HEALTH CAPITAL Topics
Volume 14
Issue 12
December 2021
Jessica L. Bailey-Wheaton, Esq., Editor
Todd A. Zigrang MBA, MHA, CVA, ASA, FACHE, Publisher

Valuation of Internal Medicine Services: Competition

Internists are considered part of the primary care industry, a service sector of growing importance to the healthcare delivery system despite increasing physician shortages. According to data from the American Board of Medical Specialties (ABMS), there are nearly 245,000 board-certified physicians in internal medicine.[1] This fourth installment of the five-part series on the valuation of internal medicine services will discuss the competitive landscape of the providers of internal medicine.

Supply of Internists

Over the next two decades, physician demand is anticipated to grow faster than supply, leading to a projected overall total shortage between 37,800 and 124,000 physicians by 2034.[2] A large proportion of the overall physician workforce is nearing traditional retirement age, indicated by the fact that more than two of every five active physicians in the U.S will be 65 or older in the next decade.[3] Combined with the strong growth in demand from the number of Americans over the age of 65 and the number of Americans with multiple chronic conditions, this indicates that the U.S. may soon face a serious shortage of internists. While the number of medical students in primary care is increasing, it is not sufficient to replace the number of retiring physicians, which means that there likely not be enough primary care (including internal medicine) physicians to treat the aging Baby Boomer population.[4] In fact, only about 25% of medical school graduates every year go into primary care fields.[5] Consequently, by 2034, the shortfall of primary care physicians, including internists, is estimated to be somewhere between 17,800 and 48,000 full-time equivalents (FTEs).[6]

In 2017, there were 2,758 individuals per internal medicine physician in the U.S.[7] Family and general practice physicians had a similar ratio of 2,804 patients per physician, while pediatricians had a much lower ratio of 1,429 patients per physician.[8] Recent studies indicate that primary care physicians generally have patient panel sizes ranging from 1,200 to 1,900 patients per physician.[9] This estimate is much lower than the 2,500 patients per physician often previously cited as the standard for panel size, and indicates a need for, and lack of, internal medicine and other primary care physicians to achieve optimum coverage of patients.[10] Further, the number of U.S. adults with a primary care physician has been falling in recent years, from 77% in 2002 to 75% in 2015, resulting in millions of Americans without a primary care physician.[11] The issue is much more pronounced in the younger adult population, where the rate declined from 71% to 64% over those years.[12]

The physician shortage has impacted those living in rural areas the most. Health Professional Shortage Areas (HPSAs) identify areas and populations that have a shortage of primary, dental, or mental healthcare providers primarily based on the number of healthcare professionals relative to the population.[13] Medically underserved areas/populations (MUA/P) are areas or populations designated by the Health Resources Services Administration (HRSA) as having too few primary care health services or having "economic, cultural, or language barriers" to healthcare.[14] As of December 2021, there were over 7,500 primary care HPSAs in the U.S. with California, Texas, Missouri, and Alaska having the greatest number of those designations.[15] Additionally, there were over 3,400 MUAs and 482 MUPs, which were concentrated in California, Texas, Illinois, Georgia, and Pennsylvania.[16]

In order to ameliorate the primary care shortage and meet the growing demand for healthcare services, healthcare enterprises are increasingly relying upon non-physician practitioners (NPPs), and have lobbied for an expansion in the role of the non-physician workforce to provide services that support, supplement, and parallel physician services. In light of the fact that the gap between the supply and demand for physician services is projected to increase significantly, as the sources of physician manpower remain insufficient, and as the drivers of demand (i.e., the aging Baby Boomer population and the increased number of insured individuals) intensify, the NPP workforce is expected to see continued growth in both scope and volume in the future, as enterprises adopt care models that strategically allocate physician and non-physician manpower resources. According to the U.S. Bureau of Labor Statistics, nurse practitioner job growth is expected to be 45% from 2020 to 2030, much faster than the average for all occupations.[17] As of 2021, 24 states, including the District of Columbia, allow nurse practitioners full independent practicing authority, which includes the ability to: "evaluate patients; diagnose, order and interpret diagnostic tests; and initiate and manage treatments, including prescribing medications and controlled substances, under the exclusive licensure authority of the state board of nursing."[18] Those states effectively allow nurse practitioners the same scope of

(Continued on next page)

practice as physicians, showcasing the potential of NPPs to help ameliorate the coming physician shortage.[19]

Demand Drivers for Internal Medicine

The growing elderly patient population utilizes a greater proportion of (and expenditures related to) medical services relative to the rest of the general population, and as such may comprise a growing part of the patient population in future years. Specifically, the demand for internal medicine services come primarily from older adults (with internal medicine constituting a major share of visits for those over age 45) and those with multiple, complex, chronic conditions. As of 2018, the number of Americans age 45-64 increased by 7%, reaching a total of 83.9 million.[20] The prevalence of chronic disease nationwide has also been on the rise, with 60% of adults having one chronic disease and 40% having two or more chronic conditions.[21]

