

RISING HOSPITAL EMPLOYMENT OF PHYSICIANS: BETTER QUALITY, HIGHER COSTS?

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In a quest to gain market share, hospital employment of physicians has accelerated in recent years to shore up referral bases and capture admissions, according to the Center for Studying Health System Change's (HSC) 2010 site visits to 12 nationally representative metropolitan communities. Stagnant reimbursement rates, coupled with the rising costs of private practice, and a desire for a better work-life balance have contributed to physician interest in hospital employment. While greater physician alignment with hospitals may improve quality through better clinical integration and care coordination, hospital employment of physicians does not guarantee clinical integration. The trend of hospital-employed physicians also may increase costs through higher hospital and physician commercial insurance payment rates and hospital pressure on employed physicians to order more expensive care. To date, hospitals' primary motivation for employing physicians has been to gain market share, typically through lucrative service-line strategies encouraged by a fee-for-service payment system that rewards volume. More recently, hospitals view physician employment as a way to prepare for payment reforms that shift from fee for service to methods that make providers more accountable for the cost and quality of patient care.

Hospitals Seek Patients and Leverage

While not new, the pace of hospital employment of physicians has quickened in many communities, driven largely by hospitals' quest to increase market share and revenue, according to findings from HSC's 2010 site visits to 12 nationally representative metropolitan communities (see Data Source).

Across most of the 12 communities, hospital employment of physicians is growing rapidly. Exceptions are Orange County, where California law bars hospitals from directly employing physicians, but physicians tend to be tied closely to hospitals through other means; Boston, where physician organizations keep non-employed physicians tightly aligned with the dominant hospital system; and northern New Jersey.

Most physicians practice solo or in private, community-based groups, with more than half having an ownership interest in their practice in 2008.¹ In return for admitting privileges, independent physicians historically served on the voluntary medi-

cal staff of one or more hospitals and performed such duties as on-call coverage and serving on hospital committees.

But in recent years, several factors have weakened community-based physicians' ties to hospitals. Technological advances allowed more care to be performed in freestanding outpatient settings, leaving physicians less reliant on hospitals and less willing to take emergency call and sometimes directly competing with hospitals for lucrative specialty services. Hospitals started to employ specialists to cover on-call duties and increase market share for lucrative service lines, such as cardiac and orthopedic care, that they were in danger of losing to competing physicians. At the same time, the increase in hospitalists who specialize in caring for inpatients likely also has contributed to more hospital-employed physicians.

The recent spate of physician employment is not hospitals' first foray into the practice. In the 1990s, the move toward

managed care and health maintenance organizations sparked a wave of hospital purchases of primary care practices to secure referral bases. Hospitals typically lost money when employed physicians' productivity dropped, and many hospitals subsequently divested the acquired practices. Unlike in the 1990s, hospitals now typically use productivity-based compensation instead of salaried arrangements (see box on page 2 for more about hospital approaches to employing physicians).

While the potential of hospital-employed physicians to improve quality and efficiency through better clinical integration across care settings has received much attention, from the hospital perspective, physician employment typically is one of many strategies to gain market share by increasing admissions, diagnostic testing and outpatient services.³ Also, hospitals usually negotiate health plan contracts on behalf of employed physicians, gaining higher rates to offer more attractive com-

Learning from Experience

Unlike the last wave of physician employment in the 1990s when salaried arrangements were common, hospitals today are using productivity-based compensation and limiting purchases of practices' capital assets. During the 1990s, hospitals often guaranteed physicians nearly 100 percent of their previous year's earnings during their transition to hospital employment.²

Now, while hospitals employ the physician and staff, many do not purchase the practice assets and often they lease rather than purchase a practice's office space or equipment. Hospital respondents also noted they are more selective about whom they employ, emphasizing that they don't buy practices "for the sake of buying," as they acknowledged doing in the 1990s, but rather buy based on "a stricter assessment of quality and service." Likewise, hospitals are maintaining control of ancillary services performed by employed physicians. A Syracuse hospital executive said, "Last time, we found out the [hospital-employed] doctors were doing ancillary services at their own offices. So we won't be letting them do that this time around. We've learned a lot from that experience."

Even though newly employed physicians in many markets retain their own offices and do not practice on the hospital campus, hospitals are increasing their contractual and administrative management and consolidation of practices to negotiate with insurers and monitor productivity and quality. Hospitals also are giving physicians a greater role in governance and management. Hospital executives believe giving physicians a larger leadership role makes employment more palatable to physicians, enhances physician loyalty and helps improve the clinical effectiveness of care. As one Indianapolis hospital chief executive officer (CEO) said, "I think the whole thing is about seeing physicians more as partners, rather than employees. If we [hospital administration] treat them as employees, they will act that way. And, in my estimation, you don't want employees taking care of patients. You want to be physician led and governed."

