Testimony to House Health Care Committee
April 10, 2015

Healthy competition in the health care marketplace should be driving a balance of quality and price for health care services. However, vertical integration of health systems may actually be having the reverse effect for the consumer.

See article on Healthy Competition by Gwen Simons, ESQ

See abstract on Growing Power of Some Providers… Robert Berenson

See abstract on Vertical Integration: Hospital Ownership of Physician Practices is Associated with Higher Prices and Spending

See two charts of: Physician Self Referral Scenario and Hospital System Self Referral. These illustrate the corporate practice of Medicine that is banned in multiple states at this time. The same corporate profit motive is present to self refer within the corporation, and effectively eliminates healthy competition.

This is detrimental to the consumer and can drive up the cost of care for the consumer as illustrated above.

Patient Choice during referrals will go a long ways to protect patient choice and help preserve competition that keeps prices lower for the consumer.

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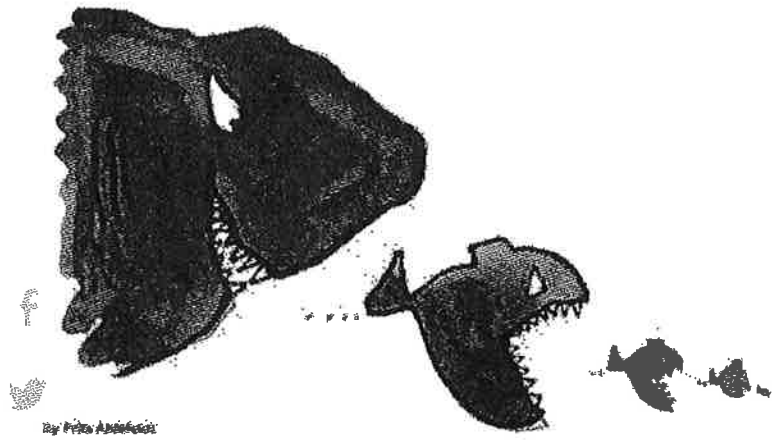
Healthy Competition?



Is anticompetitive conduct by HOPTS and ACOs driving you out of business? Maybe the Federal Trade Commission can help!

BY GWEN SIMONS, ESQ, PT, OCS, FAAOMPT

The Federal Trade Commission (FTC) historically has been concerned about hospital mergers that tend to foreclose competition between hospitals, although more recently, the FTC has grown concerned about the substantial growth in hospital acquisition of physician practices and its potential effects on health care competition. The number of physician practices owned by hospitals more than doubled between 2002-2008.[1] It's not unusual to hear that in some geographic areas of the country, 75 percent of primary care physicians are hospital employees. Declining reimbursement, greater administrative/compliance burdens, and increasing technology needs (i.e., EMR systems) have converged to facilitate a consolidation of hospitals and physicians. The Affordable Care Act seems to have incentivized this further by promoting Medicare Accountable Care Organizations (ACOs). The end result of all this consolidation, whether through acquisition, merger, or contractual arrangements between hospitals and physicians in an ACO, is a growth in Hospital-owned Physical Therapy Services (HOPTS) that is threatening the survival of private practice. The question is: "is this trend helping or harming consumers?"

A recent study published in *Health Affairs* shows that hospital acquisition of physician services (leading to "fully integrated organizations") results in a 3.2 percent increase in prices.[2] Vertical alignment of hospitals and physicians, raises can harm consumers in several ways. Hospitals can

employ physicians to increase hospital admissions, diagnostic testing, and outpatient services.[3] By employing physicians, and paying them handsomely, both physicians and hospitals can circumvent Stark and Antikickback laws.[4] Hospitals can also use exclusive relationships with physicians to gain a competitive advantage over their competition.[5] And lastly, by bundling physician and hospital services together, they may be able to charge higher prices to insurers (or at least gain a negotiating advantage).[6]