Increasing attention is also being paid to primary care, on both a research and legislation level, as a way to reduce costs and improve patient outcomes. U.S. health outcomes lag behind those of other wealthy countries, despite spending far more on healthcare than those countries.[22] Currently, only 5 - 7% of healthcare spending is devoted to primary care, with less than 5% of Medicare fee-for-service spending (i.e., spending related to patients aged 65+) going to primary care costs.[23] In contrast, countries with better health outcomes often spend two to three times more on their primary care systems.[24] Studies have shown that primary care significantly lowers patients' odds of premature death and save money by reducing unnecessary hospitalizations and by diagnosing and treating medical issues earlier.[25] With the U.S. healthcare industry's increasing focus on value-based reimbursement (VBR), which incentivizes the provision of higher-quality care at lower cost, some of this discrepancy between low spending and high proportions of office visits for primary care may ultimately be eliminated.[26]

1 "ABMS Board Certification Report 2019-2020" American Board of Medical Specialties, November 2020, available at: https://www.abms.org/wp-content/uploads/2020/11/ABMS-Board-Certification-Report-2019-2020.pdf (Accessed 11/29/21), p. 3.
2 "The Complexities of Physician Supply and Demand: Projections from 2019 to 2034" Association of American Medical Colleges, June 2021, p. viii.
3 "AAMC Report Reinforces Mounting Physician Shortage" Report for the Association of American Medical Colleges, June 11, 2021, https://www.aamc.org/news-insights/press-releases/aamc-report-reinforces-mounting-physician-shortage (Accessed 11/29/21).
4 "Physician workforce in the United States of America: forecasting nationwide shortages" By Xiaoming Zhang, et al., Human Resources for Health, Vol. 18, No. 8 (2020) available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7006215/ (Accessed 12/18/21).
5 "The Case for Primary Care" Primary Care Progress, https://www.primarycareprogress.org/primary-care-case/ (Accessed 11/29/21).
6 Association of American Medical Colleges, June 2021, p. 7.
7 "Number of People per Active Physician by Specialty, 2019" Association of American Medical Colleges, January 2021, https://www.aamc.org/what-we-do/mission-areas/health-care/workforce-studies/interactive-data/number-people-active-physician-specialty-2019 (Accessed 11/29/21).
8 *Ibid*.
9 "A Primary Care Panel Size of 2500 Is neither Accurate nor Reasonable" By Melanie Raffoul, Miranda Moore, Doug Kamerow, and Andrew Bazemore, Journal of the American Board of Family Medicine, Vol. 29, No. 4 (July 2016), p. 496-497.
10 *Ibid*.
11 "Declining numbers of Americans have a primary care provider" By Linda Carroll, Reuters, December 16, 2019, https://www.reuters.com/article/us-health-pcp-trends/declining-numbers-of-americans-have-a-primary-care-provider-idUSKBN1YK1Z4 (Accessed 11/29/21).
12 *Ibid*.
13 "What is Shortage Designation?" Health Resources and Services Administration, https://bhw.hrsa.gov/workforce-shortage-areas/shortage-designation (Accessed 12/18/21).
14 *Ibid*.
15 "Explore HPSAs" Health Resources Services Administration, December 17, 2021, https://data.hrsa.gov/topics/health-workforce/shortage-areas (Accessed 12/18/21).
16 *Ibid*.
17 "Occupational Outlook Handbook, Nurse Anesthetists, Nurse Midwives, and Nurse Practitioners" Bureau of Labor Statistics, U.S. Department of Labor, September 8, 2021, https://www.bls.gov/ooh/healthcare/nurse-anesthetists-nurse-midwives-and-nurse-practitioners.htm (Accessed 11/29/21).
18 "State Practice Environment" American Association of Nurse Practitioners, January 1, 2021, https://www.aanp.org/advocacy/state/state-practice-environment (Accessed 11/29/21).
19 *Ibid*.
20 "2019 Profile of Older Americans" Administration for Community Living, May 2020, https://acl.gov/sites/default/files/Aging%20and%20Disability%20in%20America/2019ProfileOlderAmericans508.pdf (Accessed 11/29/21).
21 "Chronic Diseases in America" Centers for Disease Control and Prevention, January 12, 2021, https://www.cdc.gov/chronicdisease/resources/infographic/chronic-diseases.htm (Accessed 11/29/21).
22 "The Importance Of Primary Care—And Of Measuring It" By Hoangmai Pham and Anne Greiner, Health Affairs, August 6, 2019, https://www.healthaffairs.org/do/10.1377/hblog20190802.111704/full/ (Accessed 11/29/21).
23 *Ibid*.
24 *Ibid*.
25 Primary Care Progress," https://www.primarycareprogress.org/primary-care-case/ (Accessed 11/29/21).
26 For more information on VBR, see "Valuation of Internal Medicine Services: Reimbursement," Health Capital Topics, Vol. 14, No 10 (October 2021), https://www.healthcapital.com/hcc/newsletter/10_21/HTML/INTERNAL/convert_internal-med-reimbursement-topics.php (Accessed 11/29/21).

