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E-Briefings

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

The Governing Board's Role in Assessing Possible Hospital Closure or Downsizing

By Anne M. Murphy, Partner, Arent Fox LLP

Hospitals find themselves at a challenging crossroads in the United States. Long viewed as central to the fabric of the community, they are relied upon as trusted providers of essential healthcare and as key employers. Never has that been truer than now, in the face of the COVID-19 pandemic.

At the same time, hospitals are vulnerable to unprecedented financial duress. For the leadership of some health systems, it will be advisable for the governing board to do an intensive assessment and develop a plan that acknowledges the future possibility of substantially altered operations that may include hospital downsizing or, in the worst-case scenario, closing. For others, it will be appropriate to embark upon the unwelcome and immediate journey of evaluating whether to close or downsize hospital operations and, if necessary, overseeing this action. This article identifies key considerations for health system and hospital governing boards in evaluating and implementing these actions.

The Backdrop

Closure Trends

Across the United States, in both urban and rural communities, hospitals have been closing at an accelerating rate. According to MedPAC, 47 hospitals closed in 2019, representing over double the 23 closures in 2018.[1] And Bloomberg reports that during 2019, at least 30 hospitals entered bankruptcy.[2]

A February 2020 analysis by the Chartis Center for Rural Health found that 120 rural hospitals have closed since 2010, with 19 of these closures in 2019. In an alarming conclusion, the report identified an additional 453 rural hospitals as vulnerable to closure.[3]

Urban hospital closures also have been increasing, particularly among smaller hospitals and in areas

1 Rich Daly, "47 Hospitals Have Closed in 2019, MedPAC Reports," HFMA, December 10, 2019.
2 Lauren Coleman-Lochner and Jeremy Hill, "Hospital Bankruptcies Leave Sick and Injured Nowhere to Go," *Bloomberg*, January 9, 2020.
3 The Chartis Group, *The Rural Health Safety Net Under Pressure: Rural Hospital Vulnerability*, The Chartis Center for Rural Health, February 2020.

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Key Board Takeaways

- Hospital closures across the country have been accelerating in recent years. Rural hospitals are especially vulnerable, but non-rural hospitals serving medically underserved populations are also experiencing significant fiscal challenges.
- The COVID-19 pandemic has amplified this financial distress. Some hospitals may have immediate concerns. Others may be strained, but more focused on long-term uncertainties for hospitals, as compounded by COVID-19.
- Against this backdrop, boards should consider assessing the current financial strain on the enterprise, and developing targeted action items on the basis of its findings. This article suggests two possible board approaches, depending on the organization's current status:
  - For many hospitals, it will be beneficial to develop a detailed management plan that could be deployed in the event of future financial distress, which lays out various possible action items that include, but are not limited to, facility downsizing or closure. This should be thought of as prudent planning for a future mission-critical event.
  - For a smaller group of hospitals, it may be necessary to evaluate on a more immediate basis possible facility downsizing or closure. Any such action requires active board oversight, and should be undertaken with the appropriate level of organization, attention, and resources given the complexity of this action.
- In either case, the board should be unflinching in its evaluation and oversight, recognizing that important fiduciary duties are being exercised.

serving medically underserved patient populations. A comparison of the MedPAC and Chartis data suggests that the majority of these closures in 2019 occurred among non-rural hospitals.

The highly-publicized closure and bankruptcy filing by Hahnemann University Medical Center in Philadelphia this past year underscored the vulnerability of safety net hospitals, even those that have been long-time community anchors and that serve as teaching hospitals.[4] The closure drew national attention to the impact on medical residents, and to the reality that some struggling hospitals with non-profit roots may now be controlled by for-profit investors.

The cause of this trend is multi-faceted, and altogether too familiar to hospital leadership. Overall Medicare and Medicaid reimbursement lags behind costs, with the potential for additional restrictions on Medicaid supplemental payments. Occupancy rates and procedure volumes have suffered in the face of the push to healthcare delivery in lower-acuity and ambulatory settings. The transition to value-based care delivery and reimbursement models is challenging. And hospitals not affiliated with large systems may find themselves losing workforce and patient volume to other area providers.