Supporters of ACOs believe better integration, communication, and coordination of care will ultimately result in better outcomes, thus justifying, perhaps, modest increases in prices. The assumption of this ACO integrated model, however, is that every patient will need multiple services from multiple health care providers who need to integrate, communicate, and coordinate their care. While improvements in coordinating care might be necessary for the 10 percent of the people who account for 64 percent of U.S. health care costs,[7] it might not be needed for the other 90 percent of U.S. citizens who just want to get the physical therapy services they need from the most qualified, cost-effective provider. Therefore, any potential procompetitive benefits to receiving care in a vertically integrated hospital-physician system won't likely outweigh the higher costs of physical therapy at a hospital. Hospital charges for physical therapy (and reimbursement) in general tend to be two to four times more than what the typical private practice is paid per visit. Add the "facility fee" onto that and the patient's 20 percent copay might end up costing as much as the entire visit at a private practice! Therefore, any relationship between hospitals and physicians, employment or contractual, that tends to divert referrals from private practitioners to hospital-owned facilities has great potential to substantially harm consumers.

The FTC is starting to recognize the impact hospital acquisition of physician practices can have on competition and the cost of health care. In a recent FTC case, a federal judge ruled that St. Luke's Health System in Idaho violated federal and state merger laws when it acquired Idaho's largest independent physician group. The FTC argued that because the acquisition would give St. Luke's 80 percent of the primary care physicians in the market, the deal would foreclose competition in the primary care market (a horizontal integration problem between physicians even though the hospital ownership of the physicians was also a vertical integration with St. Luke's). St. Luke's tried to argue the procompetitive effects of the merger, such as being in a better position to deliver integrated care. But the judge, relying on expert testimony, found that "physicians are committed to improving the quality of health care, and lowering its cost, whether they are employed or independent." In other words, financial integration is not necessary for clinically integrated care to occur. The judge ordered divestiture of the merger but as of the time this article was written, the case had been appealed to the Ninth Circuit Court of Appeals.

As hospital acquisition of physician practices and formation of ACOs continues to grow, private practitioners need to know what anticompetitive conduct that violates antitrust laws looks like. First look for how much control the hospital system/ACO (or any other competitor, for that matter) has over the market for PT services, as well as the percentage of primary care and specialty physicians the entity has control over, either through employment or contractual relationships. Anything over 50 percent is most certainly a monopoly share, but some case law indicates control over as little as 40 percent of the market could be dangerously close to acquiring a monopoly. Watch for anticompetitive conduct, including but not limited to (1)

refusing to refer a patient to your private practice even when the patient requests to come to you instead of the provider the physician originally referred the patient to, (2) preventing or discouraging private payors contracting with you as a private practitioner, (3) preventing or discouraging private payors from directing or incentivizing patients to choose a private practice provider that is not affiliated with the hospital system or ACO, (4) contracting with physicians on an exclusive basis in exchange for the physician directing all referrals for ancillary services and diagnostic testing to the hospital system/ACO, or (5) bullying or threatening physicians when they refer outside of the hospital system.

More complaints need to be filed with the FTC to keep this issue on their radar screen. Filing a complaint is not hard, but it has to describe what the harmful effect of the anticompetitive conduct will be on consumers, not you as the private practitioner. Antitrust laws are intended to protect competition, not competitors. It is recommended that you solicit assistance from an attorney with health care antitrust knowledge to ensure that your complaint includes all of the evidence necessary to support your claim so your complaint will be taken seriously. For more information on the complaint process, go to www.ftc.gov/faq/competition/report-antitrust-violation.

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Vertical Integration: Hospital Ownership Of Physician Practices Is Associated With Higher Prices And Spending

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Abstract

We examined the consequences of contractual or ownership relationships between hospitals and physician practices, often described as vertical integration. Such integration can reduce health spending and increase the quality of care by improving communication across care settings, but it can also increase providers' market power and facilitate the payment of what are effectively kickbacks for inappropriate referrals. We investigated the impact of vertical integration on hospital prices, volumes (admissions), and spending for privately insured patients. Using hospital claims from Truven Analytics MarketScan for the nonelderly privately insured in the period 2001–07, we constructed county-level indices of prices, volumes, and spending and adjusted them for enrollees' age and sex. We measured hospital-physician integration using information from the American Hospital Association on the types of relationships hospitals have with physicians. We found that an increase in the market share of hospitals with the tightest vertically integrated relationship with physicians—ownership of physician practices—was associated with higher hospital prices and spending. We found that an increase in contractual integration reduced the frequency of hospital admissions, but this effect was relatively small. Taken together, our results provide a mixed, although somewhat negative, picture of vertical integration from the perspective of the privately insured.

