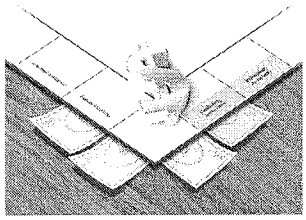
PREV Doctor review websites are a growing factor f ...

Increase Font

Medical Economics Practice Management

Monopolizing medicine: Why hospital consolidation may increase healthcare costs

February 24, 2014 By Scott Ballic



Hospitals across the United States are merging and purchasing physician practices at a faster clip than they have in decades. While some experts believe the pace of acquisition is not sustainable, the economic forces driving hospital consolidation is also driving up the cost. For employed physicians, that could mean employment trouble. For independent groups, it could signal opportunity.

The consolidation trend has been promoted by reform efforts seeking to reduce waste and reward value instead of volume, but these monopolizing forces are contributing to a rise in cost, according to recent studies. While independent practices struggle with payer pressures and management challenges, they are delivering a greater quality/value proposition overall. Some experts say it could be enough to tip the market.

Independent physicians have a strong move yet to play. Put simply, fighting to preserve physician autonomy may be one key to help rein in America's enormous medical bills.

That cost differential favoring independent physicians could theoretically give them a competitive advantage with insurers and patients, adds H. Christopher Zaenger, CHBC, chief executive officer of Z Management Group in Barrington, Illinois, and a *Medical Economics* editorial consultant, but it won't be a factor until that information can become more publicly known.

"Healthcare is less affordable than ever for the average American family," according to the Association of Independent Doctors. "Independent doctors have a critical role in our nation's ability to sustain affordable and high quality care."

Hospital acquisitions lead to higher prices

Through mergers and acquisitions, hospitals have grown larger and gathered more physicians under their control in the last decade or so. More than 105 hospital mergers occurred in 2012, up from about

RESOURCE CENTERS PARTNER CONTENT

Meaningful Use 2

Oncology: Practice Management

Preparing for ICD-10

Diabetes Care and Management

Gastrointestinal Disease

MORE

50 to 60 annually from 2005 through 2007, according to a January report in the *New England Journal of Medicine*.

As for physician employment, a 2012 survey by American Hospital Association showed that between 2000 and 2010, hospital employment of physicians increased by 32%. As of 2012, the majority of physicians were employees instead of owners, according to a survey conducted by the American Medical Association. Nearly 58% of family physicians and 50% of internists identified themselves as employees.

One reason hospitals are buying physician practices is a strategy by administrators to find new revenue streams by shifting more healthcare services out of hospitals and into outpatient centers, says Paul Keckley, PhD, a Nashville-based healthcare industry analyst and blogger.

But has the consolidation and acquisition reduced healthcare costs? The answer is no, experts say.

"Hospital acquisition of physician practices leads to higher prices," adds Paul Ginsburg, PhD, president of the Center for Studying Health System Change, a non-partisan think tank that studies the healthcare industry.

Office vs. hospital payments

Medicare fee-for-service payments for non-emergency evaluation and management (E&M) patient visits differs between office-based physicians and hospitals. In its 2013 report, MedPAC called for "site neutral" payments for E&M visits between physician offices and hospital outpatient departments.

CPT Code	Office-based physician payment	Hospital Payment*
99201	$41.11	$78.18
99202	$71.01	$124.06
99203	$102.95	$174.46
99204	$158.33	$254.87
99205	$197.06	$331.33
99211	$19.71	$61.53
99212	$41.45	$100.27
99213	$68.97	$124.40
99214	$102.27	$175.48
99215	$137.60	$235.51

SOURCE: Centers for Medicare and Medicaid Services, 2011
*Hospital payments include payment to physician and payment to hospital.

In May 2013, the *Denver Post* reported on a patient who received the same cardiac stress test twice from the same cardiologist. The first test, when the physician was independent, cost about $2,100. The second test, performed a year later after the practice was purchased by a local hospital, cost more than $8,000, mostly because of an added facility fee by the hospital, the newspaper reported.