In some hospital systems, employed physicians' compensation also rewards efficiency, providing them with incentives to avoid wasting supplies and agree on standard medical devices. One large hospital system chief medical officer (CMO) described how orthopedic surgeons' performance on quality and cost measures is tracked and reported back to them, allowing the system "to standardize [surgical device purchases] to one vendor and to [get the surgical team to] stop opening every piece of packaged surgical equipment on the table that might be needed." Surgeons have not resisted these efforts to decrease waste because part of their compensation is tied to efficiency measures.

compensation than independent physicians could negotiate on their own. Physician employment is not the only strategy hospitals use to align more tightly with physicians—in markets where some physicians are less inclined toward employment, hospitals also are developing contractual arrangements short of employment, such as physician hospital organizations, to strengthen relations.

While initial hospital moves to employ physicians generally focused on hiring specialists to build targeted service lines, such as cardiac or cancer care, hospitals increasingly are hiring primary care physicians to capture referrals for their employed specialists. "There is a mad grab to hire primary care physicians," according to a Greenville market observer, capturing the sentiment of many respondents across the markets.

Following enactment of national health reform in March 2010, hospital executives also increasingly cited physician-hospital integration through physician employment as key to preparing for expected Medicare payment reforms, including bundled payments, accountable care organizations (ACOs) and penalties for preventable hospital readmissions.

Physicians Seek Security

Physicians' reasons for seeking employment, not just by hospitals but also by other organizations, include stagnant reimbursement rates in the face of rising costs of private practice and a desire for a better work-life balance. Hospitals are hiring both primary care and specialist physicians. Primary care physicians (PCPs) in

particular face challenges in remaining in independent practice because flat reimbursement rates and growing overhead costs are more of a challenge for their practices, which typically cannot generate significant revenue through procedures and ancillary services. And, even among some specialists, there is a notable change in attitude toward employment because of reimbursement issues. As an Indianapolis hospital CEO said, "Specialists make a lot more money than PCPs, so for them to get cold feet about their independence in the future is monumental."

Additional motivations for physicians include the need to navigate complex changes in insurance and delivery systems under health care reform, implementation of costly but increasingly necessary health information technology, and avoidance of high malpractice insurance premiums, which hospitals cover for employed physicians.

For physicians just beginning practice, hospital employment also is attractive because of the perceived financial security and work-life balance. Data on medical residents' first choice for employment support this—in 2003, 4 percent said they would be "most open" to hospital employment, but by 2008, the proportion had jumped to about 22 percent.⁴ For example, attracting younger physicians to Syracuse is difficult without an employment offer given their high medical school debt. "They see the writing on the wall, where they can't buy into a practice, and joining a practice might not help with their loan forgiveness. Therefore, they're going to the highest bidder," a Syracuse hospital chief financial officer said.

Hospital Consolidation Spurs Employment

Hospital consolidation continues to be an important factor in physician employment by hospitals. In markets with high hospital concentration, physicians face pressure to align closely with one hospital system or another.⁵ And, while hospital employment of physicians is more pronounced in areas with higher levels of hospital consolidation—for example, Cleveland, Greenville, Indianapolis and Lansing—it is also taking place in less-consolidated hospital markets, such as Seattle, Little Rock, Phoenix, Syracuse and Miami.

In some markets, such as northern New Jersey and Miami, the local culture of physi-

cian independence influences physicians' willingness to become employed by hospitals. And, if they are large enough, some single-specialty and multispecialty groups can remain independent, because they have sufficient leverage with payers.

Coordinated, Higher-Quality Care?

Hospital employment of physicians theoretically can improve quality by encouraging better integration of care and communication among clinicians, but respondents indicated that clinical integration does not occur automatically once physicians become employees. Echoing the views of many hospital CMOs across the 12 markets, a Lansing respondent said, "Being able to bring all physicians together with a unified focus on quality, service and access is a challenge." At this point, most clinical-process integration appears focused on single diagnoses or conditions rather than integration across all of a patient's medical needs. For example, according to many hospital CMOs, hospitals are focusing on the "low-hanging fruit," such as reducing preventable readmissions among patients hospitalized for congestive heart failure.

Communication between inpatient and outpatient providers, even between those employed by the same hospital system, continues to be a problem. As a Lansing hospital respondent said, "Coordination of care, pre- and post-hospital, needs to be better...care processes and pathways need to be integrated." The potential for true clinical integration, including improved communication, is challenging in the current fee-for-service environment, according to respondents across the 12 markets studied. Hospital systems and clinicians vary widely in their development of integrated care processes and implementation of interoperable electronic health records (EHRs).