Health Economics Health Reform Health Spending

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Health Aff **May 2012** vol. 31 no. 5 **973-981**

The Growing Power Of Some Providers To Win Steep Payment Increases From Insurers Suggests Policy Remedies May Be Needed

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Abstract

In the constant attention paid to what drives health care costs, only recently has scrutiny been applied to the power that some health care providers, particularly dominant hospital systems, wield to negotiate higher payment rates from insurers. Interviews in twelve US communities indicated that so-called must-have hospital systems and large physician groups—providers that health plans must include in their networks so that they are attractive to employers and consumers—can exert considerable market power to obtain steep payment rates from insurers. Other factors, such as offering an important, unique service or access in a particular geographic area, can contribute to provider leverage as well. Even in markets with dominant health plans, insurers generally have not been aggressive in constraining rate increases, perhaps because the insurers can simply pass along the costs to employers and their workers. Although government intervention—through rate setting or antitrust enforcement—has its place, our findings suggest a range of market and regulatory approaches should be examined in any attempt to address the consequences of growing provider market clout.

Variations **Financing Health Care** **Health Economics** **Physician Payment** **Hospitals**

Responses on This Article

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Bruce Levinson
Health Aff published online October 28, 2013
Full Text

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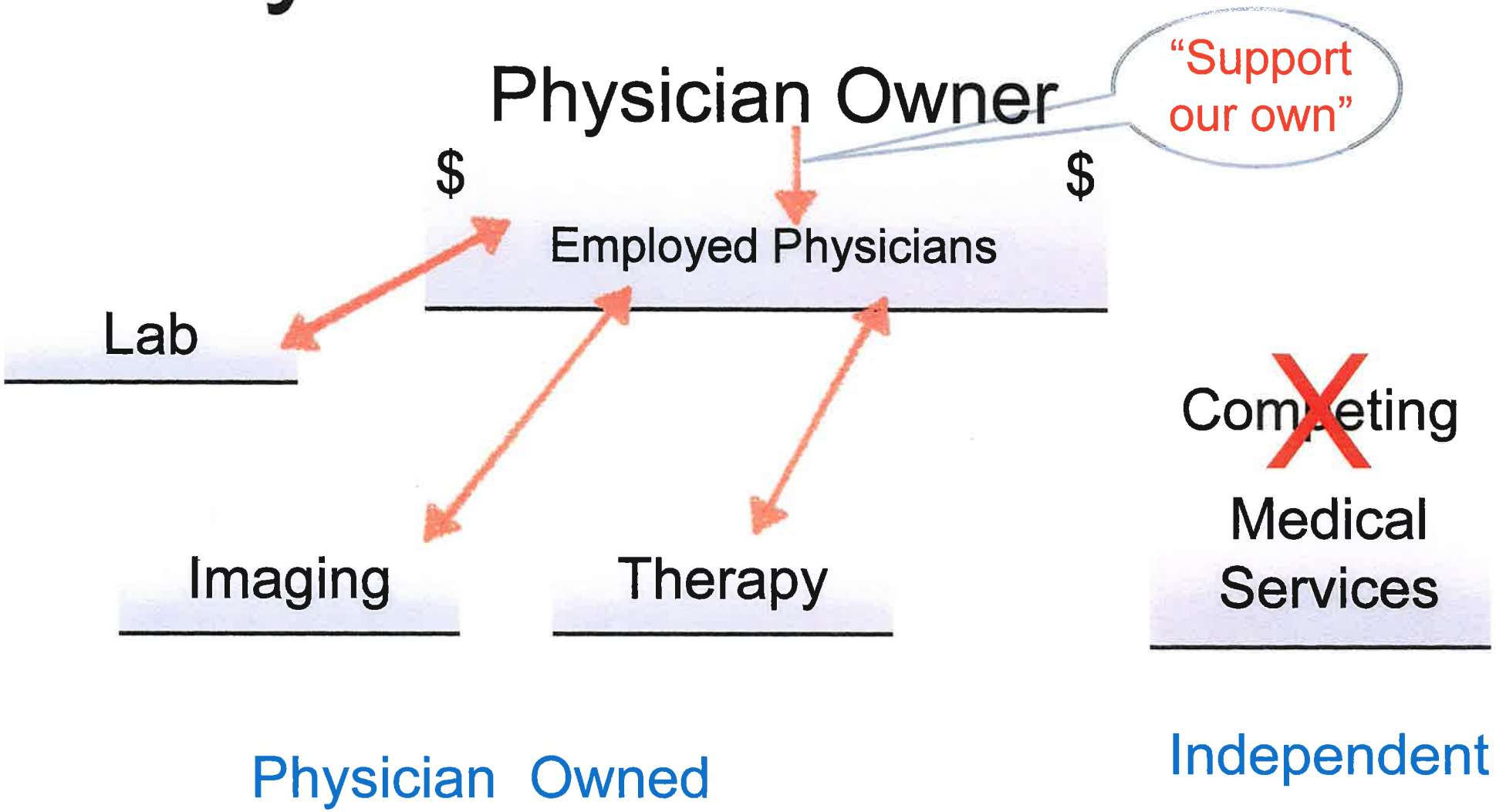
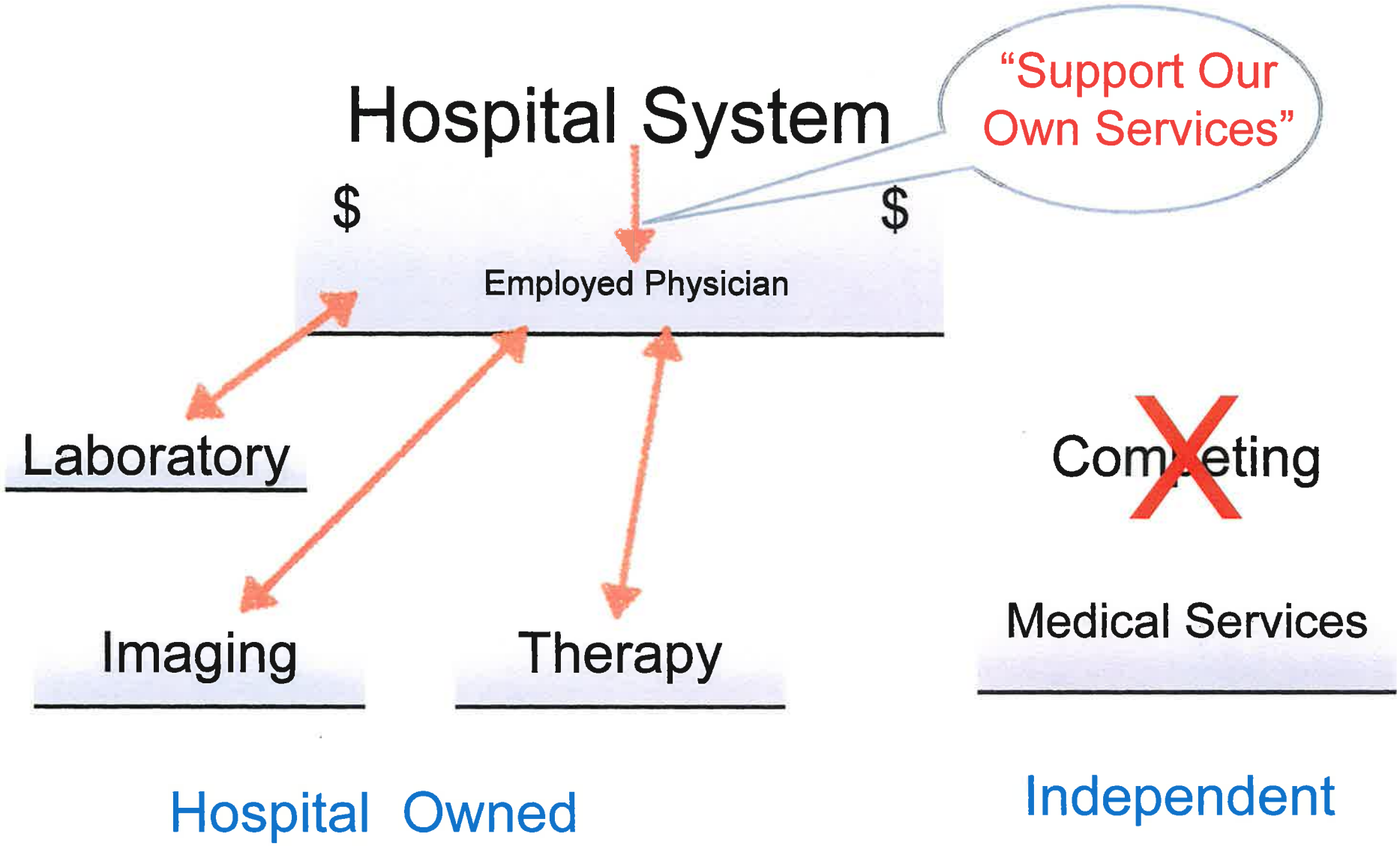
Physician – Self Referral