A March 2013 report by the Medicare Payment Advisory Commission, an independent Congressional panel that oversees Medicare, acknowledged that an office visit with a physician in a hospital outpatient department is reimbursed at a rate 80% higher than the same procedure performed in a physician's office. As a result, the report cites a steady shift of services from physicians' offices to outpatient departments from at least 2009, "consistent with the financial incentives in the current payment system." MedPAC "expressed concern that higher payment rates in OPDs [outpatient departments] may induce hospitals to acquire physician practices and deem these practices part of the OPD."

The stunning result: On only two services—evaluation and management visits and echocardiograms—Medicare paid hospitals $1.3 billion more in 2010 than they would have paid if the services had been performed in a physician's office rather than an outpatient department, MedPAC reports. In 2011, that number rose to $1.5 billion.

Economies of scale?

Advocates of healthcare consolidation argue that economies of scale will, in time, reduce waste in the system and ultimately push prices down. Hospital consolidation can promote competition to the extent that it can reduce costs through less duplication of equipment and better internal oversight, says Matthew Cantor, a partner with the law firm Constantine Cannon in New York.

Not far from the Long Island office of Michael J. Wiley, CHBC, AVA, of Healthcare Management and Consulting Services Inc., and a *Medical Economics* editorial consultant are two 400-bed hospitals just four miles apart. Both have cardiology and orthopedics units, which are particularly important for filling beds. Were the hospitals to merge, Wiley says, it would be easy to remove those duplicate services, and the "center of excellence" concept could facilitate that process.

Besides, Wiley notes, insurers find it more expensive to manage multiple providers and hospitals, so there's a potential benefit for them when health systems consolidate.

But despite these promises, economies of scale from hospital mergers and practice acquisitions are difficult to find, says David Dranove, PhD, professor of health industry management at Northwestern University's Kellogg School of Management in Evanston, Illinois. Dranove, who points to a June 2012 report by the Robert Wood Johnson Foundation.

The foundation's Synthesis Project released a report summarizing three dozen published studies on the effects of hospital mergers and hospital acquisition of physician practices on prices, costs, and quality of care. The report, written by Martin Gaynor, PhD, of Carnegie Mellon University, and Robert Town, Ph D, of The Wharton School at the University of Pennsylvania, presents some key findings:

- Hospital consolidation generally results in higher prices across geographic markets.
- When hospitals merge in already concentrated markets, the price increase can be dramatic, often exceeding 20 percent.
- Physician-hospital consolidation has not led to either improved quality or reduced costs. Such consolidation was found to have been undertaken "primarily for the purpose of enhanced bargaining power with payers" and therefore did not lead to true integration nor to enhanced performance.

One possible reason for the lackluster results is lack of clinical integration following mergers or acquisition of practices.

"Most hospitals that have hired all these doctors have done nothing with them but cut them a W-2," says Alice G. Gosfield, JD, of Alice G. Gosfield and Associates, Philadelphia, a healthcare attorney and *Medical Economics* editorial consultant.

Hospitals sometimes passively hire physicians who admit lots of patients, high-priced specialists and "random physicians to garner their referrals," Gosfield says, but this works against creating a culture that can sustain a high-value, high-quality health system. Some hospitals have been able to boost collaboration with doctors, but others tend to think that they own doctors, agrees William J. DeMarco, MA, CMC, president and chief executive officer of Pendulum HealthCare Development Corp. in Rockford, Illinois.

Fallout for physicians

The big question is why hospitals are working so hard to expand, both horizontally through mergers and vertically through acquisitions of practices, and what the fallout will be for physicians.

Hospitals are facing growing financial uncertainty due to the tension between quantity and quality, between a known reimbursement scheme based on volume and a newer one based on value.

"We're at a point of inflection," says Caroline Steinberg, vice president/trends analysis at the American Hospital Association. "Hospitals feel like they have one foot on the boat and one foot on the dock" as the healthcare sector transitions from a primarily fee-for-service model to a new world of accountable care organizations and bundled payments.

A "crossfire" between a system based on volume and another based on value is how Keckley describes it. "Hospitals have to live in both worlds simultaneously."

