Health Policy in Medicine: *Inside the Beltway*

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Hospital–Physician Integration: What is the Evidence?

by Eugene Rich, MD, FACP
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Note: For this column, Dr. Rich responds to questions posed by a colleague at Creighton about the article Reschovsky JD, Rich E. Hospital Acquisition of Physician Groups: On the Road to Value-Based or Higher-Priced Care? JAMA Intern Med. 2015 Dec 1;175(12):1939-41

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Question 1: What is the effect of Medicare Advantage programs on costs in these consolidated and integrated marketplaces? Do you believe that competition based on managed care payment structures vs. traditional Medicare can slow cost growth?

Dr. Rich's Answer: It remains a topic of some controversy whether within market competition can affect costs and growth in health care spending. The study in JAMA IM article[1], which initiated Dr. Reschovsky's and my commentary, used the Truven Health MarketScan Commercial Database. Therefore Neprash et al. were observing trends in health care costs for non-elderly commercially insured and specifically those in preferred provider organizations or point-of-service health plans. They conclude that "Consistent with prior research, physician-hospital integration was not associated with lower utilization…" Instead they observed greater costs with physician-hospital integration, largely arising from higher prices, especially for hospital outpatient department services (HOPD). Service use was not the major driver of costs; neither did hospital-physician "integration" yield greater efficiency.

This is consistent with the perspective of a number of economists who have long studied physician practice consolidation. In a recent comprehensive review, Burns et al. note "no evidence these large groups have been able to achieve scale and scope economies from their clinical operations." Instead they find evidence these consolidations occur to achieve hospital or health system interests like "to build up outpatient hospital utilization or inpatient market share" and/or "to leverage insurers for more favorable contracts and rates."[2]

One reason for the increase in costs observed by Neprash et al. is the phenomenon that hospitals may charge higher rates for services provided in hospital-owned facilities than the rates charged in physician practices. While one would think that this issue that arises in Medicare payments might be addressed by private insurers, Neprash et al. suggests perhaps not. The Medicare Payment Advisory Commission has proposed, and CMS is beginning to implement, adjustment of some Medicare fees for HOPD services, which is not a managed care market but an administrated pricing solution. As has long been the case, it remains challenging to create an effective "market" to set the rates for clinical services, and thus in most countries governments play this type of role in setting (and re-adjusting) terms of payment.[3]

Indeed, as Reschovsky and I note, CMS is now even more active in refining modes of payment for health care services, such as the new pilot requiring hospitals in some areas to accept episode-based payment for certain procedures. These payment reform initiatives are occurring under traditional Medicare, not the "Medicare Advantage" program. Hospitals in these payment arrangements will not be able to continue raising rates or diverting patients to costly HOPD services to achieve enhanced revenue. CMS will instead be rewarding those arrangements that can achieve higher quality and lower total spending on health care. Time will tell which types of provider arrangements can best achieve these goals.

Question 2: What is the future for public reporting of quality information both for hospitals and physicians on utilization and costs? Is this a strategy to improve competition?

Dr. Rich's Answer: Various public reporting initiatives are underway relevant to quality data. Medicare's Hospital Compare[4] has reported hospital performance on a number of dimensions for a number of years. My work has focused more on reporting regarding physician practice, and CMS recently established Physician Compare to "help consumers make informed decisions about their health care" and create "clear incentives for physicians to perform well."[5] The Physician Compare website presently offers information on a very limited list of quality measures and for relatively few practices – performance rates for three Diabetes Mellitus measures and one Coronary Artery Disease measure for the 139 group practices. However, the next update will add performance scores for more measures of guideline adherence as well as results from consumer surveys for those practices choosing this approach to quality reporting. The recently passed MACRA[6] revises key elements of quality and cost reporting for physician practices. Starting in 2019, these reporting and incentive programs for providers paid through the Medicare Fee Schedule will measure provider performance in four dimensions: Quality, Resources use, Clinical practice improvement activities, and Meaningful use of certified EHR technology.

Of course these reports relate to quality, not cost. And as noted above, it may be some time before a comprehensive set of reports covering all physician practices will be available to guide consumer choice. Perhaps not surprisingly, the evidence that consumers use such reports to make choices has proven quite mixed. A recent analysis from the area of hospital reporting suggests that hospital quality reports may influence provider choice in some circumstances.[7] However, these authors find that "the relationship between performance and allocation is stronger among patients who have greater scope for hospital choice." Nonetheless, Burns et al. have observed accelerating health system consolidation in the new millennium,[8] which could reduce the potential for quality reporting to guide consumer choice.

[1] Neprash HT, Chernew ME, Hicks AL, Gibson T, McWilliams JM. Association of Financial Integration Between Physicians and Hospitals With Commercial Health Care Prices. JAMA Intern Med. 2015 Dec 1;175(12):1932-9.
[2] Burns LR, Goldsmith JC, Sen A. Horizontal and vertical integration of physicians: a tale of two tails. Adv Health Care Manag. 2013;15:39-117
[3] Woerheide J, Lake T, Rich EC. The Role of Government in Physician Reimbursement. Am J Med Sci. 2016 Jan;351(1):52-8.
[4] https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/hospitalqualityinits/hospitalcompare.html
[5] https://www.medicare.gov/physiciancompare/staticpages/aboutphysiciancompare/about.html
[6] https://www.congress.gov/bill/114th-congress/house-bill/2/text
[7] www.nber.org/papers/w21603.pdf
[8] Burns LR, McCullough JS, Wholey DR, Kruse G, Kralovec P, Muller R. Is the system really the solution? Operating costs in hospital systems. Med Care Res Rev. 2015 Jun;72(3):247-72