

SB 122 Facility Fee Disclosure

Hearing February 10

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Hello,

I am Elizabeth S Rowe, legislative director of the Rowe Neurology Institute in Lenexa Kansas. The Rowe Neurology Institute is the only remaining independent Neurology practice in the greater KC area.

I am here because we believe this bill is essential to providing Kansas patients with the cost transparency that will allow them to choose wisely when visiting a doctor in Kansas.

The services of hospital employed physicians are charged at hospital rates, and include ad on fees called facility fees. Because of these extra charges, it costs patients much more to visit a hospital employed physician than a private practitioner. For some services the difference can be more than a multiple of two.

As it is now, patients have no warning when they are going to be billed for an-add on facility fee whenever they visit a doctor who is employed by a hospital. It is especially shocking for patients to receive these bills if their physician was once independent and only recently joined the ever increasing ranks of hospital employed physicians.

Transparency with regard to these facility fees, as required by this bill, is essential, particularly now that patients are more likely to have high deductibles so that they have to pay the whole bill themselves.

The charging by hospitals of facility fees for outpatient visits is controversial; **however this bill does not address any of the issues around whether it is appropriate for hospitals to charge facility fees for outpatient visits to previously independent physician offices. The bill only requires disclosure of these fees prior to an appointment where facility fees will be charged.**

In short, if there are two offices across the street or a few blocks from each other, and one costs twice as much the other for the same exact service, consumers need to know this.

The state of Connecticut recently passed a very similar bill, and it was supported across the board by all of the stakeholders in healthcare, including hospitals. Several other states are considering similar laws.

I have included in the hand out an excellent and thorough well documented research report from the Connecticut attorney general's office that provides all of the factors and issues behind the necessity of this bill. Also included in the hand outs are the series of excellent articles from the KC Star regarding Facility fees, the purchase of physicians' practices by hospitals, and other related issues.

For background I will cover 4 issues briefly, which are documented in detail in the handouts.

1. Facility fees are add on fees which hospitals add to their bills for outpatient visits to employed physicians. As is well documented in the handout, these can range up to more than one thousand dollars and can be greater than the professional fee portion of their bill. Such fees are not charged by independent private practitioners. When hospitals purchase physicians' practices, they can charge these fees even if the doctor is still practicing out of the same office, as long as it is within 35 miles of the hospital that employs him or her. Thus patients who go to the same doctor can find themselves with much higher bills than they received for the very same service prior to his becoming hospital employed.
2. There has been a large increase in hospital consolidations the past few years, encouraged by the ACA, leading to the widespread purchasing of physicians' practices. Hospitals are incentivized to hire physicians directly in order to charge these fees, and also to capture downstream referrals for testing and surgery. These also come with facility fees. In many cases, these hospital employed physicians compete directly with independent private practitioners. These trends drive up health care costs dramatically, as more and more outpatient services are being billed at hospital rates.
3. The facility fees are paid both by private insurers and Medicare. MedPAC, the commission that advises Congress on Medicare policy, has recommended that payments be equalized across settings for 66 billing codes. The president's budget now recommends site neutral payments for some services in Medicare.
4. The disclosure of facility fees to individual Kansans is particularly important because of high deductibles across the board, including employer sponsored as well as the low end exchange policies. Those who have not met their deductible are liable for the entire charge. This is particularly important in rural areas where people are more likely to have lower incomes.

All of the statements and claims I have made are documented in the handouts.

In summary, the bottom line is that when you have two providers of identical services and one costs twice as much as the other, consumers need to be informed. This bill requires just that.

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AG Jepsen Releases Report on Hospital Facility Fees, Physician Practice Acquisitions in Connecticut

Urges General Assembly to approve legislation this session

Attorney General George Jepsen today released a report concerning so-called hospital "facility fees" and hospital acquisitions of independent physician practices. The Attorney General urged state lawmakers to approve pending legislation he proposed on these subjects to require improved notification and transparency.

"From the beginning, my office has sought to bring all stakeholders to the table – including hospitals and their patients – in order to gain a greater understanding of the evolving health care landscape, the application of facility fees and the overall impact on patients," Attorney General Jepsen said. "That process was invaluable, and I've detailed my office's findings in this report. Overall, legislation that guarantees across-the-board transparency is greatly needed given the rapidly changing nature of the health care system in Connecticut."

A facility fee is a charge levied by a hospital-acquired physician practice or a hospital that is purportedly intended to cover the overhead costs of the hospital. Such fees are in addition to the professional charges billed by the provider. Facility fees can be expensive, surprising and confusing for patients. That is particularly so when patients are charged the fees by previously independent physician practices from whom they received care in the past, but which had subsequently acquired by a hospital.

Last year, Attorney General Jepsen announced his intention to seek legislation to improve consumer protections related to facility fees and asked for information from patients and the state's hospitals, including how the fees were applied and any disclosures of them already in place.

The Attorney General also examined the related subject of the increasing vertical integration of physician groups and freestanding clinics and surgical centers by hospitals in recent years and its potential impact on competition.

The report notes that independent physician groups often charged patients according to a much lower fee schedule for services. Those charges increased notably once the practices were acquired by hospitals, which are able to charge higher fees under their insurer-negotiated schedules.

The Attorney General is responsible for enforcing Connecticut antitrust laws to protect consumers and businesses from anticompetitive conduct. However, current Connecticut law does not require notice to the Attorney General when a hospital acquires an independent

physician practice or when two large practices merge, making antitrust enforcement in this area difficult.

"Although Connecticut is a relatively densely populated state with adequate hospital choice, the trend toward consolidation and acquisition may pose risks to competition," said Attorney General Jepsen. "Acquisitions and mergers often make business sense, and may lead to some efficiencies and more integrated care, but they also may result in higher prices, fewer consumer options and lack of competition. Legislation requiring notice to my office of these acquisitions will allow us to better monitor the market and enforce antitrust laws designed to protect Connecticut consumers."

The Attorney General's review found common threads running through Connecticut residents' complaints about hospital facility fees. Patients are often surprised by facility fees, and some report that the fees resulted in financial hardship. Many do not believe they were adequately notified that they would be charged such fees and, indeed, had no idea that they were receiving hospital services.

Conversely, disclosures from Connecticut hospitals demonstrated wide variation in the charging of facility fees and their individual notice practices. Many provide no notice to patients or provide notice only to Medicare or uninsured, "self-pay" patients. Of those that do provide notice, the hospitals reported significant differences in the content and timing of their facility fee notices.

"Several hospitals acknowledged the need for greater patient information and expressed their willingness to examine their facility fee policies, to their credit," said Attorney General Jepsen. "However, I strongly believe that this year's legislation is important to ensure that all patients receive adequate notice, prior to treatment, so they can make informed choices about their health care and about whether or not to visit a practice that charges facility fees. I urge both chambers of the General Assembly to approve both this bill and the acquisition bill this year."

The legislation concerning facility fees – [House Bill 5337, An Act Concerning Fees Charged for Services Provided at Hospital-based Facilities](#) – has been approved unanimously by both the General Law and Public Health Committees. The legislation concerning physician acquisitions – [Senate Bill 35, An Act Concerning Notice of Acquisitions, Joint Ventures and Affiliation of Group Medical Practices](#) – was approved in a near-unanimous vote in the Public Health Committee.

The 2014 legislative session adjourns on Wednesday, May 7.

The Attorney General's Healthcare Competition Working Group – Assistant Attorneys General Charles Hulin, Thomas Ryan, Rachel Davis, Gary Becker and Richard Porter – under the direction of Assistant Attorney General Michael Cole, chief of the Antitrust and Government Program Fraud department, and Special Counsel Robert Clark are assisting the Attorney General with this matter.

[Please click here to download a copy of the Attorney General's report.](#)

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STATE OF CONNECTICUT
ATTORNEY GENERAL GEORGE JEPSEN

**Report of the Connecticut Attorney General Concerning Hospital Physician
Practice Acquisitions and Hospital-Based Facility Fees**

April 16, 2014

I. Introduction

The United States' health care market is buffeted by myriad economic forces that are changing health care pricing, delivery and access. Among those economic forces is a dramatic increase in consolidation among health care providers. According to the *New York Times*, between 2007 and 2012 there were close to 600 hospital mergers nationally, with 247 of those occurring in 2012. Large health systems have acquired competitors and then moved to vertically integrate – purchase – physician groups and freestanding clinic and surgery centers.¹ Connecticut is not immune to this trend, as demonstrated by several well-known hospital system mergers in recent years, as well as many less well known acquisitions by hospitals of physician practices and mergers between large physician groups.

One factor motivating hospitals to acquire physician practices is the Affordable Care Act (“ACA”), which incentivizes the creation of integrated health care delivery networks that take capitated risk – known as Accountable Care Organizations (“ACOs”). The ACA offers financial incentives to ACOs, which get a bundled payment to keep a patient in good health rather than charge for individual procedures. The expectation is that over the medium and long term this will result in better health outcomes and thus lower overall health care expense. For their part, physicians are more likely than ever before to sell their practices to hospitals and become salaried staff, in part due to the uncertainties about how health care reform will evolve over time, but also to avoid the burdens imposed by implementing electronic health records,

¹ Julie Creswell and Reed Abelson, *New Laws and Rising Costs Create a Surge of Supersizing Hospitals and A Wave of Hospital Mergers*, *The New York Times* (Aug 12, 2013), viewed Feb. 4, 2014 at http://www.nytimes.com/interactive/2013/08/13/business/A-Wave-of-Hospital-Mergers.html?_r=0

higher malpractice premiums and the cost of health insurance for staff.² According to the American Medical Association, 60 percent of family doctors and pediatricians, 50 percent of surgeons and 25 percent of surgical subspecialists – such as ophthalmologists and ear, nose and throat physicians -- are employees of hospitals.³

One significant manifestation of this consolidation in the marketplace is the hospitals' ability to engage in provider-based billing. "Provider-based billing," or as it is also known, "hospital-based billing," enables hospitals that own physician practices and outpatient clinics to bill separately for the use of the office or facility as well as for the physician's "professional fee". The "facility fee," also referred to as an "outpatient hospital charge" therefore, is a separate overhead charge assessed by a hospital that is increasingly being billed for services rendered in an office setting. When billed by previously independent physicians' practices, these charges – which can be hundreds of dollars or higher – are often surprising, confusing and financially burdensome to patients. This is particularly the case for patients who received regular care from a provider over long periods of time at roughly consistent cost, and who had no notice that the provider at some point in time had become hospital-based.

II. Our Investigation

In the face of this wave of horizontal mergers (*i.e.*, hospital to hospital) and vertical provider acquisitions (*i.e.*, hospitals buying up physician practices), in early 2013 the Connecticut Attorney General formed a Health Care Competition Working Group within his office to examine the potential impacts these consolidations may have on the pricing, quality, and access to health care for Connecticut's consumers and to propose recommendations for potential investigative or legislative initiatives to address them. The Health Care Competition Work Group includes Assistant Attorneys General from the Government Program Fraud and Antitrust Department, as well as members of office's Health Care Advocacy Unit, which provides advisory assistance to Connecticut consumers experiencing difficulties in obtaining health care coverage from their insurer or managed care organization.

² Elisabeth Rosenthal, *Apprehensive, Many Doctors Shift to Jobs With Salaries*, *New York Times*, (February 13, 2014) viewed at <http://www.nytimes.com/2014/02/14/us/salaried-doctors-may-not-lead-to-cheaper-health-care.html?ref=health>.