Hospital System - Self Referral



The NEW ENGLAND JOURNAL of MEDICINE

Perspective

Hospitals' Race to Employ Physicians — The Logic behind a Money-Losing Proposition

Robert Kocher, M.D., and Nikhil R. Sahni, B.S.

N Engl J Med 2011; 364:1790-1793 | May 12, 2011 | DOI: 10.1056/NEJMp1101959

Article

U.S. hospitals have begun responding to the implementation of health care reform by accelerating their hiring of physicians. More than half of practicing U.S. physicians are now employed by hospitals or integrated delivery systems, a trend fueled by the intended creation of accountable care organizations (ACOs) and the prospect of more risk-based payment approaches. Whether physicians, hospitals, or payers end up leading ACOs will depend on local market factors, competitive behaviors, and first-mover advantage, but employment decisions made by physicians today will have long-term repercussions for the practice and management of medicine.[1]

In the 1990s, hospitals acquired many physician practices of which they subsequently divested themselves. After the current cycle of physician-practice acquisitions, it will be harder to revert to private practice if relationships sour, since new payment structures and care models will make it increasingly difficult for traditional private practices to remain profitable. Many clinicians are unaware that hospitals lose money on their employed physicians, though hiring them may be a wise long-term investment. Understanding the economics of these decisions will help physicians to anticipate the evolution of their employment situations and see why hospitals are making increasingly aggressive plans to acquire physician practices.

Hospitals lose $150,000 to $250,000 per year over the first 3 years of employing a physician — owing in part to a slow ramp-up period as physicians establish themselves or transition their practices and adapt to management changes. The losses decrease by approximately 50% after 3 years but do persist thereafter. New primary care physicians (PCPs) contribute nearly $150,000 less to hospitals than their more-established counterparts; among specialists, the difference is $200,000. For hospitals to break even, newly hired PCPs must generate at least 30% more visits, and new specialists 25% more referrals, than they do at the outset. After 3 years, hospitals expect to begin making money on employed physicians when they account for the value of all care, tests, and referrals. Skeptics note that often they already capture this value from physicians without employing them, through stable referral networks and hospital practice choices. Outpatient office practices of employed physicians seldom turn a profit for hospitals.

Hospitals are willing to take a loss employing PCPs in order to influence the flow of referrals to specialists who use their facilities. In the 1990s, hospitals usually guaranteed physicians nearly 100% of their previous year's salary during their transition to hospital employment. This arrangement invariably led to losses, since drops in productivity were coupled with higher overhead expenses and less-effective revenue-cycle management. Today, aggressive hiring of PCPs is returning, in part because hospitals fear physicians' becoming competitors by aggregating into larger integrated groups that direct referrals and utilization to their own advantage. Hospital-employed PCPs generally direct patients to their own hospitals and specialists affiliated with

them. In addition, by employing physicians, hospitals retain maximum flexibility in the market, should health plans change their reimbursement structures to require providers to bear risk and manage population health.

