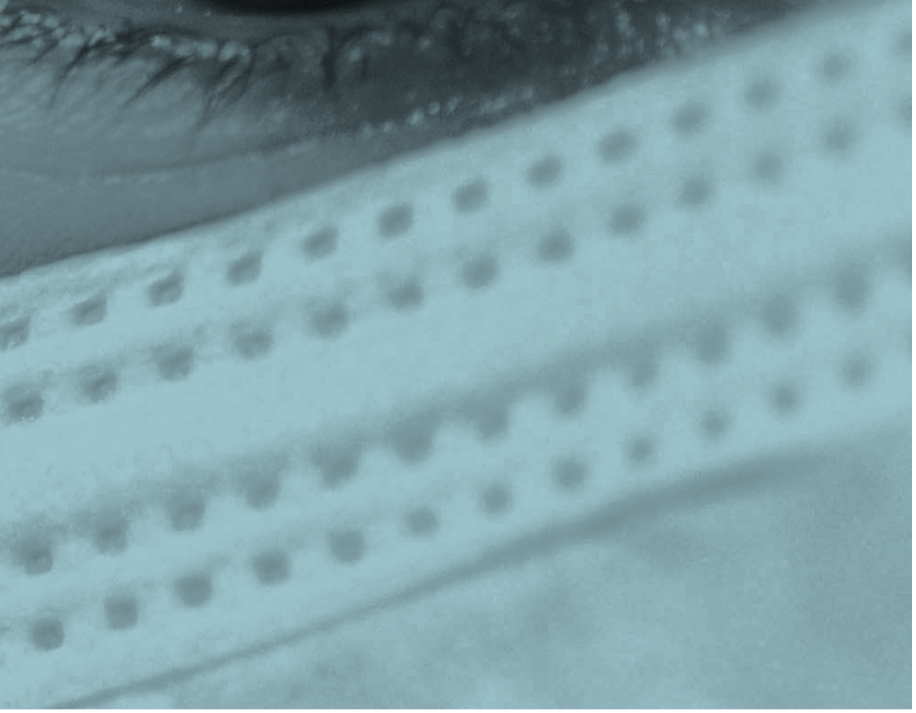

Health care integration:

Will physicians lose their voice?

by Kevin Kavanagh, MD, FACS

Health care integration is an often overlooked outcome of the health care reform process. For a physician, health care integration means (to paraphrase the U.S. White House) becoming employed by a hospital or joining a large group.[1] Many view this as a development in the distant future associated with the planned implementation of accountable care organizations. Exactly how accountable care organizations will function is still not known. However, they will likely finance health care on a pay-per-event basis, where the insurance company assumes the risk of event occurrence and the health care delivery system assumes the risk of event treatment outcomes.

Driving factors

Health care integration is being driven by two factors. The first is related to the Medicare sustainable growth rate (SGR) physician payment formula, which, if not changed, will cut the physician's gross pay by almost 30 percent by the first of next year. It is estimated that it will cost $330 billion to correct this payment schedule over the course of 10 years—a daunting sum for a nation in an economic downturn.[2] To make matters even worse, the Office of the Actuary of the Centers for Medicare & Medicaid has released a financial analysis on the effect of health care reform which is in line with the earlier Congressional Budget Office's report. Medicare is widening its deficit, and by 2019, health care costs in the U.S. will comprise 20 percent of the nation's gross national product.[2]

The second factor driving health care integration is related to hospi-

tals charging a facility fee in addition to a physician visit fee.[3] This policy places the facility at a competitive advantage, as the facility can provide physician services in a cost center that is profitable, compared with the ever-increasing unprofitable situations found in private practice. In addition, facility-employed surgeons may be required to shift the performance of outpatient surgery from a freestanding outpatient surgery center to a hospital outpatient department to take advantage of the higher facility fee reimbursement. For example, in 2010, the facility fee at a freestanding outpatient surgery center for tonsil and adenoid surgery (CPT Codes 42820 to 42836) was between $871 and $900, compared with $1,679 at an acute care hospital outpatient facility. This difference is significantly more than the physician fee of between $184 and $299, depending upon the specific procedure being performed.[4]

Comparison of these fees over time is also noteworthy. Most facility fees for these codes increased between 18 percent to almost 20 percent, compared with the physician reimbursement, which only increased 5 percent to 10 percent. The table on this page shows the reimbursement for CPT* code 42821, tonsillectomy and adenoidectomy, age 12 years or older.

Health care integration is well under way, with more than 50 percent of physician practices owned by hospitals, and the number is increasing fast.[5] Additional practices have integrated through contractual arrangements. Once 50 percent employment occurs in a facility, a tipping point is reached and hospital-employed physicians, who report to the chief executive officer (CEO), comprise the majority of members on hospital committees.

Physicians who were members of an independent medical staff that oversaw hospital functions were the most common governance structure prior to health care integration. Now, the majority of these physicians report to the CEO, and independence is lost. Some facilities even require the signing of "gag clauses" as they relate to the discussion of facility quality issues.

What needs to be done

There are three goals that need to be supported by physicians:

- Physicians should be advocates of a new model of hospital governance. Similar to the banking industry, auditing and quality assurance functions should operate like a separate corporation in the hospital, with staff being employed by, and reporting directly to, the hospital's board and not to the CEO. Hospital boards should be trained in issues of patient advocacy by independent training agencies and community board members should not have a conflict of interest with the facility.
- Physicians need to be permitted the freedom to counsel their patients, patients' families, and medical decision makers regarding health care quality and where the patient can receive the best value of health care, regardless of the facility that is recommended to the patient or the facility that currently employs the physician. Gag clauses and any form of retaliation against the physician regarding discussions of facility quality need to be strictly prohibited, provided that Health Insurance Portability and Accountability Act regulations are followed.
- Most importantly, physicians need to develop an independent voice. Integration not only affects hospital governance but also medical trade organizations. Being a patient advocate means more than telling the patient to stop smoking and lose weight. It means more than making sure health care is well funded so the doctor's medical bills are paid. It means ensuring the patient is able receive the highest value health care in both cost and quality.