³ *Id.*

A large component of the working group’s investigation was directed at meeting with, and/or seeking information from, stakeholders throughout the health care system, including, *inter alia*, trade associations representing Connecticut’s hospitals, physicians, and ambulatory surgery centers, Connecticut’s leading health insurance companies, hospitals, large Connecticut employers, state officials and members of the National Association of Attorneys Generals’ Antitrust Task Force.⁴

In November of 2013, the Attorney General sent letters to all of the state’s acute care hospitals seeking broad information about their acquisition of previously independent physician practices, free-standing ambulatory surgical centers and urgent care centers and requesting detailed descriptions of their disclosure of hospital affiliation and any facility and professional fees charged to patients seeking care. The letter also sought information related to the extent to which hospitals ensured there was sufficient public awareness that hospital-based outpatient departments were affiliated with the hospital.

The information requests generally fell into the following categories:

- Identification of all “hospital-based” providers owned or controlled by the hospital that charge facility fees.
- The substance, manner, and timing of notice given to patients seeking treatment from off-campus providers informing patients that the provider is part of a hospital, and that patients are potentially liable for both a facility fee and a professional fee.
- Whether the provider discloses to patients the actual amount of any facility fee and the amount of any professional fee for which patients will be liable, or provides patients with estimates of facility and professional fees.

All 29 general hospitals provided written responses.

In addition, the Attorney General specifically requested that Connecticut residents contact his office and describe their experiences with facility fee charges. The office received approximately 70 responses from consumers.

⁴ Attorney General George Jepsen is a Co-chair of the Antitrust Task Force.

III. BACKGROUND

A decade ago, most Americans had comprehensive health insurance with low deductibles, coinsurance and co-pays. Their inpatient care was provided in the traditional hospital setting and specialty care and routine services were provided by primary care physicians and specialists unaffiliated with large hospital systems. *Those days are over.* In 2012 the annual family premium was 30% higher than in 2007 and 97% higher than in 2002.⁵ Likewise, in 2006 10% of employer health plans had a deductible of at least \$1,000; by 2009 that number rose to 22% and in 2011 it rose again to 31% of employer health plans.⁶ It is clear, therefore, that payers are reacting to the increased costs of health care by shifting more responsibility for these costs to consumers.

At the same time there is a risk that the acquisition trend will allow hospitals and health systems to secure market power – monopolies – that give them enhanced bargaining power over their reimbursement, which will likely lead to higher health care prices. Further, acquired physician practices and employed physicians give the hospitals a larger referral base, which in turn enhances the hospitals’ negotiating leverage with payers. A recent survey of such mergers and acquisitions concluded that “[h]ospital consolidation generally results in higher prices ,” with as much as a 20% increase in already concentrated markets.⁷

These market trends place ever greater financial burdens on consumers in the form of higher out-of-pocket expenses for health care, while consolidation in the healthcare industry and opaque pricing combine to leave them with dwindling ability to understand or avoid these escalating costs.

A. Connecticut Receives an “F” for its Health Care Price Transparency Laws

The inadequacy of patient notification of hospital facility fees must be considered within the much broader context of a health care industry that lacks general cost transparency.

⁵ <http://ehbs.kff.org/pdf/2012/8345.pdf><http://ehbs.kff.org/pdf/2012/8345.pdf>http://kff.org/report-section/ehbs-2013-section-1/#TB_inline?1=1&width=800&height=580&inlineId=exhibit-1_11

⁶ <http://kaiserfamilyfoundation.files.wordpress.com/2013/03/8346-employer-health-benefits-annual-survey-summary-of-findings-0912.pdf>

⁷ The Impact of Hospital Consolidation — June 2012 Update <http://www.rwjf.org/en/research-publications/find-rwjf-research/2012/06/the-impact-of-hospital-consolidation.html>

Consumers cannot make informed choices, and markets cannot function efficiently, when the prices of goods and services cannot be readily determined. The federal government defines “price transparency” as “the availability of provider-specific information on the price for a specific health care service or set of services to consumers and other interested parties.”⁸ In March 2013, two non-profit groups, the *Health Care Incentive Improvement Institute* and the *Catalyst for Payment Reform*, published a “*Report Card on State Price Transparency Laws*.”⁹ Because states play such a pivotal role in ensuring that consumers have access to both quality and price information by setting policies and implementing laws that advance transparency, the report was designed to determine how much pricing information each state makes available to its consumers.¹⁰ The report examined the existing transparency laws in all 50 states and graded them, according to carefully defined criteria, on how well each state supported the information needs of consumers.¹¹

Only Massachusetts and New Hampshire received “A” grades. Twenty-nine (29) states, including Connecticut, received an “F”. The authors noted that “[t]here is no public resource in Connecticut that makes (comparison) pricing information available to consumers. That means there's no consumer protection against egregious pricing behaviors by providers.”^{12 13} Undisclosed or poorly disclosed hospital facility fees are a prime example of opaque pricing rampant in the health care sector, and an example that threatens to become much more common as vertical integration proliferates.

B. An Overview of Facility Fees

Hospitals contend that facility fees are used to cover their overhead costs for things like imaging equipment, electronic health records, and care for the uninsured. According to the American Hospital Association, the industry’s trade group, hospitals provide access to critical

⁸ U.S. Government Accountability Office (GAO). “*Meaningful Price Information Is Difficult for Consumers to Obtain Prior to Receiving Care*,” Sept. 23, 2011, viewed Feb. 14, 2014 at <http://www.gao.gov/products/GAO-11-791>

⁹ “*Report Card on State Price Transparency Laws*,” Mar. 18, 2013, viewed Feb. 14, 2014 at <http://www.catalyzepaymentreform.org/images/documents/reportcard.pdf>

¹⁰ *Id.* at 3.

¹¹ *Id.* at 4.

¹² *Report: Connecticut Fails Consumers Looking For Health Care Costs*, The Hartford Courant, July 25, 2013.

¹³ In 2012, Connecticut passed a law establishing an All-Payer Claims Database (“APCD”). The APCD is a database that will collect and aggregate medical, dental and pharmacy claims data. Once the APCD is implemented, Connecticut’s consumers will have access to information concerning cost and quality of health care services.

hospital-based services that are not otherwise available in the community and treat higher-severity patients for whom the hospital outpatient department is the appropriate setting. In addition, hospitals have higher cost structures than physician offices due to the need to have emergency stand-by capacity and are subject to more comprehensive licensing, accreditation and regulatory requirements than physician offices.¹⁴

On the other hand, critics contend that facility fees are a means to enable hospitals to earn more revenue for a simple office visit, which flows right to the hospital's bottom line. As the *Washington Post* reported in "*That'll Be \$418 For Use of the Examining Room,*"¹⁵ Alan Sager, a professor of health policy and management at the Boston University of Public Health, called facility fees "a tax on sick people" and nothing more than a "gimmick to generate revenue for hospitals" to make up for profit margins that sank during the recent recession.

Although hospitals have always charged patients facility fees for the use of the hospital itself, it is a relatively recent – but expanding – phenomenon that hospitals charge such fees for services rendered in the offices of formerly independent physician groups and clinics hospitals have acquired. Whether the physician's office is within the hospital, close-by or across town, all of these "provider-based" facilities are commonly deemed by hospitals to be part of their outpatient department for purposes of charging facility fees. Thus, the trend of vertical acquisition has a compounding effect for consumers: As more previously independent clinics and physicians are acquired by hospitals, more patients are charged hospital facility fees.

There is reason to question the assertion that the costs associated with acquiring and operating a hospital-based practice compel the charging of facility fees. Hospital-based physician practices have distinct economic advantages. Presumably, they may benefit from efficiencies in medical record keeping, centralized billing, procurement and other economies of scale. In addition, they can often charge payers and patients at the hospital's much higher reimbursement rates for professional services, leaving some doubt as to the financial necessity of also charging substantial facility fees. A *Wall Street Journal* article, *Same Doctor Visit, Double*

¹⁴ American Hospital Association FACT SHEET, Outpatient Evaluation & Management Services, January 10, 2014.

¹⁵ Sandra G. Boodman, *That'll Be \$418 for Use of the Examining Room*, *The Washington Post*, (Oct. 6, 2009), viewed Feb. 4, 2014 at <http://www.washingtonpost.com/wp-dyn/content/article/2009/10/05/AR2009100502910.html>

the Cost, noted that “[a]s physicians are subsumed into hospital systems, they can get paid for services at the system’s rates, which are typically more generous than what insurers pay independent doctors.”¹⁶ Moreover, the greater the market share of the hospital the more leverage it has in negotiating higher reimbursement rates for physician services from private insurers – much more leverage than that available to independent physicians.

Consider the example of the billing of physician-administered oncology drugs. One independent oncologist in southern Connecticut billed a commercial insurance company an average cost of \$87.31 per unit for a particular chemotherapy drug. After that same provider was acquired by a Connecticut hospital, the oncologist – now part of the hospital – was able to charge at the hospital’s higher fee schedule with that insurer, which averaged \$606.55 per unit, an increase of 595% over his prior charge. The same dynamic can be seen in the disparity in reimbursement Medicare pays for colonoscopies in freestanding ambulatory surgical centers and hospital-based outpatient departments. Medicare’s average reimbursement for the former is \$362, while reimbursement for the latter is \$643.¹⁷

C. The Medicare Model

The hospital practice of billing separately for facility and professional fees for outpatient services derives substantially from a long-standing Medicare reimbursement policy – a policy that incentivizes hospitals to purchase freestanding physicians’ offices and clinics and convert them to hospital outpatient departments (“OPDs”) without changing their location or patient mix.¹⁸

For care provided at an independent (i.e., unaffiliated) practice, Medicare pays a physician a single fee based on the Medicare physician fee schedule that includes some reimbursement for the physician’s services as well as the medical practice’s overhead expense. For an office visit in a hospital’s OPD, however, Medicare separately pays the facility fee to

¹⁶ Anna Wilde Matthews, *Same Doctor Visit, Double the Cost*, *Wall Street Journal*, (Aug. 27, 2012), viewed 2/4/2014 at <http://online.wsj.com/news/articles/SB10000872396390443713704577601113671007448>

¹⁷ *ASC to HOPD Conversion: Costly Consequences*, Ambulatory Surgery Center Association, viewed Feb. 14, 2014 at <http://www.wasca.net/wp-content/uploads/2007/03/ASC-to-HOPD-Conversion-Costly-Consequences.pdf>

¹⁸ Medicare Payment Advisory Commission, “*Report to the Congress: Medicare Payment Policy*,” at 48. http://medpac.gov/documents/mar12_entirereport.pdf. The Medicare Payment Advisory Commission (MedPAC) is an independent congressional agency established by the Balanced Budget Act of 1997 (P.L. 105–33) to advise the U.S. Congress on issues affecting the Medicare program.

cover the hospital's cost or overhead expense and the "professional" fee for the physician's services. As discussed above, the total of the two fees paid for visits to hospital OPDs can be considerably higher than the single fee paid to freestanding practices.¹⁹ For example, Medicare pays 80 percent more for a 15-minute office visit in an OPD than in a freestanding doctor's office.²⁰ In addition, Medicare beneficiary out of pocket cost is substantially higher when office visits are billed as OPD visits because beneficiaries have to pay a 20% coinsurance twice, once for the facility fee and once for the professional fee.²¹

For Medicare patients who receive their OPD treatment in the main hospital or on the hospital's campus (defined as within 250 yards of the main hospital), Medicare requires the hospital to notify patients that the medical provider is part of the hospital and bill accordingly. This "public awareness" requirement applies if the hospital-based provider is on campus or "off-campus" (*i.e.*, more than 250 yards from the hospital). Additional notice requirements apply to off-campus providers, including requirements for written notice of the amount of the beneficiary's potential financial liability (*e.g.*, coinsurance for an outpatient visit to the hospital and the physician service). If the exact type and extent of care needed is not known at the time the service is rendered, the off campus provider must give notice that the beneficiary will incur a coinsurance liability to the hospital that he or she would not incur if the facility were not provider-based, an estimate based on typical or average charges for visits to the facility, and a statement that the patient's actual liability will depend upon the actual services furnished by the hospital.²² "The notice must be one that the beneficiary can read and understand."²³ Although Medicare is not specific as to what constitutes sufficient "public awareness" that the OPD is part of a hospital, the American College of Physicians believes that hospitals and hospital-based providers can fulfill this requirement by ensuring that the "entity's signage, marketing materials, websites, stationery, etc. include the name of the main hospital and create the clear impression

¹⁹ *Id.* at 51.