The COVID-19 Effect

Against the backdrop of accelerating hospital distress, COVID-19 hit in early 2020.[5] For hospitals and health systems, healthcare delivery in a pandemic is absolutely mission critical. At the same time, however, it is imposing an even greater operational and financial burden at an already-challenging time. Elective procedures may be suspended, which deprives the institution of important revenue. Patient acuity, and corresponding operating expenses, may have increased. These expenses may include workforce accommodations, and numerous adjustments in order to address infection control. And in the face of all of this, government and commercial reimbursement is unclear.

In the short term, some hospitals are experiencing immediate financial challenges that may cross the line into liquidity issues. While federal and state governments are taking measures to provide supplemental support to hospitals in acknowledgement of these stresses on the delivery system, there are concerns that the extent of support may be insufficient, and may not be channeled to the hospitals needing it most.

In the longer term, it remains to be seen whether the massive slowdown in the economy limits the percentage of patients with insurance, or imposes such financial strain on state and local governments that their ability to reimburse or provide financial support for hospitals is impaired. With a presidential election later this year, it is even difficult to predict the core federal philosophy around healthcare delivery that will be in place in a

4 Soumya Rangarajan, "The Closure of a Historic Hospital Is an Ominous Warning Sign," *Scientific American*, September 17, 2019.

5 Kirk Siegler, "Small-Town Hospitals Are Closing Just As Coronavirus Arrives in Rural America," NPR, April 9, 2020.

year, and how that will translate into hospital reimbursement.

On a very fundamental level, the length of the COVID-19 pandemic, and its full impact on the overall economy and the welfare of hospitals, is an unknown. What is known is that the operational and financial strain on hospitals is unprecedented.

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Fiduciary Duties in Difficult Times

For a hospital and health system governing board, it is important to fully evaluate the range of potential short-term and long-term impacts to the organization in an era of overall operational and financial stress. From a fiduciary oversight perspective, this requires an unflinching and ongoing assessment of current realities and various future scenarios. If closure or downsizing is an immediate possibility, then the board is strongly advised to implement a comprehensive and documented action plan to ensure that its oversight is sufficient.

Core Duties

The three pillars of a hospital board's fiduciary duties are:

- The **duty of care**, which requires that directors make thoughtful and informed decisions through active engagement and oversight. Vigilance is important, and boards must assure themselves that they have sufficient information to make informed decisions, have ample opportunity to review information, and have the advice of experts as warranted. The board should adjust the extent and scope of its oversight to the circumstances.
- The **duty of loyalty**, which requires each director to act in the best interest of the organization and to put no personal interest ahead of this obligation.
- The **duty of obedience**, which requires the board of a non-profit organization to ensure the organization acts in accordance with its mission and purpose, and complies with the law.

It is important to distinguish between a situation in which a hospital or health system board should understand various alternatives for addressing significant financial distress, as opposed to that in which a hospital closure or downsizing plan needs to be evaluated immediately and, in all likelihood, executed. Each requires care and an understanding of how closures or downsizings take place, but the latter demands significantly greater board involvement.

Scenario 1: Board Assessment of Significant Financial Strain and Possible Future Responses

For many boards, it will be appropriate to establish a focused approach to assessing the current extent of financial and operational stress on a hospital or health system, and to evaluate potential future scenarios. This likely goes beyond the ongoing good work of the finance and strategic planning committees, and instead takes the opportunity for a deep dive into the current internal and external realities of financial health, reimbursement, care delivery, and market realities. Possible steps may include:

- Convene an interdisciplinary group, perhaps an *ad hoc* or advisory committee, to work with management to assess current financial realities and foreseeable possibilities in terms of organizational financial stress. Based on this financial assessment, the group should create a series of recommended actions and possible future steps for the enterprise.
- The board may want to establish, as an expected outcome of this group, a formal evaluation of both the financial conclusions and the possible future actions. Note that some or all of these future actions likely would be identified as possibilities rather than definitive action items. The goal would be to have a roadmap to guide future decision making, should it prove necessary, and to create a process for periodic board assessment of this evaluation.
- Aside from internal resources, the board may want to directly retain external subject matter experts to assist in these efforts.
- Possible future actions to be identified and understood certainly could include traditional initiatives such as expansion of service lines, launching of new facilities, effective fundraising, and pursuit of expanded government funding. At the same time, however, it should also consider, as appropriate, more aggressive measures such as the possible discontinuation of service lines, refinancing, affiliation with other organizations, and, as needed, downsizing or discontinuation of operations. For each of these measures, there should be an

understanding of what future metrics will trigger possible activation, areas of responsibility within the organization, the role of the board in decision making and oversight, the continuing process for assessing and implementing each type of measure, and the internal and external barriers to successful execution.
- This can be thought of as development of a plan that would be available to guide the organization as needed. As is the case with any such plan, it is better to know how the enterprise will organize itself, and details regarding implementation of possible responses, before the crisis hits.

