Fewer independent private hospitals in Minnesota

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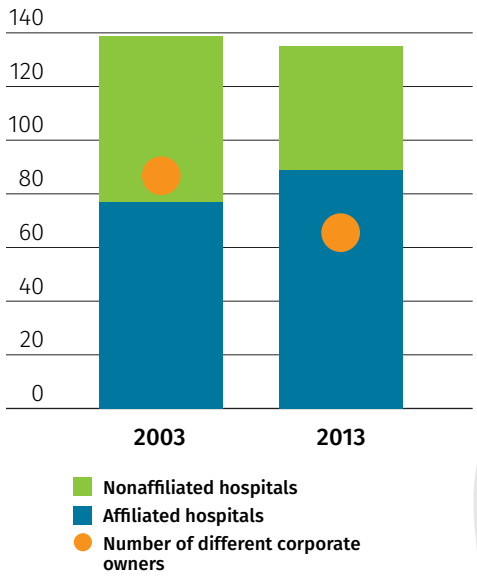
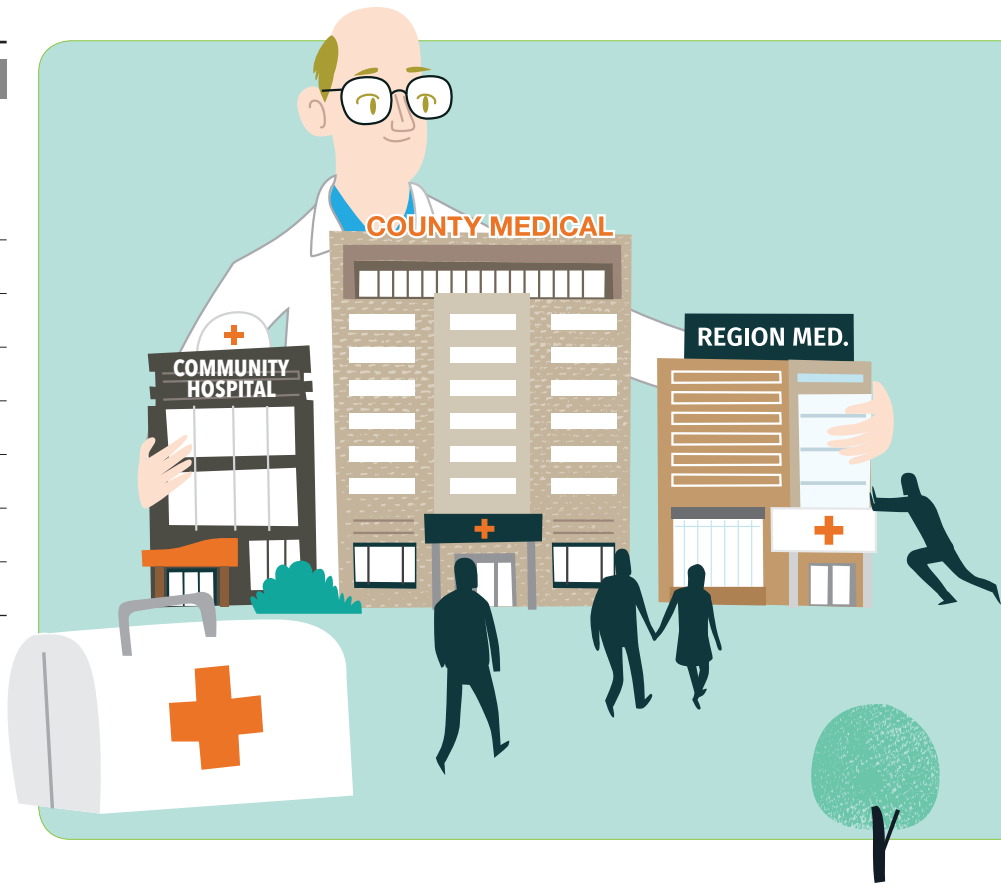


Source: Minnesota Department of Health, Health Economics Program



HORIZONTAL CONSOLIDATION garners the most attention—especially when it comes to mergers and acquisitions. This happens when a large provider, like a hospital, acquires smaller independent hospitals or when a large integrated provider merges with another health system. The goal here is to enter new regional markets or expand in existing ones. In Minnesota, the number of independent hospitals has fallen by about one-quarter since 2003.

appear to be at different stages of consolidation. Minnesota's health care sector is viewed by many as already quite integrated, said Matthew Anderson, senior vice president for policy and strategy with the Minnesota Hospital Association (MHA), who responded at length via email. While there is still consolidation activity in the state, "the rate or frequency of those transactions has not been as feverish over the past five years as in other areas in the country."

