association of American Medical Colleges projects that by 2032 there will be significant shortages of both primary care physicians and specialists. Nationwide, the primary care physician shortage could total 55,200 by that year and the specialist shortage could reach 65,800.

Supply and demand are also shaped by geography. For example, Montana is our fourth-largest state (147,000 square miles), yet its population is smaller than that of metro Milwaukee. To meet the statewide demand for medical specialists, many community hospitals in Montana are now part of telemedicine networks that allow specialists in Los Angeles or Boston to see patients remotely. As a result, technological advancements in care provision, which may not be considered in traditional physician-to-population ratio calculations, are important to understand when determining provider demand.

As the U.S. healthcare system steadily shifts from fee-for-service to value-based care, any analysis of physician demand must also take into account patient panel size (the number of patients one doctor can manage). In many population health management scenarios, a primary care physician may have a smaller patient panel than in the traditional fee-for-service arrangement (although panel size may depend on the dynamics of the community served). Quality metrics are also influencing demand. Physicians who earn high quality scores are more likely to be in greater demand, while those with lower scores can see demand drop.

The provider supply pool has been boosted in recent years by the influx of advanced practice providers (APPs), such as nurse practitioners and physician assistants. Hospitals can now recruit APPs and provide financial assistance to physician practices for such recruitment under a Stark law exception. But APPs are unable to provide all the services that physicians can—and the availability of APPs by service area only makes PNAs more complicated based on the way in which APPs are actually used in practice.

PNAs in the Context of Fair Market Value and Commercial Reasonableness

In the past, a PNA was primarily used to guide provider recruitment. But today, PNA data also helps determine fair market value (FMV) and validate commercial reasonableness (CR) opinions.

Specifically, the Stark law's FMV provisions prohibit tying physician compensation, either directly or indirectly, to the volume or value of any Medicare designated health services (DHS) referrals or other business generated by the providers to the organization that hires them (including any affiliated entities). Results of a PNA can help support the hiring of a highly compensated physician in a scenario where supply is low, demand is high, and the hospital has been recruiting unsuccessfully for that specialty for a long period of time.

1 Deborah Chiaravalloti, "Physician Shortages: Where They Are and the Most Needed Specialties," *Board Vitals*, October 24, 2018.

2 Kaiser Family Foundation, "Population Distribution by Age," 2018.

A CR opinion examines whether a proposed transaction makes business sense in the absence of a referral stream. For example, if a PNA reveals that there are already too many oncologists in the service area, it could be hard to justify hiring more.

Leveraging PNA Findings

A thorough PNA provides the support needed to assess FMV and CR of arrangements—and to guide decisions—for example, in instances where a newly hired provider posts financial losses while establishing a practice.

The financial health of every hospital depends heavily on the informed recruiting and retention of new providers in accordance with regulatory requirements that are becoming increasingly complicated—and increasingly punitive, if violated—making the attention given to a PNA all the more important.

The Governance Institute thanks Tynan Kugler, Principal at PYA, P.C., a healthcare advisory firm with five national offices and clients in all 50 states, for contributing this article. She can be reached at tkugler@pyapc.com.