²⁰ *Id.* at 48.

²¹ *Id.* at 73.

²² The Attorney General interprets this requirement to include notice of the actual or estimated facility fee, for which a beneficiary was liable.

²³ 42 C.F.R. 413.65(g)(7)(ii).

that the facility is part of that hospital.”²⁴ Commercial health plans have largely acquiesced to the Medicare payment model for facility fee claims, but legal notice requirements, such as those that exist under Medicare, do not currently exist in the state of Connecticut for patients covered under these commercial plans or, for the uninsured.

IV. Our Findings

A. Common Consumer Complaints

The common threads running through the consumer complaints the Attorney General received demonstrate the following:

- Patients charged facility fees often believed that they were receiving non-hospital services.
- Patients believed they were given no effective notice that they would be charged an additional fee and no advanced information pertaining to the amount of the fee, their financial liability for the fee or what steps they might have taken to arrange comparable care at a lower cost from an alternative provider.
- Receptionists at OPDs typically only request payment of the professional copay on the date of service. When they paid their co-pay to receptionists at OPDs, patients claimed they reasonably believed that they had satisfied their full financial liability for the service. The receptionists’ request for and acceptance of a co-pay, without any disclosure that it did not constitute the full patient liability, led patients to believe that there were no additional charges.
- Patients were surprised, after their date(s) of service, to receive bills for either additional co-payments of facility fees, or the full cost of the facility fee.
- Patients described the facility fee as a financial hardship, and felt it bore no relationship to the care they were provided.
- The complaints regarding lack of notice and price transparency came from patients covered by Medicare, private insurance and those with no insurance.

B. Facility Fees Can be Expensive

²⁴ See *American College of Physicians Policy on Provider-Based Billing*, April 2013, viewed Feb. 14, 2014 at http://www.acponline.org/acp_policy/policies/provider_based_billing_2013.pdf, at 3.

Our findings indicate that facility fees for hospital-based outpatient services can range from \$100 to in excess of \$1,000. One patient's experience is illustrative. She went to her dermatologist's office for a fairly routine skin biopsy and was charged a total of \$390 for the office visit and the medical procedure. The office was several hundred yards from the closest hospital and appeared by all accounts to the patient to be unaffiliated with a hospital. After the dermatologist's practice was acquired by that hospital, however, the patient returned again to the same office for the same procedure and was charged the same amount plus a \$170 facility fee. Although this patient did not have health insurance, it should be noted that it is not uncommon for facility fees to be applied to an insurance plan's hospital deductible, which can often be thousands of dollars more than the deductible for a physician visit meaning, of course, more money out of the patient's pocket.

The Attorney General has received to date 70 complaints from Connecticut consumers who were surprised to find out that the medical services they received in an office setting triggered a hospital facility fee.

The complaint of Ms. S is another typical example. Ms. S is 75 years old and lives with her elderly husband in northwestern Connecticut. Her husband, Mr. S, needs treatment for a pre-cancerous skin condition every six months. Mr. S receives this care from a dermatologist with offices near a hospital. Until the fall of 2013, Mr. S, who is enrolled in a Medicare Advantage Plan, was required to pay only a \$50 co-payment for this care. In October 2013, however, Mr. S paid the \$50 co-pay after receiving the usual care from the same provider in the same office, but later received a bill for an additional \$128.28 directly from the hospital. Ms. S called the doctor's office and complained that she and her husband had received no prior notice of this hospital charge. An office staff person told her that the possibility of such a fee had been explained in a notice posted on the waiting room wall.

Ms. S then called the hospital to inquire further. She was told that the \$128.28 fee was an "outpatient charge" due because the dermatologist's practice was now "under the umbrella" of the hospital. Ms. S says she and her husband are on a fixed income and the facility fee is a real burden to them. She is fearful that visits to their other doctors will also trigger facility fees in the future.

Of the many complaints received by the Attorney General, some related to “off-campus” providers (those whose offices are not near the main hospital) whose practices were taken over by a hospital. These complainants alleged that they were each charged a facility fee that was never disclosed when the appointment was made. Other complaints pertained to consumers who received care in offices located on hospital campuses of the type that could typically be provided in a non-hospital office setting. The recurring theme from these complainants was that the services appeared to be provided in physician offices or clinics that seemed to be unaffiliated with a hospital. Some hospitals claim that they disclose to patients a provider’s affiliation on signs and/or paperwork. However, it is clear from the large number of complaints that these disclosures are often inadequate to convey to consumers that the provider is affiliated with the main hospital and patients will be charged both a professional and facility fee.

The Attorney General also received a number of complaints from Medicare Advantage Plan members surprised that specialist visits, which at one time only included an office based co-pay under \$50, suddenly became hospital outpatient services with additional high coinsurance charges linked to facility fees. These complainants consistently stated that they had not received an estimate of charges, as required by Medicare and were not informed that a hospital would bill a separate fee for the facility component of the visit.

Significantly, complainants nearly universally stated that they each paid a single co-pay that was requested at the time of service. According to these complainants, receptionists did not inform them they would later be charged an additional copay, coinsurance or deductible for a facility fees. As a result, patients were effectively denied the opportunity to seek lower cost care alternatives from providers who did not charge facility fees.

Some complainants told us they were confused by hospital based systems that charged facility fees for some medical services but not others. In these instances, it had not been clear to patients when a service triggered a facility charge and when it did not; in large part because the service itself determined whether the fee applied, not the location of the service. For example, one complainant paid her \$25.00 co-pay at the receptionist counter of her physician’s office for a standard office visit. During the visit, which did not itself require a facility fee, she discussed with her doctor the need for a pulmonary function test. She agreed to have the test during the visit and followed the doctor to a different room in the same office suite. She was later surprised

to receive a bill for a facility fee co-pay of \$200 associated with the pulmonary function test. She was not informed that the test would trigger an additional charge and had never paid a facility fee copay in connection with any prior pulmonary tests.

In yet other instances, in-network providers affiliated with hospital systems referred patients to other in-network hospital-based providers for specialty services that could have been provided at a lower cost in an in-network office-based provider. One complainant identified a situation in which he was referred by a primary care physician who was affiliated with a hospital, to a hospital-based cardiology practice in an office that was not located on the main campus of the hospital. He was referred in order to receive a temporary cardiac “Holter monitor.”²⁵ The complainant was not informed that the practice was owned by the hospital and thus considered to be part of the hospital’s outpatient department. On the date he received the monitor, the receptionist requested the patient’s standard \$45 specialist co-pay, which the patient paid at the front desk. No mention was made of any additional patient financial liability. A few weeks after the initial service date, he received a facility fee of \$1,212.47 for the Holter monitor service. This amount was deemed his financial responsibility by his health insurance company because it fell within his unsatisfied annual deductible.

Complaints to the Attorney General have been consistent with media accounts. Articles published in recent years show that the imposition of new facility fee charges has become common in the health care industry. In 2012, for example, the *Wall Street Journal* described the case of one patient – a doctor – who was surprised to learn that the heart scan he had received cost his insurer \$1,605; more than four times the \$373 the insurer paid for the same procedure six months earlier.²⁶ The increased charges were the result of provider consolidation: “[the patient] was caught up in a structural shift that is sweeping through health care in the U.S. – hospitals are increasingly acquiring private physician practices.”²⁷

In July 2013, the *Connecticut Mirror* ran an article entitled “*As hospitals buy medical practices, patients face thousands of dollars in new charges,*” describing the plight of a patient required to pay an expensive facility fee after her radiologist’s practice was purchased by a

²⁵ A Holter monitor's most common use is for monitoring heart activity (i.e., electrocardiography or ECG).

²⁶ Anna Wilde Matthews, *Same Doctor Visit, Double the Cost*, *Wall Street Journal*, (Aug. 27, 2012), at 1, viewed 2/4/2014 at <http://online.wsj.com/news/articles/SB10000872396390443713704577601113671007448>.

²⁷ *Id.* at 2.

Connecticut hospital.²⁸ The article provides yet another example of a Connecticut patient's encounter with a bill for a facility fee:

[The patient's] situation is the result of something known as a facility fee, a charge that's likely to become increasingly common as hospitals acquire physician practices or take ownership of the equipment doctors use.

Patients or their insurance typically get one bill from a physician who performs an in-office procedure. But if a hospital owns the practice or the equipment used, it can charge a fee in addition to the bill for the doctor's service.

Hospital officials say the second fee reflects the overhead costs of the practice and hospital as well as higher standards that hospital-owned practices meet.

That second charge can amount to thousands of dollars.²⁹

C. The Extent of Hospital Disclosure of Facility and Professional Fees Varies Greatly Across the State.

The information requests the Attorney General sent to Connecticut's general hospitals yielded information demonstrating wide variation in the charging of facility fees and notice practices of Connecticut's hospitals.

1. Most hospitals in Connecticut charge facility fees in their out patient departments.

Twenty-two (22) of the twenty-nine (29) hospitals contacted reported that they have OPDs and charge separate facility and professional fees. One hospital replied that it had stopped billing facility fees in its OPDs because multiple bills from different providers caused and contributed to patient confusion and dissatisfaction.

2. Many Connecticut hospitals fail to provide any notice of the charging of facility fees.

²⁸ Arielle Levin Becker, *As hospitals buy medical practices, patients face thousands of dollars in new charges*, *Connecticut Mirror*, <http://ctmirror.org/hospitals-buy-medical-practices-patients-face-thousands-dollars-new-charges>, July 22, 2013.

²⁹ *Id.*

Only twelve (12) hospitals responded that they notify all of their OPD patients to expect two separate fees applied to the medical service. Thirteen (13) of the responding hospitals stated that they only provided the notice of facility fees to patients covered by Medicare. Four (4) hospitals stated that they notify uninsured or “self-pay” patients of the separate facility and professional fees in writing, and provide an estimate of the amounts with a disclaimer that actual amounts may differ. Seven (7) hospitals do not provide notice of the facility fee component to any of their OPD patients.

3. *The timing of notice to patients concerning facility fees varies among hospitals.*

Of the hospitals that do provided a notice of facility fees, most provide the notice at the time the patient arrives at the OPD for their scheduled medical service. A few hospitals told us that they notify patients prior to the date of their scheduled appointment of separate facility fees, but only if the appointment is made – in their judgment – far enough in advance to permit them to do so.

4. *There are significant differences in the content of facility fee notices.*

One hospital fee disclosure in a letter mailed in advance to confirm a physician office appointment reads as follows:

BILLING POLICY As a hospital outpatient department, the hospital portion of your bill will be submitted to your insurance company through [the] Medical Center. The physician that treats you will bill your insurance separately through his/her medical office. Both [the] Medical Center and your Physician's bill are subject to co-pays.

Few of the notices provided by the hospitals described the fact that there were separate fees in plain language using easily readable type, bullet points, or colored paper.

However, none of the hospitals that were willing to provide patients with notice of the precise amount of potential liability for separate facility and professional fees, or even a best estimate, would do so unless specifically requested by the patient.

One hospital did state that it intends to provide an estimate of facility and professional fees as part of a recently rewritten patient notice letter. Another hospital is studying the feasibility of implementing a financial counseling call center so as to provide patients with more detailed information on pricing. Others, however, claimed that it is difficult and time-consuming to provide such pricing information due to the wide variability in patients' insurance coverage, including variations in copays, coinsurance and deductibles. Hospitals expressed a concern that requiring the provision of such information to the patient/consumer may necessitate the hiring of additional staff. One hospital complained that private health insurance companies do not provide detailed enough insurance information to permit hospital billing specialists to calculate patients' out-of-pocket charges, such as amounts applicable to the remainder of patients' deductibles.