Hospitals are facing lower reimbursements from Medicare and other payers and—in an environment where performance is measured and quality increasingly drives reimbursements—they can expect to see fewer admissions than they currently do, says Gosfield.

"The problem of managing dollars and quality of care ... has been the main struggle in healthcare for decades," says Michael D. Brown, CHBC, president of Health Care Economics in Indianapolis, Indiana and a *Medical Economics* editorial consultant. "We all want quality, but finding a way to pay for it is the problem."

"One of the big uncertainties" for hospitals now, says Ginsburg, is which trend will dominate: lower admission rates or an ACA-expanded patient pool, with a high proportion of older patients. For hospitals, he says: "The future is what's done in offices, or in the home, or in retail," not on an inpatient basis.

The employment lure

This is the third cycle of hospitals buying up physician practices in recent decades, says Zaenger, who has observed the healthcare industry for about 30 years. He says this buying trend is different.

"We have legislation that gives legs to the model," Zaenger says, because the Affordable Care Act sets a framework for community-level integration among hospitals, ambulatory facilities, and physicians.

Zaenger says the primary reason physicians sell their practices and join a hospital system as an employee is that they think they're eliminating administrative chores and stress. They also hope to make as much money with less work, or more money for the same amount of work—which often turns out to be an illusion.

A boom in practice acquisitions in the early 1990s managed-care era was driven by hospitals' desire to have primary-care physicians as referral sources, says Ginsburg. The current question, he adds, is: "How much better are they at it now? Can those practices be profitable for a hospital?"

The offer of working for a hospital can certainly be compelling for physicians, says Wiley. "There's a wave toward being employed by hospitals," he says, and it appears strongest among primary care physicians (PCPs).

Take an independent PCP earning $150,000 annually, under more stress every year, and facing the need to spend $25,000 on an electronic health record (EHR) system. Wiley suggests that if a hospital were to offer that physician $175,000 annually, and "All you have to do is be a doctor," that could be a difficult proposition to turn down.

And hospitals are casting a wider net this time, Ginsburg says, targeting specialists as well as PCPs.

Research by the Deloitte Center for Health Solutions, where Keckley was executive director from 2006 until 2013, found that 60% of primary care practices are now exclusively aligned with a single hospital, though not necessarily employed by it, Keckley says.

But as hospitals absorb ever more physicians and practices, experts suggest that the choice for the remaining private practices may not be so cut and dried between independence and employment.

Many physicians are weighing the growing burdens of private practice against the ability to focus on patient care and clinical efforts as an employee. Many doctors are selling because they feel they have no better choice.

"Doctors really don't want to sell their practices," says Zaenger. "They do it kicking and screaming."

Degrees of independence

Practice management consultants say a vast and potentially rewarding middle ground exists between slugging it out as an independent and giving it all up for a hospital's paycheck.

The first strategy for preserving independence, says Gosfield, is to clinically integrate with other physicians. Clinical integration, she says, is a process of physicians working together systematically to improve their collective ability to deliver high-quality, safe patient care.

The crucial element in integration is standardization, Gosfield adds. This includes not only the expectation that all participants will use and adhere to clinical practice guidelines and protocols, but also that standards for referrals (based on clinical performance of those providers) and standardized documentation.

Physicians like independence but also want access to greater resources that only affiliation with a hospital can typically bring, says Pendulum Healthcare's DeMarco. While hospitals might sometimes seem to be saying to doctors, "Work for us—or else" he says, the doctor's question for the hospital should be "What can I do to connect with you?"

And the ways to connect are plentiful. In addition to simply forming larger group practices, one option that has seen renewed interest is the independent practice association (IPA), Ginsburg says.

IPAs, which are particularly active in areas with substantial health maintenance organization (HMO) enrollment such as California and Massachusetts, contract with HMOs for professional services and can accept some risk, such as through capitated payments.

"There are more opportunities for risk-based contracting in general," and IPAs can play into those, Ginsburg adds.

Although the individual practices remain separately owned, the IPA supports them with health information technology and EHR, and can handle functions such as utilization management. Ginsburg also notes that doctors don't have to be exclusive to an IPA.

