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Referrals Tapering Off? This May Be Why

Leigh Page | April 17, 2014

Where Are the Referrals Going?

If you are an independent, self-employed physician and your referrals are drying up, it could be part of the growing trend of hospitals hiring their own doctors. Hospital-employed physicians are often asked to refer patients to in-house physicians, disrupting referral patterns that independent physicians have counted on for years.

Jewett Orthopaedic Clinic, with 25 physicians in 6 subspecialties, has thrived for 77 years in the Orlando area. But last year, "for the first time ever, we noticed a drop-off in business," said John W. McCutchen, MD, Jewett's former president and chairman of the board, who is now retired.

Dr. McCutchen blamed the drop-off on a hiring spree by the 2 dominant hospital networks in the area. In late 2012, Orlando Health paid $50 million for Physician Associates, the largest practice in Central Florida. With 95 physicians, Physician Associates was a major referral source for Jewett, but now more of its referrals are going to Orlando Health specialists.

The other local hospital system, Adventist Health, is also no slouch in hiring physicians, who then often change referral patterns, according to Dawn J. Lipthrott, a local patient advocate who runs a Website called Ethical Health Partnerships.

Lipthrott said she believes that Adventist has used its size to steer patients away from independent surgeons, fundamentally changing local referral patterns in a very short period of time.

A marriage counselor, Lipthrott became interested in physicians' referral patterns in her area several years ago in a conversation with her doctor, a breast surgeon. The doctor said she was losing referrals to newly arrived doctors employed by Adventist, so Lipthrott decided to research the problem, using data from the Florida Agency for Health Care Administration.

Tracking the volume of breast surgeries in the area, she compared the volume of surgeons who had long specialized in breast procedures with that of the Adventist surgeons, all but 2 of whom were new to the area.[1] Normally, it would take years for new surgeons to build a reputation, but their volume shot up and quickly surpassed that of the established surgeons.

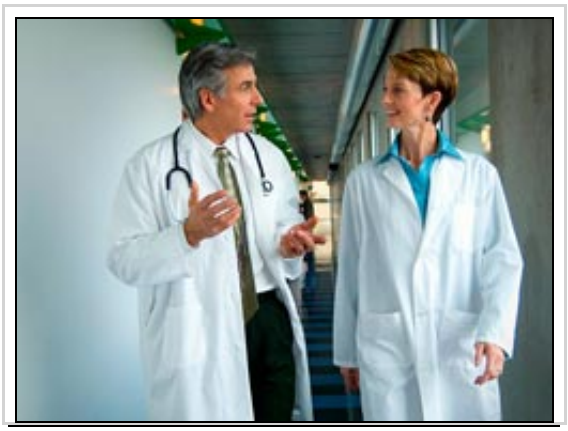
In state data from 2006, Lipthrott found that the established surgeons logged more than 500 breast surgeries -- still way ahead of the Adventist surgeons, who logged about half as much. But by the next year, the Adventist surgeons' volume had almost doubled and had already beaten out the established group, whose volume had fallen to just over 400 surgeries.

Steven Lester, MD, a radiation oncologist in the Orlando area, read Lipthrott's findings and found them all too familiar. "Those data mirror what I've seen in my practice and what other independent physicians have seen with regard to practice referrals," he said.

Dr. Lester said his own practice has seen a decline in referrals from hospital-employed urologists, adding that freestanding imaging centers in the area have seen referral patterns from hospital-employed orthopedic surgeons "change overnight."

There Are 2 Sides to the Story

However, the 2 Orlando hospital systems see the situation differently. In their view, they are engaging in "care coordination," in which caregivers are aligned with each other to lower costs and improve quality. Hospitals across the country have jumped on the bandwagon, looking to models in highly respected systems such as Geisinger Health System and Mayo Clinic, where employed physicians have been referring patients in-house for years.



"Our goal is to move to a new payment model and reduce the costs of healthcare," Wayne Jenkins, MD, Director of Orlando Health's division of employed physicians, told the *Orlando Sentinel.* [2]

Still, say Lipthrott and many specialists, hospitals use their market clout to often obtain higher fees from insurers than independent specialists are able to charge.

Even Medicare pays more to hospital-employed physicians than to independent physicians, through the addition of a facility fee. The Medicare Payment Advisory Commission, in its June 2013 report,[3] showed that, for example, under evaluation and management code 99213, for a 15-minute office visit for an established patient, hospital-employed physicians are able to charge 70% more than independent physicians.

Furthermore, critics assert that controlling referrals could potentially harm the quality of care. It limits access to a relatively small pool of hospital-employed specialists, bypassing independent doctors who might have more expertise.

When specialists lose referrals to hospital-employed competitors, they are reluctant to tell their story because it might affect their remaining referral relationships, said Tommy Thomas, an Orlando-area accountant.