For example, Cleveland Clinic, with a large proportion of employed physicians using the same EHR, is further along the spectrum of information exchange for care integration than many other systems. Other markets are at an earlier stage. As a Phoenix hospital CMO said, "The lack of communication between outpatient and inpatient physicians is problematic...we know we need to start addressing it."

Potential for Higher Costs

While hospital-employed physicians may spur clinical integration that will ultimately improve efficiency and help control costs, they are more likely to increase costs in the short run.⁶ First, hospitals and their employed physicians continue to practice in a predominantly fee-for-service environment that has incentives to increase the volume of services delivered. And, productivity-based compensation used by many hospitals for employed physicians reinforces these incentives. Numerous physician respondents noted that employed physicians face pressure from hospitals to order more expensive testing alternatives. In one market, at least two cardiologists declined hospital employment offers because they perceived the pressures to drive up volume were stronger than those in their mid-sized, independent cardiology group.

In addition, hospitals routinely charge facility fees for office visits and procedures performed in formerly independent physicians' offices, where the physicians have converted to hospital employment. The terms "hospital-based facility" or "provider-based facility" refer to a facility or office that is part of a hospital but may not be located on the hospital campus. The provider-based status produces substantially higher Medicare payments than when physicians remain in independent practice, because there are now separate payments for professional services and for hospital outpatient facility fees. In short, it is possible for a physician practice to be acquired by a hospital, not change locations or even practice operations, yet the hospital now receives significantly higher Medicare payments if it meets the criteria for achieving provider-based status. Most commercial insurers follow the Medicare fee schedule with some modifications, so this practice can affect not only Medicare patients but privately insured patients.

Hospitals charging facility fees for physician visits not only results in higher costs for payers, but also for patients because facility fees are subject to deductibles and coinsurance. In isolated cases, litigation has resulted, and institutions have reimbursed insurers and patients for facility fees under consumer protection laws, and the hospitals now post their pricing practices.⁷

Furthermore, increasingly aligned hospitals and physicians are gaining leverage with health plans over payment rates. In



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Data Source

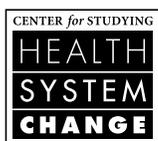
HSC periodically conducts site visits to 12 nationally representative metropolitan communities as part of the Community Tracking Study to interview health care leaders about the local health care market and how it has changed. The communities are Boston; Cleveland; Greenville, S.C.; Indianapolis; Lansing, Mich.; Little Rock, Ark.; Miami; northern New Jersey; Orange County, Calif.; Phoenix; Seattle; and Syracuse, N.Y. During the seventh round of site visits, almost 550 interviews were conducted in the 12 communities between March and October 2010. This Issue Brief is based on responses primarily from representatives of hospitals—chief executive officers, chief financial officers and chief medical officers—physician organizations, health plans and other knowledgeable market observers.

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markets with particularly high levels of physician employment, such as Greenville and Indianapolis, insurers reported growing difficulty containing both hospital and physician payment rate increases.

Finally, respondents in a few markets expressed concern that employment of some specialists, particularly those in geographic areas served by multiple hospital systems, contributes to higher costs because of artificially high compensation generated by bidding wars. An Indianapolis physician said, “Hospitals are paying cardiologists over \$1 million a year... hospital costs are going up dramatically in our market.... You are seeing a number of compensation offers that are multiples of what physicians had made historically.”

Mixed Effects on Access to Care

Increased hospital employment of physicians appears to affect patients’ access to care in a variety of ways. From the patient perspective, physician employment by a hospital may be invisible as many employed physicians continue to work in the same offices they occupied when independent.

A potential benefit of physician-hospital alignment may include better access to employed specialists for low-income patients, especially those with Medicaid coverage, who historically have had poor access to independent specialists. At the same time, with increased hospital employment of physicians, access to care can shift markedly for patients when a major hospital system drops out of a health plan network.⁸

Policy Implications

While the potential of hospital-employed physicians to improve quality and efficiency has received attention, the potential for higher costs has received less attention. The existing fee-for-service payment system that encourages hospital strategies to use employed physicians to increase referrals and admissions, coupled with the market power of hospitals to gain higher payment rates, risks overshadowing potential quality gains.

In essence, physician employment is attractive to both hospitals and physicians under volume-driven fee for service, and the growing employment trend does not guarantee improved clinical integration will occur. The recent acceleration in hospital employ-

ment of physicians runs the risk of raising costs and not improving quality of care unless broader payment reform reduces incentives to increase volume and creates incentives for providers to change care delivery to achieve real efficiencies and higher quality. ■

Notes

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