Given its smaller population and expansive geography, horizontal consolidation among hospitals "has not taken hold in Montana yet. However, there are a number of larger hospitals that have begun conversations" in hopes of expanding their markets and reducing costs, said Dick Brown, president of the Montana Hospital Association. There has been recent activity too. Earlier this year, Benefis Health System (Great Falls, Mont.) paid just $500,000 for Teton Medical Center (Choteau, Mont.), which included a 10-bed critical access hospital, clinic and 36-bed long-term care facility.

Activity in North Dakota has reportedly been heating up. "I think North Dakota has been isolated from consolidation for a lot of years," said Jerry Jurena, president of the North Dakota Hospital Association (NDHA). The state has an independent streak, and health care

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Loss of independent physicians: Follow the money

The downward trend among independent physician groups seems innocuous in the broader context of health care consolidation. But certain reimbursement policies have facilitated the shift.

For physician-partners at an independent clinic, income is directly related to a clinic's net income, all of which is paid out to partners, said Mike Foley, administrator and chief operating officer at the Apple Valley (Minn.) Medical Center, which operates a joint venture with Allina Health in the Twin Cities. AVMC runs primary and urgent care centers—employing its own doctors—along with some miscellaneous operations, according to Foley, while Allina runs "everything else."

Contrast that with the flow of money in larger health care systems, where an increasing number of doctors are employed in hospital outpatient departments (HOPDs). Here, doctors are typically paid market-rate salaries on the basis of being able to generate "downstream revenue"—patient referrals to other more expensive and more profitable care services within the same health care system—rather than their ability to generate net income for the HOPD, Foley said.

As such, HOPDs are used as a loss leader similar to those used in retail, where a grocer will sell soda at a low price—even at a loss—to get shoppers in the door on the expectation that they will also pick up a few higher-margin products. According to the Medicare Payment Advisory Committee (MedPAC), hospital outpatient margins have consistently been in the red—negative 10 percent or worse—for about a decade.

There is also a reimbursement quirk that compounds the salary matter: The negative margins exist despite the fact that Medicare pays HOPDs more for certain services than it does for similar services at a traditional clinic in the belief that HOPDs are part of hospitals, which offer more comprehensive services and have higher carrying costs than a physician's office and thus are due higher reimbursement.

In a report this spring to Congress, MedPAC pointed out that Medicare usually pays more for services in HOPDs "even when those services are also safely performed in physician offices." For example, Medicare pays an outpatient facility $492 for a Level II echocardiogram compared with $228 in a freestanding physician's office. "This payment difference creates a financial incentive for hospitals to purchase freestanding physicians' offices and convert them to HOPDs without changing their location or patient mix." In 2013, echocardiograms billed from HOPDs increased 7 percent, while those from physicians' offices declined 8 percent. This increases Medicare spending for taxpayers and cost-sharing beneficiaries, MedPAC pointed out, with no known change in patient care.

For its part, the American Hospital Association commissioned a study this year by KNG Health Consulting to look at patient populations. It found that HOPD differentials were warranted because their patient base was more likely to be uninsured or on Medicaid (which does not pay a higher differential), have more severe chronic conditions and have higher prior utilization of hospitals and emergency departments, all of which increased overall treatment and operating costs.

Whatever the case, doctor-owners at independent clinics converted to HOPDs stand to see a nice payout for their ownership stake in a clinic and a salary bump of as much as 30 percent, according to Foley. While doctors in an HOPD lose much of their previous autonomy, "there is also a certain amount of stress in running your own business" that is relieved by the transition.

Foley himself recently had to tamp down rumors of AVMC being fully acquired by Allina. "I think there is logic to the rumor," he said. "It's just not true."

—Ronald A. Wirtz