5. *Hospitals often use ineffective mechanisms for giving notice of facility fees.*

Of the 29 hospitals, only one notifies patients of the existence of separate billing for the hospital and physician fee in a patient brochure, provided at the registration desk, and on a poster shown on an interior door. A second hospital uses multi-purpose written notices with a section captioned “Separate Hospital and Physician Services” that clearly describes possible patient liability for facility and professional fees, which is provided at registration. A third hospital provides patients with a letter mailed to the patient in advance of the service date, if feasible, which focuses only on professional and facility fees, and describes in detail how the fees differ, and why the patient may receive separate bills.

By contrast, however, a number of hospitals pointed to their “Treatment Agreement” as the notice that informed the patient of the hospital’s OPD billing practice. A Treatment Agreement or “Consent for Treatment” is primarily a contract between a patient and a hospital intended to, among other things, ensure “informed consent” for medical treatment. Treatment Agreements often include a number of other terms and conditions, including some related to use of protected health information, health insurance, assignment of insurance benefits, guarantees of prompt payment, and responsibility for valuables brought into the hospital. Given the multiple purposes of the Treatment Agreement, such contracts are not an effective means to communicate notice of the billing of separate facility and professional fees. None of the treatment forms provided to the Attorney General included the exact amount or an estimate of the patient’s financial liability. Moreover, the treatment agreement is invariably provided to the patient when they arrive at the OPD just prior to the medical service and far too late in the process for the patient to have a viable alternative should they choose to search for a provider that may not impose a facility fee. At such time, patients are often asked to fill out other paper work as well, such as medical history reports, which further obscure any communication regarding facility fees that might be contained in a Treatment Agreement.

Many of the hospitals provided photographs of outdoor and indoor signs and websites identifying that the OPD was part of a hospital. Of course, the extent to which consumers understand the signage is determined by its content and placement. It bears noting that most complainants were unaware of information about facility fees in either a Treatment Agreement or signage at the OPD.

V. CONCLUSION AND NEXT STEPS

Clearly the extent of the disclosure that a provider is affiliated with a hospital and that the patient will be charged a separate facility fee varies greatly among Connecticut's hospitals. The level of variation is equally applicable to disclosure of specific and estimated facility and professional charges and the timing of notice by those hospitals that provide it.

To their credit, several hospitals acknowledged in their responses an understanding of the problem and indicated a willingness to reexamine and improve their current fee disclosure policies for OPDs. We furthermore appreciate the cooperation demonstrated by all Connecticut hospitals in engaging in a voluntary and productive exchange of information with this Office.

Our conclusion, however, is that Connecticut residents need and deserve far greater notification and transparency in the charging of facility fees in order to facilitate real choice, and that hospitals should be required, under a uniform legal standard, to provide it. In addition, the ability of the Attorney General to better ensure a competitive health care marketplace in Connecticut necessitates the disclosure of smaller scale provider acquisitions that are not currently legally mandated.

For that reason, the Attorney General has proposed that the Connecticut General Assembly consider enacting the following bills:

AN ACT CONCERNING HOSPITAL FACILITY FEES. In essence, the proposed bill will ensure that all Connecticut consumers who are not covered by Medicare, Medicaid or health care through a worker's compensation plan will receive clear and easily understood notice when they will be charged a facility fee and a separate professional fee and, in certain instances they will also receive their actual financial liability for both or an estimate. In addition, for non-emergency care scheduled ten (10) days or more in advance of the medical service, consumers will receive the notice in writing. This will give the consumer the option of seeking potentially lower cost alternative services, *i.e.*, providers who do not impose a facility fee or can provide the service at a lower cost. Finally, the bill will require OPDs to clearly hold themselves out to the public and payers as being hospital-based, including at a minimum by stating the name of the hospital or health system in its signage, marketing materials, websites, and stationery.

AN ACT CONCERNING NOTICES OF ACQUISITIONS, JOINT VENTURES AND AFFILIATIONS OF GROUP MEDICAL PRACTICES. While most hospital mergers are well known to the public and reported in the news media, a large majority of the hospital acquisitions of medical groups, clinics and ambulatory surgical centers are not. In a similar vein, large physician group acquisitions of competing physician groups are also generally not reported. The purpose of the bill is to provide the Attorney General with notice of such acquisitions, mergers and joint ventures and thereby enable his office to better monitor these transactions in order to fulfill his legislative mandate to ensure that competitive health care markets are maintained in Connecticut. Thus, the proposed bill requires that the Office of the Attorney General be notified of changes in business relationships of physician practices. It also requires that all hospitals and hospital systems file with the Office of the Attorney General and the Commissioner of Public Health a written report regarding the group practices which the hospitals or hospital systems own or are affiliated with.

We are confident that the legislation described above would provide the Office of the Attorney General and others greater insight into the makeup of the evolving health care market in Connecticut and, where appropriate, assist the initiation of legal action to preserve competition when it is threatened. Of course, issues surrounding health care competition and transparency will persist far beyond the current legislative session. The Office of the Attorney General will remain engaged on these vital subjects, cognizant of their profound impacts on individuals, families, businesses and communities. We will also continue to urge policy makers to address these issues with thoughtful deliberation, and look forward to contributing to that process in collaboration with affected stakeholders.

In the meantime, our staff remains available to assist individuals requiring assistance with complaints concerning health care. Complaint forms, contact information and other consumer resources are available at <http://www.ct.gov/ag>.

THE KANSAS CITY STAR.

ST. LOUIS — It was a minor skin infection. The visit to the dermatologist's office at SSM Cardinal Glennon Children's Medical Center took just a few minutes.

Before she left, Allison Zaromb paid \$40 for her 4-year-old son's care, the amount listed on her insurance card for an office visit to a physician specialist.

Zaromb assumed she had settled the bill, until a shocker arrived in the mail: After paying for the doctor, she still owed about \$200 for a "facility fee" charged by Cardinal Glennon.

"I had no idea you would have to pay another fee because the doctor's office was on a hospital campus," Zaromb said.

"It's just not fair. It's like paying the barber for a haircut and then being charged extra for sitting in the barber chair."

Fair or not, facility fees are built into the way Medicare and commercial insurance plans pay for health care. Hospitals have charged them routinely for years for services at their outpatient clinics.

But the fees are getting new scrutiny now that hospitals nationwide are buying up physician practices and putting thousands of physicians on their payrolls.

Sometimes by making few visible changes beyond putting their logos on the door and issuing new ID badges, hospitals can declare newly acquired practices part of their outpatient department and start OCbilling patients more.

The doctor's office doesn't have to be in the hospital or even on the hospital campus to charge facility fees. It can qualify if it's as far as 35 miles away.

Facility fees can more than double the cost of a visit to the doctor, a major hardship now that many people have high-deductible insurance plans with substantial out-of-pocket expenses.

The full cost of the fees has never been calculated, but the extra payments just from Medicare, the federal insurance program for the elderly and disabled, amount to billions of dollars.

"It doesn't make sense," said Kevin Kavanagh, a retired surgeon and chairman of the patient advocacy group Health Watch USA.



Sid Hastings | Special to The Star

Allison Zaromb was surprised by a bill for a facility fee from a St. Louis hospital. "It's just not fair," she said. As part of the settlement of a class-action lawsuit over the fees, Zaromb eventually received a full refund.

About this series

Alan Bavley wrote these stories as part of a yearlong Reporting Fellowship on Health Care Performance sponsored by the Association of Health Care Journalists and supported by The Commonwealth Fund.

Either hospitals are making extra money by charging facility fees, or they're operating far less efficiently than a doctor's office can, Kavanagh said. In either case, facility fees "are extremely expensive to the health care system."

The fees may be one of the primary factors driving physicians out of private practice and into hospital employment, Kavanagh said. "You can't compete against an enemy paid almost twice as much as you are."

Hospitals defend facility fees by saying it's unfair to compare their expenses to those of a physician in private practice.

Essential community services such as emergency rooms and burn units must be maintained, said Herb Kuhn, president of the Missouri Hospital Association. "And the regulatory environment between a hospital and a doctor's office is so different."

That argument doesn't convince Seattle attorney John Phillips.

"It's a complete fiction that hospitals are doing cost accounting. They charge what they can charge. It has nothing to do with the hospital's own analysis of what its overhead is. It's just additional revenue."

Phillips has settled four class-action lawsuits on behalf of patients who were charged facility fees by hospitals in Seattle and St. Louis.

The lawsuits alleged that the hospitals violated state consumer protection laws by not telling patients clearly upfront that they would be charged the fees. Zaromb, who was among the plaintiffs, received a full refund.

"We felt like from an organizational perspective our billing was clear and transparent. We were following all the rules and regulations," said Karen Rewerts, chief financial officer of SSM Health Care, which operates Cardinal Glennon.

"We learned through this case that it could be more clear and transparent."

Phillips said the most he can do for patients is get them a refund and fuller disclosure of the fees.

More information

A Medicare patient's routine 15-minute "evaluation and management" visit to a doctor's office costs 70 percent more when the office is part of a hospital's outpatient department.

Independent doctor's office Hospital doctor's office

Physician fee Facility fee Total

Medicare payment \$58.00 \$39.76 \$58.74 \$98.70

Patient payment \$14.50 \$9.94 \$14.74 \$24.68

Total payment \$72.50 \$49.70 \$73.68 \$123.38

(Amounts are for 2013)

Source: Medicare Payment Advisory Commission

The cost of an outpatient echocardiogram for Medicare patients more than doubles when hospitals tack on a facility fee.

Service in an independent physician's office

Payment to physician: \$188.31

Service in a physician's office that is part of a hospital outpatient department

Payment to physician: \$62.40

Payment to hospital: \$390.40

Total payment: \$452.89

(Amounts are for 2013 and include both what Medicare and patient pay)

Source: Medicare Payment Advisory Commission

Hospitals are acquiring independent ambulatory (outpatient) surgery centers because Medicare often pays substantially more when the centers are part of a hospital's outpatient department.

Outpatient Procedure How much more Medicare pays

hospital surgery centers versus

independent surgery centers

shoulder arthroscopy/surgery \$1,460

correction of bunion \$1,002

repair wrist joint(s) \$1,184

fragmenting of kidney stone \$1,265

repair detached retina \$1,234

laparoscopic gallbladder removal \$1,442

(Amounts are for 2011)

Source: Ambulatory Surgery Center Association

“We’ve never been able to say you can’t charge these (facility fees) as a matter of law because Medicare permits it,” he said.

Closer scrutiny

That could be changing.

The Department of Health and Human Services’ office of inspector general, the agency charged with detecting waste, fraud and abuse, has facilities fees in its sights.

An examination of whether hospitals are following Medicare billing rules for the physician practices they own is part of the agency’s current work plan. The agency also plans to scrutinize hospital acquisitions of outpatient surgery centers, another venue where hospitals are paid higher rates.

Last year, the group that advises Congress on Medicare rates recommended phasing out facility fees for simple office visits to the doctor. The fees can boost charges by 70 percent.

“We started noticing purchases of physician practices. We thought some of the motivation was to instantly increase revenue,” said Mark Miller, executive director of the Medicare Payment Advisory Commission, or MedPAC.

“Hospitals do have some higher costs,” Miller said. “There are certain costly standby services with highly trained staff and equipment, like the emergency room, that are needed by the community.

“The question becomes, how much more should we pay? If patients can get it cheaper elsewhere, why pay more?”

An independent physician typically is paid \$72.50 to see a Medicare patient for about 15 minutes. The money covers both the professional fee and office overhead.

That same visit to an office owned by a hospital yields two payments: a physician fee of \$49.70 and a facility fee of \$73.68, for a total of \$123.38. Patients have to pay about \$25 of that, \$10 more than they pay for an independent physician.