Scenario 2: Board Action in the Face of Immediate Financial Duress

If a hospital or health system board finds that the organization's financial realities call into question its viability, then a more immediate, intensive, and action-oriented approach is needed. While third-party corporate affiliation or refinancing might be possible, it may be the case that the organization needs to evaluate closing or downsizing one or more facilities or service lines.[6] In this situation, the board should consider the following:

- The board bears ultimate responsibility for closure or downsizing, through the execution of its fiduciary duties. This requires that the board be fully engaged and organized, despite the inherent challenges of doing so under stressful circumstances.
- Aside from the duty of care, a non-profit board also should appreciate that the duty of obedience requires adherence to the hospital's mission, and therefore there should be a thoughtful and well-documented assessment of alternatives to closure or downsizing and why they were not feasible. This assessment also may prove beneficial in any regulatory or attorney general inquiries.
- These events are complex, and there should be a detailed closure or downsizing plan with clear responsibilities to ensure that the many governance, financial, workforce, clinical, patient safety, risk, legal, contractual, communications, and other issues are addressed.
- The board should understand which wind-down areas present the greatest risk. Frequently, for example, significant patient safety issues arise in the closure of a hospital, as staff dwindles.
- In some states, hospital closure or downsizing requires regulatory approval. For a non-profit organization, the state attorney general may oversee the disposition of assets for the benefit of the community.
- It is especially important that the organization, and perhaps the board separately, have access to competent outside experts. This includes financial and legal advice. If bankruptcy is possible, then insolvency counsel also should be included from the outset.
- Hospital closure or downsizing tends to be very contentious. A well-crafted and executed plan for communications and community engagement is advisable, and outside communications and government relations resources may be needed. Failure to address these issues can create impediments to timely action, up to and including litigation and government inquiry.

Conclusion

Hospitals and health systems have been experiencing significant stress and uncertainty in recent years, as reflected in the accelerating closure of facilities across the country. The COVID-19 pandemic amplifies this strain, especially for rural and safety net hospitals. Boards should take steps in the near term to evaluate financial and strategic metrics in an organized and interdisciplinary way, in order to develop a working plan for how future financial and operational realities will be addressed. This process should be unflinching in its assessment of the current state and the full range of possible future outcomes, and should lay out a process by which the board and management will continue to confront these issues on an ongoing basis. For boards of hospitals and health systems with immediate or foreseeable viability concerns, it is imperative to establish governance oversight in an engaged manner, taking into account the complexities associated with potential insolvency and possible closure or downsizing of facilities.

6 For an example of hospital closure guidelines, see *Hospital Closure Guidelines: Best Practices from the Field*, New Jersey Hospital Association Health Planning Department, 2008.

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Opportunities for Innovation in Addressing Patient Affordability: Reducing Patient Out-of-Pocket Costs

By Reshma Gupta, M.D., M.S.H.P.M., Executive Medical Director of Value and Population Care, UC Davis Health, and Evaluation and Outreach Director, Costs of Care, Inc., and Jordan Harmon, M.H.A., Vice President, Care Delivery Innovation, HSS Innovation Institute, and Director of Advocacy, Costs of Care, Inc.

Patient affordability is the leading healthcare concern for Americans and has dramatically worsened over the last decade. Recent efforts to improve "value" focus on "total costs of care," yet out-of-pocket costs for individual patients and unexpected medical bills continue to soar, creating a worsening affordability crisis. Meaningful ways to address patient affordability, particularly out-of-pocket costs, have been minimal, and hospitals and health systems have lacked tools and pathways to help guide implementation of improvement interventions. Consumers and patients are left with exposure to "financial toxicity," which has increased bankruptcy due to medical bills, reduced necessary care, and prevented individuals from getting adequate coverage.

