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COVID-19 and Health Equity

Outreach by health departments, health systems lays groundwork
for continued equity efforts – Page 10



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Study: Vertical Integration Not Financially Beneficial for Physicians

Difference in compensation varies by specialty, market

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A study released in the December 2021 issue of *Health Affairs* examined the correlation between hospital/health system ownership of physician practices and physician compensation. While a number of studies have analyzed the “rapidly growing trend” of vertical integration from the hospital/health system perspective, this is the first study to evaluate vertical integration from the physician practice perspective.¹

The latest iteration in the push toward value-based reimbursement, which commenced in 2010 with the passage of the Patient Protection and Affordable Care Act, has driven the pursuit of closer relationships between hospitals and physicians through strategies such as vertical integration.



The researchers found that those physicians whose practices were acquired by a hospital or health system received slightly less compensation under hospital ownership, with some differences among specialties; further, hospital-owned physician practices were “associated with larger reductions in physician income in more competitive hospital markets and in nonprofit hospitals.”¹ This article will discuss the study’s findings and potential implications.

Vertical integration may be defined as “[t]he combination in one firm of two or more stages of production normally operated by separate firms.”² Firms engage in vertical integration transactions in pursuit of certain benefits typically associated with this form of organization, including:

- (1) The development of economies of scale,³ i.e., the ability of large firms to produce large quantities of a good at a reduced cost per unit⁴
- (2) The development of economies of scope,⁵ i.e., the ability of large firms to produce a variety of goods more cheaply than producing those goods separately⁴
- (3) Vertically integrated firms with centralized management structures can, if strategically constructed and implemented, create superior production efficiencies relative to more fragmented business structures and markets³

In the U.S. health care industry, vertical integration describes the “integration of providers at different points along the continuum of care, such as a hospital partnering with a skilled nursing facility or a physician group,”⁶ which organizational model can provide additional benefits to health care delivery organizations, as well as, to the communities they serve.

The latest iteration in the push toward value-based reimbursement, which commenced in 2010 with the passage of the Patient Protection and Affordable Care Act, has driven the pursuit of closer relationships between hospitals and physicians through strategies such as vertical integration. In fact, from 2010 to 2018, hospital/health system ownership of physician practices increased 89.2%, from 24.1% of physician practices owned by a hospital/health system in 2010 to 45.6% by 2018. While research has found that hospitals profit from vertical integration (an approximately 19% increase in revenue), “little is known about the degree to which the income of physicians whose practices have been acquired has been affected.”¹

In analyzing physician compensation and physician practice ownership, the *Health Affairs* researchers examined data for 41,648 physicians (48.3% of whom were in independent practices and 51.7% of whom were in hospital-acquired practices), during the study period of 2014 through 2018. Physician compensation data was obtained from the Career Navigator Survey conducted by Doximity, “an online social network for physicians ... that includes more than 70% of U.S. physicians.” This data was then compared to information on practice ownership data during the period of 2010 to 2018 from the SK&A Office-Based Physicians Database administered by



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IQVIA, “a commercial database of health care providers, which provides a nearly complete sampling frame of U.S. office-based physicians,” i.e., over 95% of office-based physicians.¹

This compensation and ownership data was then matched up at the physician level and analyzed from a myriad of angles. First, the researchers examined the association between vertical integration and physician compensation among overarching physician specialty types—primary care, nonsurgical specialists, and surgical specialists. Second, the researchers analyzed whether this association varied by the tax status of the hospital—for-profit or nonprofit. Third, the association was examined by the competitiveness of the market in which the hospital operated (at the county level)—concentrated or competitive.¹

The researchers noted that while physicians may not experience the same level of financial benefit from vertical integration as hospitals, there may be other, non-financial benefits associated with integration that were not captured by the study.



While physicians overall generally saw a small reduction in compensation of 0.8% post-integration (an absolute difference of -\$2,987), the change in physician compensation post-integration varied depending on the specialty of the physician. Nonsurgical specialists experienced a *decrease* of approximately 2.4% (an absolute difference of -\$9,652) post-integration, while primary care physicians saw an *increase* of approximately 1.2% (an absolute difference of \$3,179) and surgical specialists saw an increase of 2.1%, in compensation (an absolute difference of \$10,741), post-integration.¹

The association between physician income and vertical integration also varied depending on the marketplace in which the hospital operated. Physician income did not significantly change post-integration in highly concentrated markets, but it did decrease approximately 2.2% in competitive (i.e., not highly concentrated) markets. Further, physicians acquired by a non-profit hospital saw a 1.9% reduction in their annual compensation; in contrast, physicians acquired by a for-profit hospital saw no statistically significant change in their income. The researchers theorized that the variances between these two attributes (competitive marketplace and tax status) may be due to “differential bargaining power between physicians and hospitals in less concentrated hospital markets and with for-profit hospitals.”¹

The researchers noted that while physicians may not experience the same level of financial benefit from vertical integration as hospitals (or any financial benefit at all), there may be other, non-financial benefits associated with integration that were not

captured by the study. For example, physicians may be willing to sacrifice some part of their income for a steady paycheck and consistent schedule; this “risk protection” may be more favorable than the variable income and scheduling that results from practice ownership.¹

Additionally, physicians may appreciate hospitals taking on the administrative services (e.g., billing) and regulatory responsibilities (e.g., compliance), as well as interactions with insurance companies, that are required to operate a physician practice. As office-based physicians have experienced tightening reimbursement over the last few years, at the same time that they are being required to heavily invest in capital-intensive infrastructure such as health care information technology (e.g., electronic health records) that aggregates the requisite data and information required to report the metrics to the federal government (or commercial insurers), it is understandable that they may be willing to sacrifice some degree of autonomy and income for the relative stability of hospital ownership. In essence, physicians may prefer to make less money in return for being able to focus solely on treating patients. —

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