Louis Lux, 84, of Grain Valley started seeing this difference firsthand after his wife’s doctor moved from an independent practice to employment at Centerpoint Medical Center. Facility fees began to show up on her bills.

For a brief visit to her doctor in July, Naomi Lux received a bill for \$152 from her doctor and a bill from Centerpoint for “ancillary charges” totaling \$581.52.

Medicare knocked those list prices down to their usual rates, but Louis Lux still doesn’t think it’s right to get two bills.

“If you decide to ride the bus and you pay your fare, then you pay more for the bus being there — it’s just how the world has gotten. All screwed up.”

Corinne Everson, spokeswoman for Centerpoint’s parent corporation, HCA Midwest, said its doctors and hospitals “bill based on what is outlined by the health insurance plan” or by Medicare and Medicaid.

MedPAC estimated in 2012 that equalizing the amount paid for routine visits to hospital-based and independent physicians could save Medicare as much as \$5 billion over five years.

The commission now is looking at what would happen to Medicare costs if hospital payments were brought into line with those of private practices for other kinds of services, such as minor surgeries and diagnostic imaging.

Doing that for echocardiograms and cardiac nuclear stress tests alone, MedPAC estimated, would cut Medicare spending by \$500 million per year, including about \$100 million less in patients' out-of-pocket expenses.

In its report to Congress this June, MedPAC warned that maintaining the status quo could prove costly.

With the rapid migration of doctors from private practice to hospital employment, the percentage of outpatient visits eligible for facility fees is soaring.

At the present rate of growth, by 2021 the increase in facility fees for routine doctor visits and for cardiac imaging tests will cost Medicare an extra \$2.3 billion and patients an extra \$590 million in out-of-pocket expenses each year, according to MedPAC estimates.

The same kind of math applies to outpatient surgery. According to data from the Ambulatory Surgery Center Association, the trade group of independent outpatient surgery centers, when a hospital acquires a surgery center and makes it part of its outpatient department, its Medicare rates jump by about 75 percent. For example, eye surgery to remove a cataract that cost Medicare \$951 when the center was independent costs \$1,691 after it becomes part of a hospital.

Meanwhile, the commercial insurance industry's response to the growing prevalence of facility fees has been muted.

Its trade association, America's Health Insurance Plans, rails against hospital mergers and medical practice acquisition as stifling competition and raising charges.

But all that its spokesman Robert Zirkelbach would say about facility fees is that "it's an important issue that needs to be looked at. Consumers need to know what they're charged and why."

Officials in several states are trying to get more information about facility fees to consumers. A bill requiring full disclosure of the fees for outpatient services was introduced this summer in the Pennsylvania House of Representatives. The Connecticut attorney general recently asked state lawmakers to consider similar transparency legislation next year.

Angry patients — and doctors

Kansas City area hospitals routinely charge facility fees, say officials at Blue Cross and Blue Shield of Kansas City.

But Wayne Powell, the company's chief of staff, said that to his knowledge Blue Cross subscribers have lodged no questions or complaints about facility fees.

He hasn't heard from John Sheldon's patients.

Sheldon does radiation therapy; a lot of his patients are men with prostate cancer. He's part of an independent practice but is based at Research Medical Center.

Routine visits to discuss results of a test that may indicate the return of the patient's cancer come with facility fees of \$313. Sheldon himself charges \$73 to \$150.

"The patient gets angry, and he gets angry at me. 'Why should I ever come back to you, Dr. Sheldon?'"

Because so many of his patients were dropping these important follow-up office visits after their treatments, he started doing the consultations for free by phone and fax.

Unless patients complain, as Sheldon's did, doctors may not even be aware of how high the facility fees can get, or even that patients are being billed for those extra charges.

Internal emails from a Seattle hospital show that doctors were stuck between patients who complained about the charges and administrators who insisted the charges were part of doing business.

The emails were obtained by attorney John Phillips after he filed a class-action suit against Virginia Mason Medical Center.

A neurologist warned hospital administrators of a revolt among patients who were surprised when the hospital started to charge them facility fees for their Botox injections.

“Unfortunately, this has generated a significant volume of complaints ... and I fear we may have lost some of our patients because this information was not related to patients or to anyone in Neurology,” he wrote.

A dermatologist was prompted to write to hospital administrators after he received a complaint from the mother of a patient who was charged facility fees of \$348 and \$754 for two visits to treat warts.

He called the charges “an embarrassment to me and to the medical center.”

“I was aware of facility fees, but have not previously questioned them, in part because I did not appreciate the scope and dollar costs,” he wrote. “I believe these fees are not only excessive, but ethically unfair.”

The answer the doctor got back was that Virginia Mason wasn’t permitted to selectively exempt patients from facility fees. “Medicine is a business and businesses must be compliant or they get fined.”

In places where hospitals have been sued or facility fees have become a community issue, hospitals have taken steps to let patients know in advance that they will be charged the extra amount.

From the patient billing page of Cardinal Glennon’s website, you can click to another page with information about facility fees.

“If you are planning to visit a physician at any of the clinics listed below, please be advised that you may receive 2 separate bills for the services your child receives,” the Web page advises.

Earlier this year, Mercy Regional Medical Center in Lorain, Ohio, launched an advertising campaign boasting that it doesn’t charge facility fees for primary care visits.

“Just because you can, doesn’t mean you should,” Mercy’s ads said. Mercy’s larger competitors, like the Cleveland Clinic, do charge the fees at most of their outpatient clinics.

Hospitals are required to alert Medicare patients if they will be billed a facility fee at offices and clinics off the hospital’s main campus. For anyone else who’s concerned about the charges, the best advice may be to do as Allison Zaromb does now.

When she had strep throat last year, she went to a hospital urgent care center because it was closer than her regular doctor. She asked about facility fees.

“‘Oh, we don’t know anything about billing.’ I walked right out,” Zaromb said.

Read more Doctors Inc. <http://www.kansascity.com/doctorsinc/index.html>

A Medicare patient's routine 15-minute "evaluation and management" visit to a doctor's office costs 70 percent more when the office is part of a hospital's outpatient department.

	HOSPITAL DOCTOR'S OFFICE			INDEPENDENT DOCTOR'S OFFICE
	Physician fee	Facility fee	Total fee	Total fee
Medicare payment	\$39.76	\$58.94	\$98.70	\$58.00
Patient payment	\$9.94	\$14.74	\$24.68	\$14.50
Total payment	\$49.70	\$73.68	\$123.38	\$72.50

(Amounts are for 2013)
Source: Medicare Payment Advisory Commission

The cost of an outpatient echocardiogram for Medicare patients more than doubles when hospitals tack on a facility fee.

Service in a physician's office that is part of a hospital outpatient department	Service in an independent physician's office
Payment to physician: \$62.40	
Payment to hospital: \$390.49	
Total payment: \$452.89	Total payment: \$188.31

(Amounts are for 2013 and include both what Medicare and patient pay)
Source: Medicare Payment Advisory Commission

Hospitals are acquiring independent ambulatory (outpatient) surgery centers because Medicare often pays substantially more when the centers are part of a hospital's outpatient department.

	How much more Medicare pays hospital surgery centers versus independent surgery centers
Shoulder arthroscopy/surgery	\$1,460
Correction of bunion	\$1,002
Repair wrist joint(s)	\$1,184
Fragmenting of kidney stone	\$1,265
Repair detached retina	\$1,234
Laparoscopic gallbladder removal	\$1,442

(Amounts are for 2011)
Source: Ambulatory Surgery Center Association

THE KANSAS CITY STAR.

DOCTORS INC. (DOCTORSINC)

Heart test costs rise as cardiologists flock to hospitals

December 29

BY ALAN BAVLEY
The Kansas City Star

It was late in 2009, and Willie Lawrence and the other heart specialists in his practice faced a dilemma.

Should they renew their expiring office lease and commit themselves to their independent cardiology practice at Research Medical Center or shut down their business and take the jobs that local hospitals were offering?

Medicare helped make the decision for them. Like many cardiologists in the 2000s, Lawrence and his partners had been making good money by using their own equipment to run sophisticated nuclear stress tests and ultrasound scans. These heart-imaging services were a lucrative and growing part of many cardiology practices.

Then Medicare, the federal health insurance program for the elderly, put on the brakes. In July 2009, it announced new rules that cut payments by as much as 35 percent to 40 percent.

The reductions, which started in January 2010, triggered a stampede of independent cardiologists to the shelter of hospital employment.

And that just created a new and expensive problem for Medicare: Those pricey imaging tests migrated to hospitals along with the cardiologists, and the hospitals have tacked on facility fees that make the tests even more costly.

Here's how it worked for one imaging test.

When the Medicare payment cuts took effect, the number of echocardiograms performed dropped 6 percent in the first year. But the number done at hospital outpatient departments shot up by almost 18 percent, the Medicare Payment Advisory Commission told Congress in June.

And because hospitals can charge more for their expenses than a doctor can, the price went up. Medicare and the patient paid a total of \$453 for an echocardiogram done at a hospital outpatient facility this year; the price at a doctor's office is \$188, the advisory commission said.



Patients with commercial insurance policies also are encountering higher charges, the commission reported.

The combination of technological advances and the opportunity to make more money had triggered the boom in heart tests that cardiologists did in their offices.

“All of a sudden you could easily perform those procedures in your office. We bought our own nuclear cameras, echocardiology machines. Anything we could do in an office,” said Lawrence, who is on the national board of the American Heart Association.

“From a financial standpoint, the business of medicine is testing, not seeing patients one at a time. For entrepreneurial physicians, why not test in your office if you’re going to do it anyway?” But Lawrence acknowledged that there was always a potential downside to doctors owning the technology: “Inevitably, you run the risk of overtesting.”

From 2003 to 2008, diagnostic imaging of Medicare patients increased by more than 7 percent per year. By 2008, imaging tests had grown to about 38 percent of the average cardiologist’s income from Medicare.

Studies from that time found that Medicare spent twice as much on nuclear stress tests for heart patients when their doctors used their own equipment. About 14 percent or more of the tests were unnecessary.

Congress and Medicare tried before to rein in this testing by tightening payments. Cardiologists made up some of the difference by doing more tests.

But the 2010 reductions came as a mortal blow.

“It was clear you would have to take a significant pay cut,” Lawrence said. “You weren’t going to be able to survive.”

The heart specialists lobbied strenuously against the cutbacks and unsuccessfully sued Health and Human Services Secretary Kathleen Sebelius to stop them.

“These cuts will devastate patient access to care,” warned Alfred Bove, then president of the American College of Cardiology.

“Already practices are closing their doors and their patients have nowhere to turn. ... Tests will be delayed, diseases will worsen and patients will become sicker and sicker.”

There’s no evidence that patients were harmed, but hospitals did seek out anxious cardiologists with offers to buy their practices. Heart care is a highly profitable service line for hospitals.

“Everyone was dancing and trying to figure out who to take to the dance,” Lawrence said.

Lawrence accepted an offer from Research Medical Center’s corporate parent, HCA Midwest.

The other cardiologists in his practice became employees at St. Joseph Medical Center.

A survey by the American College of Cardiology found that between 2007 and 2012, the share of cardiologists working for hospitals tripled from 11 percent to 35 percent. In the Kansas City area, virtually all the cardiologists are now affiliated with a hospital organization.

Through all this, most cardiologists have transitioned comfortably to hospital employment.

They’re still among the highest-compensated specialists, with an average income of \$357,000, according to a recent survey by Medscape.

And as employees, they can leave much of the business side of medicine to the hospitals.

“We’re insulated from that. Billing, bad debt. I haven’t said those words in three years,”

Lawrence said. “The good part is we can concentrate on patients.”

Read more Doctors Inc. <http://www.kansascity.com/doctorsinc/index.html>

THE KANSAS CITY STAR.