As the nation now faces the COVID-19 crisis, it also faces an unprecedented economic crisis that burdens individual citizens throughout the country. Now, more than ever, there is a need to address financial toxicity, the overall cost burden to patients for a disease or condition. Patients, moreover, may avoid needed care if the costs of testing or hospitalization become unaffordable amid pandemic-related work and school restrictions. While multiple insurers such as Medicare, Cigna, and Anthem have reduced co-pays, there remain risks of surprise bills related to hidden COVID-related costs such as coverage for out-of-network facilities or what insurers may consider inappropriate care.[1] In light of this pandemic, the nation's patients may be at risk of increased viral spread, morbidity, and mortality if hospitals, health systems, payer, and policymakers lose ground in addressing patient affordability.

Key Board Takeaways

Boards should discuss the following questions with senior management:

- What data can we begin using (e.g., pharmacy data) to provide true patient price transparency to frontline care teams?
- What strategic plans exist to increase the training of our clinicians and staff to discuss the costs of care with patients?
- What structures could be built and resources available in the next year to develop clinical and financial care pathways to improve patient out-of-pocket costs?
- How can we best develop working relationships with financial and billing experts in our institution?
- What clinical venues are most cost-effective to reduce unnecessary medical bills for patients?

Financial toxicity is an area ripe for innovation. While new in healthcare, innovation to improve value and affordability for consumers is commonplace in other industries. Affordable care can be made possible by improving the pace of change to develop, test, and implement affordability interventions. Patient affordability efforts remain without clear roadmaps in which to innovate but create opportunities for health systems and medical groups to lead. This article highlights key areas healthcare boards and senior leaders should focus on when looking to improve patient affordability in their organizations.

Addressing Patient Affordability

To develop innovations addressing this problem, we outlined an affordability scale and methods to impact patient affordability (see table on the next page).[2] The patient affordability scale aims to help leadership identify tools and

1 Juliette Cubanski and Meredith Freed, "FAQs on Medicare Coverage and Costs Related to COVID-19 Testing and Treatment," Kaiser Family Foundation, March 30, 2020; "Health Insurance Providers Respond to Coronavirus (COVID-19)," AHIP Blog, April 6, 2020; Elisabeth Rosenthal and Emmarie Huetteman, "He Got Tested for Coronavirus. Then Came the Flood of Medical Bills," *The New York Times*, March 30, 2020.

2 Reshma Gupta, Jordan Harmon, and Patrick H. Conway, "The Next Frontier in Reducing Costs of Care: Patient Affordability," *NEJM Catalyst*, August 22, 2019.

improvement efforts throughout the country. Hospital and health system leaders need real solutions that allow their organizations to make positive changes that impact patients today. While new policies and incentive alignment by payers are required to create change, we believe that healthcare leaders can no longer stand by and wait for global solutions to the issue.

Improving patient affordability is one way that hospitals and health systems can deliver care with potential to increase the patient experience, ensure adherence to care plans and quality outcomes, and reduce financial harm to patients. Developing affordability improvement includes four key components.

Key Components for Health Care Systems to Address Patient Affordability

This table outlines ways to address patient affordability by using meaningful, actionable out-of-pocket cost and payment transparency; training clinicians to better address patient affordability concerns; developing clinical and financial pathways to address affordability; and delivering care by lower-cost, high-quality sites of care and care teams.

Components	Subcomponents
Use Meaningful, Actionable Out-of-Pocket Cost and Payment Transparency (i.e., functional with point-of-care decision-making)	• Arrange patient-facing data by payer, sites of care, and clinicians, which may involve creating strong relationships with payer entities • Establish a clear strategy to deliver transparent data to clinicians and staff about process and outcome measures to maintain accountability. Can include using unblinded, frequent data transparency for coaching purposes.
Train Clinicians to Better Address Patient Affordability Concerns	• Train clinicians and staff to use financial tools and have cost conversations • Establish accountability at all levels of care • Develop resources and general strategies to address affordability concerns
Develop Clinical and Financial Pathways to Address Affordability	• Implement universal screening • Support care pathway development • Institute high-risk committees to address needs of patients (particularly those who lack needed resources and agency)
Deliver Care Through Lower-Cost, High-Quality Sites of Care and Care Teams	• Medical care • Pharmaceutical care • Diagnostic testing