Most of his clients are independent physicians, and he has watched as they felt besieged by local hospitals and their employed physicians. In March 2013, he helped several physicians found the Association of Independent Physicians. The group, which has Dr. McCutchen and Dr. Lester on its executive committee, now has 250 members, including both specialists and primary care physicians (PCPs).

Even though few independent specialists have come forward, Thomas said, they have been suffering from the trend. "I do not know of any physicians who have been put out of business," he said, "but I do know of a lot who have had to cut staff or reduce employee hours."

According to Thomas, the trend has also divided the medical community. Just as employed PCPs refer to employed specialists, independent PCPs tend to refer to independent specialists because they have been burned by employed specialists sending their patients on to hospital-employed PCPs instead of back to them.

Tapping Into the Whole Continuum of Care

In Idaho, the growth of hospital-employed PCPs has also affected specialists' referral patterns. In 2012, St. Luke's Medical Center in Boise made a $27 million offer to buy Saltzer Medical Group, a 41-physician multispecialty practice in nearby Nampa.

Clark Robinson, MD, an orthopedic surgeon who was then at Saltzer, did not like what he saw. Asked later to testify in an antitrust lawsuit against St. Luke's, he stated that in a meeting, St. Luke's officials told Saltzer physicians that the foremost reason for acquiring them was "to secure Saltzer's primary care referrals."

"St. Luke's wanted control of the patient from beginning to end," Dr. Robinson said in a legal deposition.[4] The hospital was creating "a system in which patients saw St. Luke's primary care physicians, had their surgeries performed by St. Luke's specialists at St. Luke's facilities, and received all of their ancillary services at St. Luke's facilities."

Surgeons like Dr. Robinson felt like second-class citizens in the deal. While St. Luke's offered the PCPs a 30% increase in income, the surgeons were offered less than half that -- a 14% increase -- and only if they agreed to sell their interests in a nearby surgery hospital. If they did not, St. Luke's would pay them a much lower salary that, in Dr. Robinson's case, would have been 5%-10% below what he had been making.

Dr. Robinson rejected the offer and opted to leave Saltzer. Even before the purchase went through, he noticed a "significant decrease" in referrals from the practice's PCPs. It is unclear how Dr. Robinson has fared since then because he did not respond to requests to be interviewed for this article.

Meanwhile, the Saltzer purchase became the object of an antitrust lawsuit against St. Luke's in federal court. The suit was filed by the hospital's rival, Saint Alphonsus Health System, and was later joined by the Federal Trade Commission (FTC), which enforces antitrust laws.

When the FTC investigates hospitals, it usually focuses on hospital mergers rather than practice acquisitions, but in recent years, it has been more attentive to purchases of practices.[5] These purchases have involved specialists, such as cardiologists, and their referrals to the hospital, but in the St. Luke's case, the FTC tackled the issue of PCPs.

The agency concluded that with the Saltzer purchase, St. Luke's controlled 80% of PCPs in Nampa, which it saw as a separate market from Boise, just 15 miles away. On January 24, 2014, the judge hearing the case ruled[6] against the hospital and ordered it to undo the Saltzer buyout. St. Luke's officials said they expect to appeal the decision.

Where Employed Physicians Refer

David Pate, MD, the St. Luke's CEO, insisted that his organization does not stop employed physicians from referring outside. "My own wife was referred by a St. Luke's physician to a St. Al's [Saint Alphonsus] physician for her particular condition because he felt the St. Al's physician was the best for this problem," he told *The New York Times.* [7]

However, hospitals do not have to overtly direct their PCPs, according Dr. Lester, the Orlando-area radiation oncologist. Even if it is not stated in the physician's contract -- and it usually is not -- "it's understood that you'll refer in-house," he said. If employed physicians allow too much "leakage" of referrals, the hospitals might not renew their contract, which usually lasts only 1-3 years, he added.

In addition, Lipthrott said hospitals use "physician liaisons" to check employed physicians' referral patterns and have a word with the "splitters," those who refer too many patients outside. "Part of the physician liaison's job is to maintain complete loyalty to the system," she said. Electronic health record (EHR) systems make it easy to profile physicians and track their referrals. The data can be captured from the CMS-1500 form, where the name of the referring physician is a required field.

Are Hospitals Violating the Stark Law?

Paying an employed physician extra for more referrals is illegal under the Stark Law, which prohibits referrals to facilities for services in which the physician has a financial interest, according to Charlene McGinty, a partner at the law firm of McKenna, Long, & Aldridge in Atlanta, Georgia. But she said hospitals can still require employed doctors to refer in-house, as long as they follow certain rules.

Not so long ago, the Centers for Medicare and Medicaid Services (CMS) interpreted the Stark Law to mean that hospitals simply were prohibited from directing referrals. CMS stated[8] in 1998 that if the entity's payments to the physician were "predicated, either expressly or otherwise, on the physician making a referral to particular provider," the arrangement would violate Stark.