DOCTORS INC. (/DOCTORSINC)

Day 1: Medicine goes corporate as more physicians join hospital payrolls

December 28
BY ALAN BAVLEY
The Kansas City Star

In unprecedented numbers, America's doctors — those most entrepreneurial and fiercely independent of professionals — are trading in their autonomy for regular work hours and a hospital paycheck.

Quickly and quietly, hospitals across the country have been buying up hundreds of doctors' medical practices and hiring thousands of formerly independent physicians. Since 2000, the number of doctors on hospital payrolls nationwide has risen by one-third, according to the American Hospital Association.

In the Kansas City area, fully 55 percent of physicians are now employed by hospitals, Blue Cross and Blue Shield of Kansas City estimates. That includes virtually all cardiologists and most cancer specialists. The future solvency of the nation's health care system may rest on how doctors adapt to a corporate style of medicine and on whether hospitals put the doctors to work improving patient care or fattening the hospitals' bottom lines.

The hope of the Obama administration, as well as many independent health care experts, is that hospital systems will use their new employee-doctors both to keep people healthier and save money by preventing unnecessary trips to emergency rooms. It's far from clear whether those goals will be realized.

What is certain:

- Hired doctors already are bringing hospitals billions of dollars in revenue by funneling patients to their services. There's enough money at stake, and a great enough concern about monopoly power over health care markets, to draw the attention of federal government watchdogs.



FRED BLOCHER | THE KANSAS CITY STAR
Jill Stower went to several St. Luke's doctors until she was diagnosed with lung cancer. "We felt we were trapped," said she and her husband, John.

About this series

Alan Bavley wrote these stories as part of a yearlong Reporting Fellowship on Health Care Performance sponsored by the Association of Health Care Journalists and supported by The Commonwealth Fund.

Hospitals doing most recruiting of physicians

Each year, the physician search company Merritt Hawkins tracks efforts to recruit physicians into different types of medical settings, including hospitals, group practices, physician partnerships and community health centers. Increasingly, it's hospitals that are doing the most recruiting.

Hospitals' percentage of all physician search assignments

2004: 11%
2005: 19
2006: 23
2007: 43
2008: 45
2009: 45
2010: 51
2011: 56
2012: 63
2013: 64

Source: Merritt Hawkins

- As they buy out independent doctors and acquire their clinics, many hospitals are tacking “facility fees” onto those employee-physicians’ bills. For Medicare patients, these fees can bump up costs by 70 percent compared to the bills for basic office visits to independent doctors.
- Young physicians are embracing hospital employment for a variety of personal and financial reasons, while older doctors are selling their practices out of frustration over declining payments for their services. Some observers say we’re seeing the death of independent medical practices. The trend is playing out across the country, particularly in growing suburbs with well-insured residents like Overland Park, Spartanburg, S.C., and Phoenix, where hospitals have been buying up large independent practices. Other hospitals, like the Cleveland Clinic and Heartland Regional Medical Center in St. Joseph, have been hiring physicians to staff new outpatient facilities in direct competition with independent doctors.

“No one wants to be left out,” said Joy Grossman, a senior health researcher with the Center for Studying Health System Change, a Washington think tank. “It becomes a war between hospitals to acquire practices.”

Fueled by referrals

For hospitals, the spoils of that war begin with referrals. It’s a business model adopted by hospitals across the country: Hospital-employed primary care doctors refer patients to the hospital’s employed specialists, who admit the patients to the hospitals that employ them. As those patients make their way through, the employed doctors order their tests, lab work, MRIs, surgeries and other lucrative services through their hospital system. By one estimate, these revenues average \$1.5 million a year per physician.

Data analyzed by The Star for the Kansas City area suggest that while independent physicians spread their referrals among many hospitals and physicians, employed doctors overwhelmingly favor the hospitals that pay their salaries.

“The walls are going up around the hospitals,” said Aaron Seacat, marketing director for an independent neurology practice that has seen referrals dry up as hospitals hire other doctors.

“One of those doctors sells out to a hospital, and suddenly the person who has been sending us two or three patients a week is sending us zero. We go from being their best friend to ‘we can’t help you.’ ”

The Kansas City area’s largest hospital groups, HCA Midwest and St. Luke’s Health System, said they don’t require their employed doctors to refer patients to the specialists or hospitals within their organizations.

“Our physicians make decisions about where to send patients based on the quality ... basically what’s best for the patients,” said Corrine Everson of HCA Midwest. “And patients don’t just do what their doctors tell them. They can select for themselves.”

Tests and other services that employee-physicians funnel into a hospital system often come at premium prices. Hospitals with strong exclusive networks of doctors have far greater leverage than independent doctors to negotiate higher payments from insurance companies. Costs can soar where hospitals command large shares of the market.

“We see it every day in hospitals across the country. They use their clout to increase prices for physicians,” said Robert Zirkelbach, vice president of America’s Health Insurance Plans, the industry’s trade association. “When a hospital buys a practice, its rates will increase in the following year’s contract. Increases of 20, 30 or 40 percent are not uncommon. It’s not 3 or 4 percent, that is for sure.”

While there may be some “anecdotal” cases, there’s no comprehensive evidence so far that opportunities for higher payments are encouraging hospitals to hire more doctors, said Herb Kuhn, president of the Missouri Hospital Association. “We just don’t know yet,” he said.

One patient's story

Jill Stower of Overland Park encountered the new breed of employee-physicians after she developed a stubborn cough. Her first stop in January was her primary care doctor, an employee of the St. Luke's system.

That doctor sent Stower to a lung specialist on St. Luke's staff, who referred her to a cancer specialist employed by St. Luke's. The cancer specialist wanted Stower in St. Luke's immediately to start treatment for lung cancer.

Stower, 61 and a nonsmoker, was stunned. She told the doctor she wanted a second opinion, perhaps at the University of Kansas Cancer Center.

She didn't have time for KU, the doctor insisted. Besides, at KU she would see young doctors still in training. " 'Don't go to KU. You won't like it there,' " Stower said the doctor told her. "We felt we were trapped." "We felt like a bag of money, not people," said her husband, John Stower. " 'Don't let that bag of money out the door.' "

Stower didn't follow the urging of her St. Luke's doctor. Instead, she traveled to the Mayo Clinic in Minnesota and is now under treatment at KU.

St. Luke's declined to comment on Stower's case, citing patient confidentiality laws.

But St. Luke's Hospital CEO Julie Quirin said there is "no mandate or policy" for employed physicians to refer within the St. Luke's system.

However, she added: "Our doctors believe many times their colleagues are the best choice and can coordinate care better."

Integrated care

Improving patient care, which could help lower costs, stands high among the potential benefits when hospitals hire physicians.

Hospitals say it's easier to make sure the best medical practices are used uniformly when doctors are employees. That keeps patients healthier and needing less medical care. The equipment, supplies and drugs can be standardized, which improves efficiency.

And integrating health professionals into teams to care for patients — something that's being encouraged by both the Affordable Care Act and commercial insurance plans — is easier when doctors are employed.

"Employing physicians allows more integration and more communication of the team taking care, especially of a complicated patient," said Mark Laney, CEO of Heartland Regional Medical Center, which has about 176 physicians on its payroll.

"We are continuously working on how to treat cases. We've reduced variability among doctors' treatments, in devices such as heart valves, knee joints. You can still vary from the plan, but you have to have a good reason."

But so far, there's not enough evidence to say this is really the motivation of most hospitals for hiring physicians, or if the approaches taken by organizations such as the Mayo Clinic, where teams of employed physicians confer on patients, can be easily applied elsewhere.

Some health policy experts such as Robert Berenson of the Urban Institute are skeptical that these newly integrated systems will lower patients' costs.

Integrated care is a great idea, Berenson said, but "it could backfire if we don't have the ability to address the issue of pricing."

Independent doctors say they are freer than employed doctors to act in their patients' interests.

"We can refer to any specialist or hospital we think is best for our patients," said Nathan Granger of the Clay Platte Family Medicine Clinic, a nine-physician independent practice in Kansas City, North. "We have the ability to look at the cost and quality data and look at what's best," Granger said. "We have that ability, whereas if you're employed, there's definite incentives not to."

The growing potential for conflicts between the interests of patients and employers was enough of a concern to the American Medical Association that it issued guidelines last year for maintaining the professional autonomy of employed physicians.

“The physicians have got to be able to keep the patient in the center of this; the patient comes first,” AMA president Ardis Dee Hoven told The Star.

“If it’s in the patient’s best interest, physicians should be able to refer outside (a hospital system) without penalty.”

Fighting ‘leakage’

Hospital administrators talk about referrals that slip outside their system as “leakage.” Some use their electronic records to identify doctors who make these outside referrals.

Some hospitals also write requirements into their employment contracts that doctors routinely refer within the system except in cases where patients say they want to go somewhere else or the doctor thinks there’s a medical need for an outside referral.

Other hospitals allegedly have given what amount to kickbacks to their employed doctors. Halifax Health Medical Center in Daytona Beach, Fla., faces a civil trial in federal court on accusations that it gave six oncologists and three neurologists prohibited bonuses that grew with the number of patients they referred for treatments.

Hospitals also use more subtle tactics, such as throwing up administrative hurdles to outside referrals. A hospital’s computer system may make “default” referrals to its own facilities and employed physicians.

The physician referral line of at least one Kansas City area hospital was preferentially giving out the names of its employed physicians, as one independent practice discovered when it tracked down the reason it was getting fewer patients.

Referring within a hospital system may be more convenient to both physicians and their patients when the needed specialists and testing facilities are nearby, said Grossman of the Center for Studying Health System Change.

And it may be socially awkward for physicians to refer outside rather than to the physicians they see every day in their clinic, she said.

At the Rowe Neurology Institute in Lenexa, senior administrator John Hunter ran through a list of formerly independent practices in Johnson County that had drastically reduced referrals in the past few years as they’ve been bought up by hospitals.

“We saw a pretty dramatic shift,” Hunter said.

Some practices now send Rowe only the most extreme cases.

“It’s more common we get the train wrecks,” Hunter said.

Ed Moore is CEO of Diagnostic Imaging Centers, an independent radiology practice with 16 physicians and six clinics around the metro area. He also has seen the numbers of patients referred to his clinics decrease after a hospital buyout.

“We have heard from physician practices that they feel pressure to refer within the system.

We’ve heard it in Olathe, in Overland Park, in the Northland,” Moore said.

Both Moore and Hunter have been trying to circumvent the traditional referral route through physicians by seeking out potential patients directly. They have expanded their marketing and built up their online presence.

Other practices have decided to join hospitals rather than fight for referrals.

Mark Myron was the president of the Kansas City Cancer Center, until recently one of the region’s largest independent cancer practices. Its network of clinics and nearly three dozen oncologists dwarfed the cancer programs of local hospital systems.

Even so, remaining independent wasn’t an option.

“In our particular situation, we saw we weren’t going to maintain our practice as before if we didn’t become part of a hospital,” Myron said. “We were competing with hospital-employed oncologists who were getting referrals from hospital-employed primary care doctors.”

Myron’s group merged with the University of Kansas Cancer Center in 2011, creating one of the largest groups of cancer treatment specialists in the nation. The merger also gave KU the boost it needed to become a National Cancer Institute designated cancer center.

“I was counting on that,” the brand names of KU and the National Cancer Institute, to regain market share, Myron said.

Lure of hospitals

This isn't the first time hospitals have bought up physician practices.

They tried it in the 1990s when managed-care health insurance plans with tightly controlled referral networks were all the rage and hospitals wanted to make sure they kept their share of the business.

But the public revolted against the harsh limits of managed care, and insurance plans dropped their restrictions.

Meanwhile, hospitals discovered that doctors on a straight salary weren't as motivated as they had been in private practices, where they were paid by the number of patients they saw. Many hospitals sold off money-losing practices. This time could be different, experts say.