"Small independent practices have been subjected to a lot of pressures" from the financial side and from meaningful use, Ginsburg says, so an IPA could make it possible for a small practice to thrive.

Ginsburg does sound one note of caution: "There are more paths to remain independent these days, but only if there are enough partners left to do these things with," he says. "If too many independent practices are bought up," it limits the opportunities to form IPAs.

There are other approaches, which Gosfield calls "alignment strategies," that fall short of hospital employment. These include co-management, a contract under which a hospital leases nurse practitioners to a practice (the doctor bills retail, but pays wholesale), or leasing an entire practice to a hospital through a professional services agreement.

"Grouping is becoming a model," Zaenger says, but adds, "The downside to grouping for physicians is the loss of control." Physicians, especially those in the 45 to 55 age range tend to be independent, he says, but they still want leverage with insurers.

Still, the benefits are there. Zaenger knows of a gastroenterology group in the Chicago area that has grown from seven doctors to more than 35 over a period of about four years and is now the largest such group in suburban Chicago. The group's "strategic business unit" model lets each individual practice maintain some independence and divide revenue internally however they wish.

These days, some type of collaboration or alignment is needed, but the form can be flexible, such as through an accountable care organization, says DeMarco. An affiliation agreement between a practice and a hospital, short of selling the practice, might involve services often otherwise provided by a management service organization, such as help with billing, EHRs, office staff and coding, and continuing medical education, he says.

In addition to the physicians it employs outright, says DeMarco, the Cleveland Clinic offers an affiliate program and an associate program, and the Mayo Clinic provides similar options. An ob/gyn group in

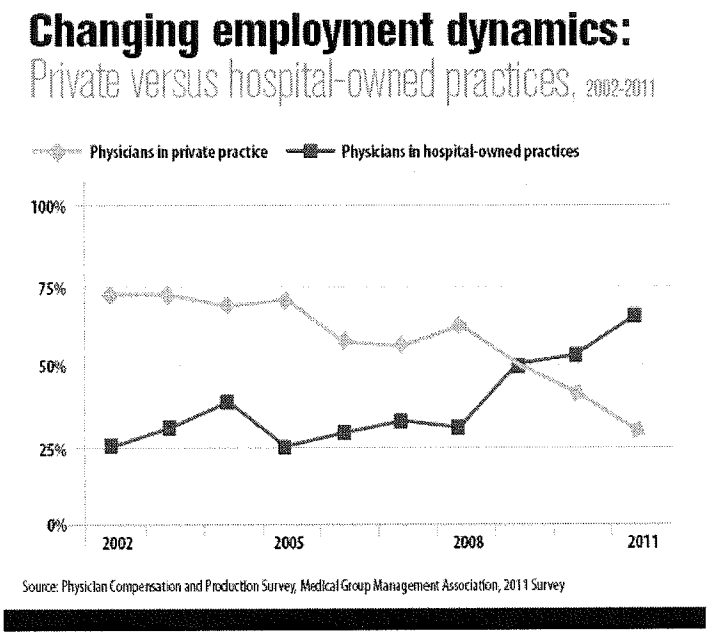
Cedar Rapids, Iowa, affiliated with Mayo and was so successful that it eventually drove the only other local ob/gyn practice out of business, he says.

Just remember that the ultimate goal of any affiliation won't necessarily be to achieve an ideal compromise, but simply to find a solution that can work over the long term.

Shifting employment environment

If, as Dranove predicts, practices will continue to increase in size, it could be driven by the attitudes of younger physicians. They don't mind being employees, says Ginsburg.

Physicians who are in training now expect to work within healthcare systems, Keckley agrees, while Baby Boomer physicians have a stronger entrepreneurial, go-it-alone streak. "Boomer doctors don't make good employees," he says.



The physicians who are most willing to sell their practices, says Zaenger, are predominantly "the green and the gray docs," that is, those freshly out of school and those nearing retirement.

Still, several factors point toward a more challenging job setting in the future. Cantor says greater hospital control might lead to reduced employment opportunities for certain physicians. Steinberg foresees layoffs and reductions in services, citing a hospital that closed its obstetric unit and one in New Hampshire that recently closed its skilled nursing facility.