Hospitals are clearly acquiring practices again (see Figure 1). A recent survey by the Medical Group Management Association shows a nearly 75% increase in the number of active doctors employed by hospitals since 2000, and recent hospital announcements suggest this trend is accelerating. A September 2010 survey revealed that 74% of hospital leaders planned to increase physician employment within the next 12 to 36 months.[2] Furthermore, the young doctors being hired today tend to value better work–life balance and are more willing than preceding generations to trade higher incomes for the lifestyle flexibility and administrative simplicity provided by hospital employment. Whereas hospitals prioritized PCP employment in the 1990s, they are now targeting both PCPs and specialists (see Figure 2); many organizations are constructing what could effectively become closed, integrated health care delivery systems.

FIGURE 1

Percentages of U.S. Physician Practices Owned by Physicians and by Hospitals, 2002–2008.

FIGURE 2

Percentages of Active U.S. Primary Care Physicians (PCPs) and Specialist Physicians Employed by Hospitals, 2000–2012.

Strategically, hospitals with a robust employment strategy will be well positioned to compete under various reimbursement scenarios. If the fee-for-service system persists, large physician networks will provide hospitals with greater pricing power when they are contracting with health plans. This scenario favors greater hiring of specialists. Conversely, if payment systems move toward population health management and risk-based reimbursement, then large outpatient networks will allow a system to shift patients away from higher-cost hospital-based care and recapture lost revenues as shared savings or capitation surpluses. This scenario favors greater hiring of PCPs.

A major concern in either scenario is the potential for hospitals to convert greater market power into higher prices and less competition.[3] High-cost markets are typified by dominant local providers who exercise pricing power. This is perhaps most clearly illustrated in Massachusetts, where Attorney General Martha Coakley determined that high prices and price variation are largely correlated with market share. She found that "price variations are not explained by quality of care, the sickness or complexity of the population being served, the extent to which the hospital is responsible for caring for a large portion of patients on Medicare or Medicaid, or whether the hospital is an academic teaching or research facility."[4] Payers acquiesce in price negotiations because they cannot afford to lose access to large provider networks. Similar patterns have emerged around the country; for instance, in Roanoke, Virginia, the dominant system, Carillion, reportedly charged 4 to 10 times as much for a colonoscopy as local competitors or providers in similar markets.[5] Although ACO-type organizations that integrate physicians and hospitals offer the promise of better care coordination, fewer complications, and cost savings, it is unclear whether these benefits will be passed along to patients as lower prices.

In the future, physicians should anticipate a shift from guaranteed salaries to incentive-driven compensation linked to productivity and clinical behavior — with base compensation that is lower than their previous earnings but incentives that can increase it to that level or higher. This approach attempts to maintain productivity levels, while encouraging physician behaviors that reduce costs or increase revenues. Today, in markets where most physicians who are highly profitable to hospitals are free agents, hospitals tolerate higher operating costs in order to attract and retain these physicians' loyalty. As more physicians become employees, hospitals will be better able to reduce excess costs associated with unnecessary practice variation and unnecessarily expensive supplies selected by physicians. These reductions will be achieved through such actions as standardizing surgical supplies, using evidence to choose cost-effective medical devices, requiring use of health information technology, requiring adherence to clinical guidelines, scheduling elective procedures in ways that maximize asset utilization, and discharging patients consistently early in the day. Although some physicians may not want to trade autonomy for employment, they must understand that hospitals are under pressure to implement cost-saving strategies, which may benefit consumers if savings are passed on through lower prices.

Understanding the economics of physician employment and the actions hospitals will probably take to stem losses will help physicians make wiser judgments. Hospital owners will not engage in long-term strategies that lose money indefinitely. Though hospital employment may offer physicians some protection from system reforms, it comes with more performance management than it once did, and the option of reverting to independent practice later may be far less attractive in the future. Employment choices that physicians make today may not be able to be undone.

Of course, these choices will also affect patients. As patients accumulate more, and more complex, medical conditions, their care will require greater coordination, greater use of clinical data, and collaborative provider teams — which integrated delivery systems are best positioned to deliver. In the long run, any pricing distortions derived from market power and friction associated with changing the role and behaviors of physicians are likely to dissipate and be outweighed by improved productivity, outcomes, and patient experiences, and more efficient health care markets may translate into lower prices over time.

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

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