Hospitals have learned to base at least part of their doctors' pay on productivity. Advances in computerization make it easier to track their performance.

“Hospitals really wield the power now,” said Kurt Mosley, vice president of strategic alliances for Merritt Hawkins, a national physician recruitment firm. “The doctors really need the hospitals. I just don't see that trend reversing.”

Many independent physicians are feeling the strain of increasingly stingy insurance payments.

Over the past decade, Medicare rates for doctors increased 9 percent, while the cost of running a practice rose 27 percent.

Physicians also must foot the bill for converting their practices to computerized medical records. And the Affordable Care Act is encouraging new ways to pay doctors based more on how successfully they keep patients healthy and less on how many patients they see or how many procedures they do.

That has many doctors worried about their future earning power.

“Older doctors are saying, ‘I can't make it anymore.’ Hospitals are accommodating them,”

Mosley said. More than 12 percent of doctors surveyed nationally in April and May said they left a private practice for a hospital or other employment in 2012. A similar number said they would be doing so this year.

James Day jumped last year from an independent family medicine practice to become an employee at a Northland outpatient clinic run by Heartland Regional Medical Center.

“I feel like I'm in the right place for where medical care is going in this country, and my patients are comfortable with it, so I'm comfortable with it.”

Day said that as an employee, he is paid for the quality of the time he spends with his patients, not for “how many people can you push through in a day.”

Independent primary care doctors have become “dinosaurs,” Day said.

“It's pretty hard for (them) to make it. They live off fee for service. I saw this was not going to be a long-term, viable situation. Medical economics are changing.”

Hospitals may lose as much as \$250,000 a year on newly employed physicians during their first three years as they build their practices and adjust to their new work environment.

But even though some practices may never be really profitable, hospitals still expect to make money from them.

Although Day said he never feels pressure from Heartland, he is well aware of how his hospital pays for him and the other primary care doctors they employ: “They make that up in referrals to the system.”

On regulators' radar

The Kansas City area still has a diverse health care market with large hospital groups like HCA Midwest and the St. Luke's Health System, academic centers like the University of Kansas Hospital and community hospitals like Shawnee Mission Medical Center all vying for patients.

But in other parts of the country, hospitals have been acquiring so many physician practices that they have caught the attention of the Federal Trade Commission, the agency charged with promoting market competition.

“They’re on our radar more because we’re seeing it to a greater extent,” said Jeff Perry, who is in charge of the FTC division dealing with hospital mergers and acquisitions.

“If you employ a larger and larger number of physicians, your leverage (with insurance plans) increases and you can raise prices.”

Last year, the FTC filed a complaint against the Renown Health hospital system after it bought the two largest cardiology practices in Reno, Nev., giving it 88 percent of the area’s heart specialists.

Renown quickly settled by agreeing to let about a third of the cardiologists out of their contracts. A major court case is playing out in Idaho, where the FTC says the state’s largest hospital system has been buying up medical practices to improve its bargaining power with insurance companies and funnel lucrative patients to its facilities.

In March, the FTC, along with the Idaho attorney general, sued to force the sprawling St. Luke’s Health System (no relation to St. Luke’s in Kansas City) to relinquish control of a large independent practice it had acquired.

With its 44 physicians, the Saltzer Medical Group had about 39 percent of the market for adult primary care services in Nampa, a fast-growing city west of Boise in the Treasure Valley.

When St. Luke’s acquired Saltzer, St. Luke’s market share became a commanding 57 percent, according to the FTC.

“As a result, St. Luke’s will have even greater bargaining leverage with health plans, leverage it has shown that it is willing to exploit,” the FTC alleged in its suit.

The evidence: In an area of southern Idaho called Magic Valley, St. Luke’s started buying up hospitals and physician practices in 2004 and turned its facilities there into some of the most expensive in the state, according to the Federal Trade Commission.

St. Luke’s documents uncovered by the FTC describe the health system’s “success” in Magic Valley as a “precursor to what we may be able to achieve across the region if we can attain the critical mass of physicians committed to partnering in the St. Luke’s Health System.”

St. Luke’s considered the Saltzer physicians such a lucrative acquisition, it agreed to pay raises for the practice’s adult primary care physicians that were almost double what hospitals typically offer when they acquire a physician group, the FTC said.

According to a St. Luke’s document, those raises would be recouped.

“Funding for compensation increase(s) is provided through higher hospital based reimbursement ... and other downstream revenue sources,” such as surgeries and ancillary services. St. Luke’s has argued that it has been buying physician practices as part of its plan to transform itself into a fully integrated health care system.

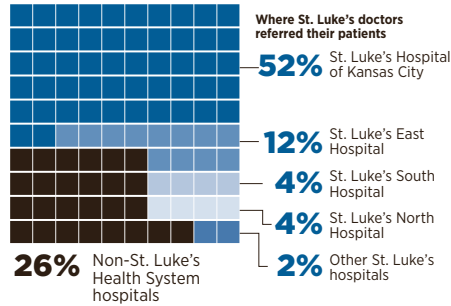
But as one St. Luke’s board member said in an email to St. Luke’s chief financial officer: “Let’s be realistic. Employing physicians is not achieving better cost, it’s achieving better profit.”

STAYING IN THE SYSTEM

Doctors working for the Kansas City area's two largest hospital systems refer most patients to their employer's hospitals.

ST. LUKE'S HEALTH SYSTEM

Medicare data show that doctors employed the St. Luke's Health System referred about 74 percent of their patients to St. Luke's hospitals, and only 4 percent to hospitals owned by HCA Midwest.

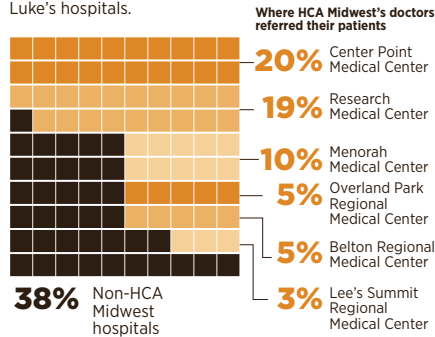


Including:

- 6% University of Kansas Hospital
- 3% Truman Medical Center Hospital Hill
- 3% Western Missouri Medical Center
- 2% Golden Valley Memorial Hospital
- 2% Menorah Medical Center
- 1% North Kansas City Hospital

HCA MIDWEST

HCA Midwest's employed doctors sent about 62 percent of their patients to HCA hospitals and just 5 percent to St. Luke's hospitals.

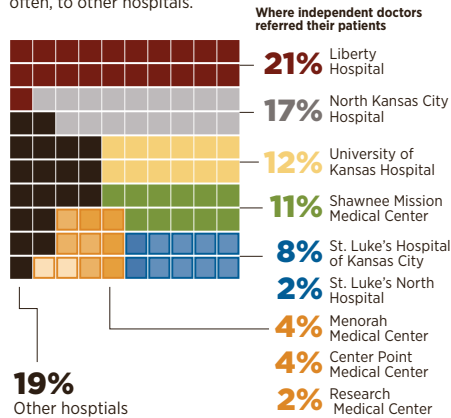


Including:

- 7% University of Kansas Hospital
- 4% St. Mary's Medical Center
- 3% St. Joseph Medical Center
- 3% Truman Medical Center

INDEPENDENT DOCTORS

Independent doctors referred their patients to St. Luke's and HCA hospitals in roughly equal numbers, but more often, to other hospitals.



To track referral patterns in the Kansas City area, The Star used data analyzed by DocGraph Journal, a Houston-based healthcare data journalism company. DocGraph crunches Medicare billing data to show how health care providers team together to treat patients. The Star provided DocGraph with lists of physicians employed by the St. Luke's Health Care System and HCA Midwest Health System and a comparison list from the Kansas City Metropolitan Physician Association, an organization of independent doctors. The data accurately show trends, but should not be considered precise measures.

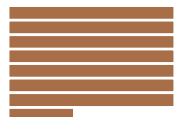
PHYSICIANS EMPLOYED BY KANSAS CITY AREA HOSPITALS

More than 2,800 physicians (MDs and DOs) are employed directly or indirectly by the region's hospitals. Here's a head count, as of Oct. 2013, of some of the larger hospital systems.

Source: The hospital systems

THE KANSAS CITY STAR

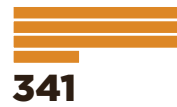
Children's Mercy Hospitals & Clinics



740 doctors

(Includes 2 physicians in Wichita)

HCA Midwest Health System



341

(In Midwest Physicians)

North Kansas City Hospital



87

(In Meritas Health)

Olathe Medical Center



75

(In the 33 medical practices in Olathe Medical Services)

St. Luke's Health System



356

(In St. Luke's Physician Practices)

Shawnee Mission Medical Center



65

(In Shawnee Mission Physicians Group)

Truman Medical Centers



377

(Includes 180 members of University Physician Associates, the nonprofit organization of staff physicians; direct employees; and contract physicians)

University of Kansas Hospital



791

(Includes 91 physicians employed directly by the hospital and 700 members of University of Kansas Physicians, a nonprofit organization of hospital staff physicians)

FAMILY FINANCE HEALTH CARE

Why 1 in 3 Americans Is Scared to Go to the Doctor

Kara Brandeisky @karabrandeisky | Dec. 2, 2014

More insured Americans are skipping out on health treatments that they need because of cost, a new Gallup poll finds.

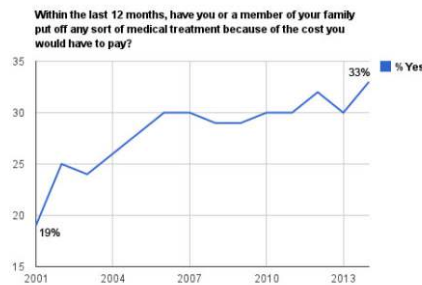
The Affordable Care Act kicked into gear over a year ago. And more than **86% of Americans** now have health insurance, up from 82% in mid-2013.

Even so, according to a **new Gallup poll**, a third of Americans say they aren't getting the medical care they need because of cost.

In fact, more Americans are putting off medical care than ever before in the 14-year history of the poll.



Paul Tillinghast—Getty Images

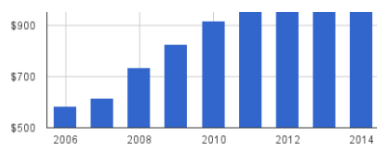


Source: Gallup

Uninsured Americans aren't the only ones delaying medical treatment. Some 34% of Americans with private health insurance say they've skipped out on care because it was too expensive, up from 25% last year. Additionally, 28% of households that earn \$75,000 or more report that family members have delayed care, up from just 17% last year.

One likely culprit? Rising out-of-pocket costs. Americans who get healthcare coverage through their employers have seen deductibles more than double in the past eight years.





Source: Kaiser Family Foundation, Employer Health Benefits 2014 Annual Survey. Note: Data is for covered workers with a general annual health plan deductible for single coverage.

It's part of a movement towards what's come to be termed "consumer-driven health care."

The thinking is, when patients are more aware of healthcare costs and more discerning about what care they really need, they will also be more discerning in their usage—which in theory would lower costs for everyone involved. Two-thirds of large employers think consumer-driven healthcare is one of the most effective tactics to reduce costs, according to the National Business Group on Health.

But Gallup found that more Americans are skimping on care that they think they really do need. According to the survey, 22% of Americans say they've put off treatment for a serious condition, vs. 19% last year. The percentage of Americans who say they put off care for a non-serious condition stayed flat at 11%.

[Previous studies](#) have found that when consumers are asked to share more of the costs, they put off both necessary *and* unnecessary care.

For example, [one study](#) found that people on high-deductible plans are less likely to buy expensive, brand-name drugs (which may be sensible), but they're also less likely to buy generic drugs they need to treat chronic conditions (likely not sensible).