(Continued on next page)

HCC
HEALTH CAPITAL CONSULTANTS

(800)FYI - VALU

Providing Solutions in the Era of Healthcare Reform

Founded in 1993, HCC is a nationally recognized healthcare economic financial consulting firm

- HCC Home
- Firm Profile
- HCC Services
- HCC Experts
- Clients & Projects
- HCC News
- Upcoming Events
- Contact Us
- Email Us

HCC Services

- Valuation Consulting
- Commercial Reasonableness Opinions
- Commercial Payor Reimbursement Benchmarking
- Litigation Support & Expert Witness
- Financial Feasibility Analysis & Modeling
- Intermediary Services
- Certificate of Need
- ACO Value Metrics & Capital Formation
- Strategic Consulting
- Industry Research Services

Todd A. Zigrang, MBA, MHA, CVA, ASA, FACHE, is the President of **HEALTH CAPITAL CONSULTANTS** (HCC), where he focuses on the areas of valuation and financial analysis for hospitals, physician practices, and other healthcare enterprises. Mr. Zigrang has over 25 years of experience providing valuation, financial, transaction and strategic advisory services nationwide in over 2,000 transactions and joint ventures. Mr. Zigrang is also considered an expert in the field of healthcare compensation for physicians, executives and other professionals.

Mr. Zigrang is the co-author of "*The Adviser's Guide to Healthcare – 2nd Edition*" [2015 – AICPA], numerous chapters in legal treatises and anthologies, and peer-reviewed and industry articles such as: *The Accountant's Business Manual* (AICPA); *Valuing Professional Practices and Licenses* (Aspen Publishers); *Valuation Strategies; Business Appraisal Practice*; and, *NACVA QuickRead*. In addition to his contributions as an author, Mr. Zigrang has served as faculty before professional and trade associations such as the American Society of Appraisers (ASA); American Health Lawyers Associate (AHLA); the American Bar Association (ABA); the National Association of Certified Valuators and Analysts (NACVA); Physician Hospitals of America (PHA); the Institute of Business Appraisers (IBA); the Healthcare Financial Management Association (HFMA); and, the CPA Leadership Institute.

Mr. Zigrang holds a Master of Science in Health Administration (MHA) and a Master of Business Administration (MBA) from the University of Missouri at Columbia. He is a Fellow of the American College of Healthcare Executives (FACHE) and holds the Accredited Senior Appraiser (ASA) designation from the American Society of Appraisers, where he has served as President of the St. Louis Chapter, and is current Chair of the ASA Healthcare Special Interest Group (HSIG).

Jessica L. Bailey-Wheaton, Esq., is Senior Vice President and General Counsel of HCC. Her work focuses on the areas of Certificate of Need (CON) preparation and consulting, as well as project management and consulting services related to the impact of both federal and state regulations on healthcare transactions. In that role, Ms. Bailey-Wheaton provides research services necessary to support certified opinions of value related to the Fair Market Value and Commercial Reasonableness of transactions related to healthcare enterprises, assets, and services.

Additionally, Ms. Bailey-Wheaton heads HCC's CON and regulatory consulting service line. In this role, she prepares CON applications, including providing services such as: health planning; researching, developing, documenting, and reporting the market utilization demand and "need" for the proposed services in the subject market service area(s); researching and assisting legal counsel in meeting regulatory requirements relating to licensing and CON application development; and, providing any requested support services required in litigation challenging rules or decisions promulgated by a state agency. Ms. Bailey-Wheaton has also been engaged by both state government agencies and CON applicants to conduct an independent review of one or more CON applications and provide opinions on a variety of areas related to healthcare planning. She has been certified as an expert in healthcare planning in the State of Alabama.

Ms. Bailey-Wheaton is the co-author of numerous peer-reviewed and industry articles in publications such as: The Health Lawyer; Physician Leadership Journal; The Journal of Vascular Surgery; St. Louis Metropolitan Medicine; Chicago Medicine; The Value Examiner; and QuickRead. She has previously presented before the ABA, the NACVA, and the NSCHBC. She serves on the editorial boards of NACVA's QuickRead and AHLA's Journal of Health & Life Sciences Law.

Janvi R. Shah, MBA, MSF, serves as Senior Financial Analyst of HCC. Mrs. Shah holds a M.S. in Finance from Washington University Saint Louis. She develops fair market value and commercial reasonableness opinions related to healthcare enterprises, assets, and services. In addition she prepares, reviews and analyzes forecasted and pro forma financial statements to determine the most probable future net economic benefit related to healthcare enterprises, assets, and services and applies utilization demand and reimbursement trends to project professional medical revenue streams and ancillary services and technical component (ASTC) revenue streams.