Hospitals are going to have to do more with less, Wiley predicts, adding that it's more cost-effective to get a given amount of work done with two $500,000-a-year doctors than three $400,000 doctors, especially once you consider the savings in benefit packages and malpractice insurance.

Another piece of the new environment, Wiley says, is productivity measures using Relative Value Units, versus the previous model of a flat salary with no corresponding productivity requirements.

"If you came from a private practice, you know the need to be productive," but productivity requirements, which have long been used by hospitals, can still be a shock for physicians who aren't used to them. "To be profitable, hospitals have to change that mind set," Wiley says.

One bright spot is that although hospitals traditionally relied on specialists, reform efforts require strength in primary care, says Keckley. "As you transition from volume to value, primary care physicians become more important."

Sharable short link to this article:

medec.com/medicinemonopoly

Facebook

Tags hospital employment hospital mergers hospitals Modern Medicine Feature Articles

physician pay physician recruitment private practice Health Law & Policy Practice Management

linkedin

Scott Baltic

Email

MORE

4 COMMENTS

Increase Font

You must be signed in to leave a comment. Registering is fast and free! SIGN IN / REGISTER

All comments must follow the ModernMedicine Network community rules and terms of use, and will be moderated. ModernMedicine reserves the right to use the comments we receive, in whole or in part,in any medium. See also the Terms of Use, Privacy Policy and Community FAQ.

ChristopherMajdi Jul 16, 2014

I think we will see many more practice acquisitions by independent medical groups and private equity groups. For the most part, hospital acquisitions don't offer physicians much in the way of goodwill and intangibles. Given the focus on payment disparity issues by CMS and MedPac, as well as other operational concerns related to practice-hospital integrations, you're going to see a lot of these hospital deals fall apart. Overall I think the future climate bodes well for private practice physicians despite all the doom and gloom rhetoric. This is especially relevant for primary care providers given the reimbursement rebalancing related to health reform. - Christopher Majdi, MS, CHBC, CBA, CVA. http://transitionconsultants.com/articles/524-healthcare-mergers-and-acq...

Login or Register to post comments

GEORGEROGU Feb 24, 2014

Selling out to a hospital or a system is exactly that "Selling out"

Login or Register to post comments

Anonymous Feb 24, 2014

Somehow I missed the part where higher fees for hospital based physicians is a bad thing. Hospitals aggregate physicians services giving them more leverage to negotiate higher fees. Private practice physicians have no leverage at all and have to accept whatever insurance companies grudgingly pay us. This is the reason most physicians have joined hospital groups and why private practice medicine is dying. Aside from the administrative burden it difficult to do business in an environment where the doc down the street working for the hospital is getting paid twice as much for any given service. Joining a hospital owned group gives a physician the opportunity to recoup some of the income that his been stolen from him over the years by large insurance companies who had all the power. Joining a hospital group balances the equation in favor of the physicians.

Login or Register to post comments

Anonymous Feb 24, 2014

Spoken like a physician looking for the "good old days" of medicine when high usual and customary charges were routinely paid. Though I agree that private practice physicians only leverage is to say no to low paying health care plans(often not really any leverage at all) it is important to recall that hospitals are institutions run with an eye toward growth and revenues, despite many of them hiding behind 'not-for'profit' status; and as institutions they will do whatever it takes to remain profitable

There is no loyalty to the physician employee, and unfortunately too many physicians are again learning this lesson. To join a hospital staff to receive the higher reimbursement which in many instances the hospital keeps for itself for the exact same service as provided in a physician office is short sighted and unsustainable for the health care system overall. Every house of cards comes down at some point.

Facebook

Login or Register to post comments

linkedin

Email

Increase Font

BUSINESS & TECHNOLOGY
WOMEN'S HEALTH
CHILDREN'S HEALTH
MEN'S HEALTH
SKIN
PHARMACY
EYECARE
CAREERS

Medical Economics

CONNECT

HOME
BUSINESS
TECHNOLOGY
MONEY
POLICY
EHRS