Source: The Authors

NEJM Catalyst (catalyst.nejm.org) © Massachusetts Medical Society

1. Out-of-Pocket Cost and Payment Transparency

Efforts to improve patient affordability will be at least partially reliant on having close partnerships with insurers and finance-billing specialists to have increased price transparency. As this field develops, hospitals and health systems can learn from others who have made strides in making out-of-pocket costs available to better prepare patients for future financial impacts. Real-time benefit information can be utilized to capture and provide cost information before any care is received. In addition, there are many institutions that are currently providing meaningful, actionable cost information. For example, the University of Utah Health created a pricing transparency tool that, with patient inputs about their health plan deductible or co-payments, provides estimates of out-of-pocket costs for common procedures.[3] Blue Cross Blue Shield of North Carolina posts cost and quality information online for consumers and when consumers select a high-value service at a lower-cost site, they are eligible for cash reimbursements. These are meaningful ways to ensure patients

3 See University of Utah Health, "Estimate Your Out-of-Pocket Costs" (available at https://healthcare.utah.edu/pricing).

Now, more than ever, there is a need to address financial toxicity, the overall cost burden to patients for a disease or condition.

get the care they need while reducing financial toxicity risks.

2. Clinicians Trained to Better Address Patient Affordability Concerns

Healthcare providers must be trained to deliver more affordable care. Engaging clinicians and staff who discuss costs, access data at the point-of-care, and incorporate it into care plans is critical to patient affordability. This may mean training care teams on proper resources available to them in the institution or beginning a conversation about affordable care trade-offs. With this information, care teams can use shared decision-making approaches to help patients make choices that are personal, appropriate, effective, and affordable.[4]

3. Clinical and Financial Pathways to Address Affordability

While the concept of clinical pathways has existed for decades, there is a unique opportunity in developing financial pathways that help patients and their care teams to navigate how to use resources wisely, expand billing process transparency, and reduce out-of-pocket costs. While knowledge and awareness of financial risk will help clinician-patient decision making, ultimately, there remains an additional challenge to build systems capable of reducing this risk like any other medical or social barrier to care. Kaiser Permanente Southern California integrated a financial screening tool that helps to identify community services. For example, when a patient screens positive for risk of financial harm, the care teams follow pathways to identify the patient's specific needs and social influencers of health, and then connect patients with community organizations to address them (e.g., Health Leads helps patients with financial counseling, assistance with transportation issues, or addressing food insecurity). For complex cases in which patients require care that is necessary and expensive, hospitals and health systems may require special committees to discuss ways to reduce costs including improved partnership with insurers and finance-billing specialists. These teams may need to create more robust partnerships with payers to help unique situations such as patients undergoing COVID-related care, as helping these patients will aid both financial and public health efforts.

4. Care Delivery by Lower-Cost, High-Quality Sites of Care and Care Teams

Finally, delivering care through lower-cost, high-quality care sites is critical to improving affordability. Hospitals and health systems can guide their patients toward more affordable care by developing networks that include care sites (i.e., medical, pharmaceutical, and diagnostic) that deliver higher value. In addition, network development may include creating systems to identify clinicians and staff (i.e., locally or remotely) trained to deliver more affordable care and to create new relationships with them. Costs of Care, for example, partnered with San Francisco-based Amino, to create a badge added to clinician profiles trained to hold "cost conversations" and highlight those who have extra training in this area.

To improve affordability, Costs of Care remains committed to increasing awareness, highlighting and developing evidence-based tools and models, and advocating for policy changes in patient affordability efforts. In December 2019, therefore, we launched our Affordability Moonshot, in which we "envision a world in which nobody has to choose between their life and their life-savings." Americans should be able to trust that when they need it the most, healthcare will be accessible and affordable. At Costs of Care, we are collecting stories, advocating for more affordable care, and sourcing real solutions through the Moonshot and forthcoming efforts. Please join us at www.costsofcare.org or moonshot.costsofcare.org.

4 At Costs of Care, we have helped publish over 500 stories on financial impacts of care as well as developed tools such as education modules for clinicians to utilize. Visit https://costsofcare.org for more information.

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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.

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.

Why PNAs Are Growing More Complex

From the outset, a PNA must take 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

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

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.

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.

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

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