Since then, however, CMS decided to make it easier for hospitals to direct referrals, apparently in recognition of the new trend toward care coordination. CMS regulations[9] introduced in 2004 allow directed referrals provided certain

requirements are met. For example, the hospital's directive must be "set forth in a written agreement signed by the parties."

In other words, employed physicians' obligation to refer must be stated in their contract. But, as already noted, very few contracts for hospital-employed physicians say this. That is fine, according to health lawyers, as long as the hospital really is not directing employed physicians' referrals. But if, for instance, the hospitals' physician liaisons are pressuring employed physicians to refer in-house, they could presumably be in trouble.

The 2004 regulations also state that if "the patient expresses a preference" for an independent specialist or other provider, the referring physician must honor that request. Also, the referral must be in the patient's "best medical interests," although that is left up to "the [referring] physician's judgment."

Thomas, at the independent doctors group, said patients could theoretically insist on seeing an independent specialist. For example, a heart patient who has a longstanding relationship with a cardiologist might want to maintain that relationship. But generally, "patients are going to pretty much do what their primary care physician tells them," he said. And even if they wanted to overrule their PCP, "the problem is that patients don't know the [Stark] rules," he said.

Complicating the Matter Even Further

What makes the situation thornier is that patients may not even know their referring physician is employed by the hospital. Lipthrott said this is a particular problem at Adventist practices. For example, on the main Web page for Loch Haven OB/GYN, owned by Adventist, there is no mention of the connection unless you scroll down to the end of the page, where it simply says, "Florida Hospital," which is the flagship of Adventist Health. Even then, it might be unclear to a patient whether the group is employed or simply on staff.

Legislation recently introduced in Georgia and Maine would require hospital-employed physicians to reveal their affiliations. Under the Georgia bill, the physician would also have to tell patients they have a right to choose an independent physician, according to Misty Holcomb, a lobbyist for Independent Doctors of Georgia, which has similar aims as the Florida-based organization.

Both bills, however, face stiff opposition from hospitals. Holcomb reported that a committee tabled the Georgia bill, and it is effectively dead for this session. The Maine bill[10] was only introduced in February, but the state hospital association is fighting it.

Is There Anything You Can Do?

Independent physicians who are struggling to hold onto patients can exploit several advantages that they have over employed physicians, according to Aaron Seacat, Marketing Director for Rowe Neurology Institute. Although the institute is the only independent neurology practice left in the Kansas City area, it has managed to keep its volume relatively steady, he said.

One obvious advantage is price. Seacat said hospital-based neurologists charge 2-7 times more than Rowe neurologists, a factor that will become more significant as patients' out-of-pocket payments continue to rise.

Another common advantage is access. Rowe's hospital-employed competitors, overwhelmed with in-house referrals, are booking appointments 2-3 months out, but Rowe gets them in within 1-2 days. "You can imagine what patients are thinking when they are told they have to wait that long," Seacat said. "They may have numbness and tingling down their arm, and they're wondering, 'Do I have MS?'"

High patient satisfaction can be another advantage. Seacat said he believes that Rowe neurologists spend considerably more face time with patients than competitors, which helps create strong word-of-mouth recommendations, a major source of patients.

Seacat also posts on Facebook and uses search engine optimization on the group's Website, so that the practice comes up when patients Google for neurology specialists. Though he still nurtures referral relationships, he said most of Rowe's new patients come in on their own.

These tactics, however, may not work in some other specialties. Dr. Lester, the Florida radiation oncologist, said cancer patients don't tend to choose radiation oncologists on their own. Even though he has a Website, he estimated that no more than 1 patient directly contacts his practice every 6 months. Generally, patients with life-threatening illnesses rely on their PCPs for referrals, and this is also true for specialists like diagnostic radiologists and pathologists, he said.

Organizing Independent Doctors

Dr. Lester thinks independent specialists have to think beyond their own practices and organize so they can change laws and regulations that favor hospitals. His Florida-based group recently hired a lobbyist in Washington, mirroring Holcomb's work in the Georgia legislature. Another group of independent doctors reportedly operates in Tennessee.

These organizations have a variety of goals. For one, they want to require hospital-employed physicians to inform patients that they can see independent physicians. They also want to end higher reimbursements to hospitals, make nonprofit hospitals pay taxes, and prevent hospitals with employed physicians from kicking independent physicians off their staffs. These changes, they say, would help level the playing field.

Independent specialists face "fee discrimination based on significantly higher charges at hospitals," said Lawrence Huntoon, MD, a neurologist in Derby, New York, and a past president of the Association of American Physicians and Surgeons, another organization that supports independent specialists.

"What happens is that the employed physician is accountable to the organization and not to the patient," he said. "And that's a problem."

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