When forced to pay more out-of-pocket, men in particular are more likely to skip care for serious problems like irregular heartbeats and kidney stones.

What's especially frightening about these findings is that delaying needed care to save money in the short term may result in more costly complications and more difficult-to-treat health issues in the longer term. Skipping the cholesterol screening now, for example, could mean [racking up a \\$100,000 tab for a heart attack](#) later.

Are you avoiding treatment you need because you're afraid of the bill? Try these strategies to [get the same healthcare for a quarter of the price](#). If you're on a high-deductible plan, use your Health Savings Account to [budget for your expected—and unexpected—costs](#).

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FAMILY FINANCE HEALTH CARE

How to Get the Same Health Care at a Quarter of the Cost

Amanda Gengler @GenglerA | July 16, 2014

The prices for getting tested and treated are all over the map. To save on your medical bills, learn to shop smarter.

You know that visiting doctors and hospitals outside your insurer's network is pricey. What might surprise you is how big a bill you could face even when you stay in network. In a recent analysis of 93 types of services and procedures, Change Healthcare, a company that tracks medical claims, found that in-network prices for the same service often vary by 300% and can differ by as much as 750%.

Picking the higher-price option can cost you: You'll typically owe full fare until you meet your deductible, and then usually a percentage of the bill. "Most people assume if you go in-network everyone is paid the same, so the financial implication for you will be the same," says Douglas Ghertner, CEO at Change Healthcare. "But that is absolutely not the case."

Your insurer or employer probably has a [web tool](#) that lists what you'll pay for certain services at local providers, factoring in your deductible and co-insurance. Use it. For these types of care in particular, the swings in insurers' negotiated in-network rates are wide—and you may have time to shop around.

Imaging: \$511 to \$2,815 for an MRI; \$307 to \$2,747 for CT scan

Imaging bills typically run two to three times higher at hospitals than at freestanding radiology centers, according to health insurer Cigna. At hospitals, says Brian Keigley, founder of price-comparison firm [New Choice Health](#), "radiology is often subsidizing other service lines." Ask your doctor for options other than the hospital (or the MRI machine his practice owns). When comparing costs, confirm that the price includes a pro to read the scan. Check that the facility is ACR-accredited, says Keigley, and make sure your doctor will accept the results.

Specialists: \$67 to \$207 per visit

When you need a specialist such as a cardiologist or neurologist, you frequently end up seeing whomever your primary-care doctor recommends. But you ought to know what's behind the suggestion. Often he or she will refer you within the same health system, says Christine Riedl of health insurer Aetna. Ask your doctor how crucial it is to see this specialist vs. another MD, and get a few additional names. For common specialties, your plans' pricing tool most likely factors in quality metrics by practice, so you can see if the one charging less meets those standards.

Physical therapy: \$620 or \$2,280 for 10 sessions



Sarina Finkelstein—Ales Veluscek/Getty Images

Even within your insurer's network, prices for the same service often vary by 300%.

Hospital facilities often negotiate higher prices with insurers than standalone PT practices do, says Justin Moore of the American Physical Therapy Association. If your doctor suggests a therapist, find out if he or she specializes in your condition. Check on how many visits you'll need, the cost per visit (some pricing tools do not include PT), and what you'll owe (confirm that with your insurer). Ask what signs will indicate progress, such as being able to walk down a hallway in X amount of time. Says Moore: "Being able to spell that out is an indication of the quality of care."

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The New York Times

HEALTHY CONSUMER

Why We Should Know the Price of Medical Tests

By Elisabeth Rosenthal

August 5, 2014 1:20 pm

One of the common arguments against mandating or providing upfront prices for medical tests and procedures is that American patients are not very skilled consumers of health care and will assume high prices mean high quality.

A study released Monday in the journal *Health Affairs* suggests we are smarter than that.

The insurer WellPoint provided members who had scheduled an appointment for an elective magnetic resonance imaging test with a list of other scanners in their area that could do the test at a lower price. The alternative providers had been vetted for quality, and patients were asked if they wanted help rescheduling the test somewhere that delivered “better value.”

Fifteen percent of patients agreed to change their test to a cheaper center. “We shined a light on costs,” said Dr. Sam Nussbaum, WellPoint’s chief medical officer. “We acted as a concierge and engaged consumers giving them information about cost and quality.”

The program resulted in a \$220 cost reduction (18.7 percent) per test over the course of two years, said Andrea DeVries, the director of payer and provider research at HealthCore, a subsidiary of WellPoint, which conducted the study. It compared the costs of scanning people in the WellPoint program with those of people in plans that did not offer such services.

Better still, Dr. Nussbaum said, the exercise in price transparency had a ripple effect: Hospitals in areas with the program lowered their prices too, because “they were beginning to lose patient referrals.”

Tests like M.R.I.s show some of the widest price variation in American medicine, studies show, often varying by a factor of 10 even in the same city. Hospital scanners tend to charge the highest prices, a practice that in part reflects higher overhead but also reflects hospitals' power in a market. Physicians affiliated with a hospital often refer to the hospital's radiology department. In some cases, this is because hospitals require them to do so; in others, it is a matter of familiarity and convenience because the results will turn up more rapidly on their office computers.

After two years of the price transparency program, price variation between hospital and nonhospital facilities was reduced by 30 percent in areas where it was implemented, the Health Affairs study found.

The study also suggests that patients are more vigilant custodians of cost than their doctors. Several years ago, WellPoint gave physicians similar price information on scanning providers in their practice area but did not see a change in referral patterns, Dr. Nussbaum said.

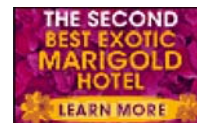
The newer study did not delve into patient motivations. Some patients probably chose the cheaper scans because their insurance plan required a 20 percent copay, so it made a huge difference if the scan was billed at \$300 or \$3,000. But others had probably already met their annual out-of-pocket maximum, so choosing the cheaper site was merely a matter of principle, Dr. DeVries said.

From experience, I can say that shopping for scans is not always easy. When I learned the price a hospital was charging for an M.R.I. a neurologist had recommended for one of my children, I scheduled the test at an outside center that was two-thirds cheaper. The upside was much better value for my health care dollar. The downside: The hospital and the radiology center would not communicate with each other, though they could have easily done so electronically. I had to go to the center and pick up a disk with the scan and carry it to the hospital neurologist.

Join the Conversation: The New York Times's Paying Till it Hurts Facebook Group is a forum for conversation, analysis and insight into health care pricing and costs in the United States.

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Edited by David Leonhardt

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THE NEW HEALTH CARE

When Hospitals Buy Doctors' Offices, and Patient Fees Soar

FEB. 6, 2015

Margot Sanger-Katz

Imagine you're a Medicare patient, and you go to your doctor for an ultrasound of your heart one month. Medicare pays your doctor's office \$189, and you pay about 20 percent of that bill as a co-payment.

Then, the next month, your doctor's practice has been bought by the local hospital. You go to the same building and get the same test from the same doctor, but suddenly the price has shot up to \$453, as has your share of the bill.

Patients around the country are getting that unpleasant surprise, as more and more doctors' offices are being bought by hospitals. Medicare, the government health insurance program for those 65 and over or the disabled, pays one price to independent doctors and another to doctors who work for large health systems — even if they are performing the exact same service in the exact same place.

This week, the Obama administration recommended a change to eliminate much of that gap. Despite expected protests from hospitals and doctors, the idea has a chance of being adopted because it would yield huge savings for Medicare and patients.

In the dry language of the annual budget, the White House asks Congress to “encourage efficient care by improving incentives to provide care in the most appropriate ambulatory setting.” In normal English, that means reducing financial incentives that are causing many doctors to sell their practices to hospitals just to take advantage of extra revenue.

The heart doctors are a great example. In 2009, the federal government cut back on what it paid to cardiologists in private practice who offered certain tests to their patients. Medicare determined that the tests, which made up about 30 percent of a typical cardiologist’s revenue, cost more than was justified, and there was evidence that some doctors were overusing them. Suddenly, Medicare paid about a third less than it had before.

But the government didn’t cut what it paid cardiologists who worked for a hospital and provided the same test. It actually paid those doctors more, because the payment systems were completely separate. In general, Medicare assumes that hospital care is by definition more expensive to provide than office-based care.

You can imagine the result: Over the past five years, the number of cardiologists in private practice has plummeted as more and more doctors sold their practices to nearby hospitals that weren’t subject to the new cuts. Between 2007 and 2012, the number of cardiologists working for hospitals more than tripled, according to a survey from the American College of Cardiology, while the percentage working in private practice fell to 36 percent from 59 percent. At the time of the survey, an additional 31 percent of practices were either in the midst of merger talks or considering it. The group’s former chief operating officer once described the shift to me as “like a migration of wildebeests.”

Cardiologists are not the only doctors who have been migrating toward hospital practice. In the last few years, there have been increases in the number of doctors working for hospitals across the specialties. And spreads between fees for office services exist in an array of medical services, down to the basic office visit. The president's proposal would apply to all doctors working in off-campus, hospital-owned practices.

Shifting practice ownership patterns have ripple effects for patients with private insurance, too. Like Medicare, most private insurers pay higher prices to hospitals than to independent doctors.

Private insurers tend to copy many of Medicare's payment policies. And, in general, large hospital groups tend to have more negotiating clout with insurers, meaning they can bargain for higher prices than smaller practices.

The administration's proposal would essentially end that system of different prices for similar services. Medicare would pay the same for any visit, test or procedure offered by doctors who work in private practice and by those who work in off-campus practices that are owned by hospitals. Doctors who work in the hospital building could still be paid the higher hospital rate. But the free-standing practice that suddenly changes hands would not continue to be paid more.

The result, in dollar terms, is estimated to be very large. According to the White House's calculation, Medicare would save nearly \$30 billion over 10 years if Congress required the payment switch. That's more than Medicare could save if it raised the eligibility age to 67. And that doesn't even count the money that could be saved by Medicare patients whose co-payments will also go down.

Hospitals don't like the idea. Nearly all the money would come out of their pockets, and they argue that running a medical practice really does cost more for hospitals than it does for independent physician practices. Hospitals have to stay open at all hours, run emergency rooms and comply with an array of regulatory requirements that physician-owned practices don't need to worry about.

"You can't just convert it and be exactly the same," said Rich Pollack, an executive vice president at the American Hospital Association. "You have to meet the requirements."

The Medicare Payment Advisory Committee, a group of experts that advises Congress, thinks that the pay differences should be narrowed, but only for a select set of medical services in which it's really clear that there's no difference between the care offered by a hospital and a physician office.

The pay differences, of course, are not the only reason that more doctors are going to work for hospitals. There are generational trends: Younger doctors are less interested in entrepreneurship and more interested in predictable hours and salary. And another Medicare program is trying to create financial incentives for health

systems to manage patients' entire health care experience, which many hospitals find easier to do if they employ the doctors.

Still, Robert Berenson, a physician and a senior fellow at the Urban Institute, said it's clear that a lot of recent doctor-hospital mergers have been driven by Medicare's disparate pay policies. He thinks the budget proposal lacks needed subtlety, but he supports equalizing many payments in concept. "If hospitals are going to employ physicians, it should be done for the right reasons, not the wrong reasons," he said.

The change would have big consequences, especially for hospitals, which have already endured several rounds of recent Medicare cuts. But in contrast to a lot of things in the president's budget, it's hard to dismiss this proposal as mere wishful thinking. Congress is often looking for places to save money in the Medicare budget, in part because it must find money every year to keep all doctors' pay from declining precipitously — the result of a misguided payment formula passed in the 1990s.

"The list of available offsets is dwindling," said Eric Zimmerman, a partner at the lobbying firm McDermott Will & Emery, who represents many health care providers. In an email, he described the doctor's pay proposal as one that "may be moving to the top of the list."

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