Hospital Acquisition of Physician Groups
On the Road to Value-Based or Higher-Priced Care?
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An important goal of the Affordable Care Act is to transform the US health care system from one characterized by high costs, poor quality, and fragmented care to one focused on comprehensive, coordinated, and efficient care. The Centers for Medicare & Medicaid Services (CMS) is working to meet this goal primarily through efforts to strengthen primary care and to introduce innovative new payment and delivery models. These new models are designed to reduce clinicians’ reliance on fee-for-service reimbursement, instead rewarding value over volume. For example, with bundled payment, clinicians are rewarded for lowering the cost of an episode of care, and with accountable care organizations (ACOs), clinicians are rewarded for lowering costs for a population of patients, contingent on meeting quality of care metrics. Conversely, clinicians are (or will be in the future) financially penalized for increasing costs.

Invited Commentary


The new models will require greater care integration across physicians, hospitals, and other health care delivery providers to achieve cost savings and to provide well-coordinated care. One means of integrating care (though not the only one) is the purchase of physician practices by hospitals. Compared with individual physician practices, hospitals and hospital systems have more resources and infrastructure to set up integrated health information, administrative, and financial systems. These employment arrangements can also be attractive to physicians for a variety of reasons, providing them more stable incomes, better work-life balance, lower costs for malpractice insurance, and reduced or eliminated practice-management issues.

Given the possibilities for better-integrated care, the purchase of physician groups by hospitals would be expected to improve efficiency and save costs. But overall this does not seem to be the case. The article by Neprash and colleagues in this issue of *JAMA Internal Medicine* shows that hospital purchase of physician practices was linked to greater net costs between 2008 and 2012. This confirms previous research, but for the first time, the findings are based on national commercial insurance data. Importantly, Neprash and colleagues found that the greater costs largely arose from higher prices, especially for outpatient services. Service use was not the major driver of costs, but hospital-physician “integration” did not lead to greater efficiency.

Several factors may be contributing to these findings. First, hospitals have been purchasing physician practices to maintain or grow their local market share, mostly acquiring primary care physicians and specialists in lucrative lines of business such as cardiology, oncology, and orthopedic surgery, as well as purchasing strategically situated multispecialty groups. These purchases guarantee a flow of inpatient admissions and referrals to profitable outpatient services. Differing market conditions explain why hospitals’ acquisition of physician groups varies widely across local areas.

Second, the purchase of physician groups often allows hospitals to generate more revenue from the services the physicians provide. Ambulatory services receive higher reimbursements from Medicare and most other payers when they are provided in hospital outpatient departments than when the identical services are provided in community-based settings. An office visit under Medicare costs 70% more when provided in a hospital outpatient department than in a physician’s office, and the prices paid by commercial insurers often differ by orders of magnitude across these settings. Services rendered by community-based but hospital-owned physician practices are now often billed at these higher hospital outpatient department rates.

Finally, physician group ownership gives the hospital more bargaining power in price negotiations with insurers. Market power is achieved not only through consolidation of hospitals into systems but also through the control over a significant share of local physicians. Vertically integrated hospitals can use this market power to increase inpatient, outpatient, and physician reimbursements.

The data used in the analysis by Neprash et al extends to 2012, and since then, the number of Medicare ACOs has risen dramatically, now covering 5.6 million beneficiaries in nearly 600 ACOs. There has also been substantial growth in ACO arrangements involving private insurers and state Medicaid programs. Similarly the principal CMS bundling pilot program has seen tremendous growth. Given these trends, it will be important to investigate whether hospitals are changing their strategies to increase efficiency under ACOs and other new payment models. Even for hospitals developing integrated delivery systems, market power does not preclude them from extracting favorable terms on ACO contracts with commercial insurers—costs ultimately borne by patients. And although some hospitals have successfully created integrated delivery systems, physician-led Medicare ACOs have thus far proven somewhat more successful at lowering costs and achieving shared savings than hospital-led ones, and smaller provider organizations in general have been more adept at improving patient outcomes than larger ones.

Policy makers can influence the direction vertically integrated hospitals take in the future. The Medicare Payment Advisory Commission, for example, has made modest proposals to set Medicare fees for some hospital outpatient department services at community-based levels. Although hospitals do bear regulatory and mission-related cost burdens that need to be covered, wholesale price premiums on all hospital outpatient department services is likely to be the least efficient means of compensating hospitals for these extra costs they bear, and there is little justification for allowing hospital outpatient department fees to be charged for services rendered outside of the hospital.

Rolling back hospital consolidation or vertical integration owing to anticompetitive behavior is unlikely to be feasible or necessarily desirable. There appears to be little appetite for state regulation of hospital rates, and market-based efforts to constrain hospital pricing are limited. The CMS is strongly pushing adoption of “alternative payment models,” arrangements that link provider payment to the quality and cost of care delivered to a population (as in ACOs) or for an episode of care (as in bundled payment). New patient-centered medical homes that have the potential to reduce demand for hospital services are also being advanced. The ultimate success of the CMS alternative payment models is still to be determined, and many new models are under development.

Purchase of physician practices is often a hospital’s strategy of hedging on which direction the US health care system will go, but it may represent an attempt to suppress potential competition from physician-led ACOs. The CMS initiatives, such as a new pilot program that requires hospitals in some areas to accept episode-based payment (a form of bundling) for certain procedures, portend more aggressive actions to spread the coverage of risk-based alternative payment models. If hospitals are forced into these payment arrangements, they will not be able to continue raising rates or diverting patients to costly hospital outpatient department services. They will instead need to work with their acquired physicians’ groups to use fewer services and lower prices while achieving higher quality care, a skill evidently not widely demonstrated during the 2008-2012 timeframe examined by Napresh et al. This skill is one that hospitals might postpone developing only at their own peril.
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REFERENCES