To this end, transparency and public reporting are very important to health care integration. Public reporting of infections is currently supported by the Centers for Disease Control, the Association for Professionals in Infection Control, the Infectious Disease Society of America, the Society for Healthcare Epidemiology of America, the Council of State and Territorial Epidemiologists, and the Trust for America's

Differences in the increase in procedural versus facility CPT code reimbursement

Year	CPT code	Surgery center	Hospital outpatient department	Surgeon
2008	42821	$768	$1,418	$282
2010	42821	$920	$1,679	$299

†All specific references to CPT (Current Procedural Terminology) terminology and phraseology are © 2011 American Medical Association. All rights reserved.

Health.[6-8] In addition, at least 27 states now mandate public reporting of health care-acquired infections.[9]

Placing a guarantee on services is something that is common in other industries and is expected by the public.[10] This guarantee includes support of nonpayment of hospital-acquired conditions—a policy which was universally applied to surgeons when global surgical fees were introduced in the mid 1980s. Global surgical fees have been viewed as good policy for the surgeon and the patient. Certainly, it is also good policy for facilities. The concern of inhibiting health care for the sickest patients is not valid due to the fact that it is the doctor, not the facility, who determines which patients are admitted. Under the current diagnosis-related groups system, facilities that treat the sickest patients who are at the greatest risk of developing hospital-acquired conditions will often still receive the maximum payment because of the presence of other coexistent, co-morbidity factors. The Geisinger Health System adopted this payment policy in February of 2006 for coronary artery bypass graft and currently with other ProvenCare procedures covered by its Geisinger Health Plan Insurance.[11,12] Soon, this payment policy may become standard in accountable care organizations, which may receive one fee for all services related to an event.

Conclusion

Physicians have their work cut out for them to regain the leadership position in our health care delivery system. Physicians are at risk of belonging to a trade, as opposed to a profession, and therefore, they need to develop an independent voice, apart from the facility administration, a voice that truly advocates for patients. Ω

References:

1. Lowes R. Physicians say White House should not write off small practices. *Medscape Med News.* Available at: http://www.medscape.com/viewarticle/727420. Accessed March 14, 2011. Login required.
2. Alonso-Zaldivar R. Gov't: Spending to rise under health care overhaul. Associated Press. Available at: http://www.realclearpolitics.com/news/ap/politics/2010/Sep/09/gov_t__spending_to_rise_under_health_care_overhaul.html. Accessed March 14, 2011.
3. Mathews AW. When hospital fees catch you off guard. *Wall St J.* Available at: http://online.wsj.com/article/SB10001424052748703819904574555723216593610.html. Accessed March 14, 2011.
4. 2010 Tonsil & Adenoidectomy Reimbursement Fact Sheet. Ethicon Endosurgery. Available at: http://www.ethiconendosurgery.com/sites/default/files/Fact_Sheet_2010_Tonsil_and_Adnoid.pdf. Accessed March 14, 2011.
5. Mathews AW. When the doctor has a boss: More physicians are going to work for hospitals rather than hanging a shingle. *Wall St J.* Available at: http://online.wsj.com/article/SB10001424052748703856504575600412716683130.html?KEYWORDS=hospital+ownership+of+physicians. Accessed March 18, 2011.
6. CDC Statement: Public Reporting of Healthcare Acquired Infections. Media Statement. Centers for Disease Control and Prevention, U.S. Dept. of Health and Human Services. Feb 2, 2010. Available at: http://www.cdc.gov/media/pressrel/2010/s100202.htm. Accessed March 14, 2011.
7. Srinivasan A. Media Telebriefing on State Healthcare-Associated Infection Data. Centers for Disease Control May 27, 2010. Available at http://www.cdc.gov/media/transcripts/2010/t100527.htm. Accessed March 14, 2011.
8. Experts Support National Public Reporting of Healthcare-Associated Infections. Available at: http://www.healthwatchusa.org/mrsa/pdf_downloads/20090722-Experts_Public-Reporting-HAIs.pdf. Accessed March 14, 2011.
9. Frieden TR. Maximizing infection prevention in the next decade: Defining the unacceptable. *Infect Control Hosp Epidemiol.* 2010 Nov;31 Suppl 1:S1-3. Available at: http://www.journals.uchicago.edu/doi/full/10.1086/656002. Accessed May 16, 2011.
10. Employers support nonpayment for "never events." News in brief. *Am Med News.* Available at: http://www.ama-assn.org/amednews/2009/03/23/gvbf0323.htm. Accessed March 14, 2011.
11. Abelson R. In bid for better care, surgery with a warranty. *New York Times.* Available at: http://www.nytimes.com/2007/05/17/business/17quality.html. Accessed March 14, 2011.
12. Giesinger Health System. Frequently Asked Questions. Available at: http://www.geisinger.org/provencare/faq.html. Accessed March 14, 2011.

Dr. Kavanagh *is a nonpracticing otolaryngologist in Somerset, KY, and founder of Health Watch USA, a 501(c)3 organization whose mission is to promote health care transparency and value-purchasing.*