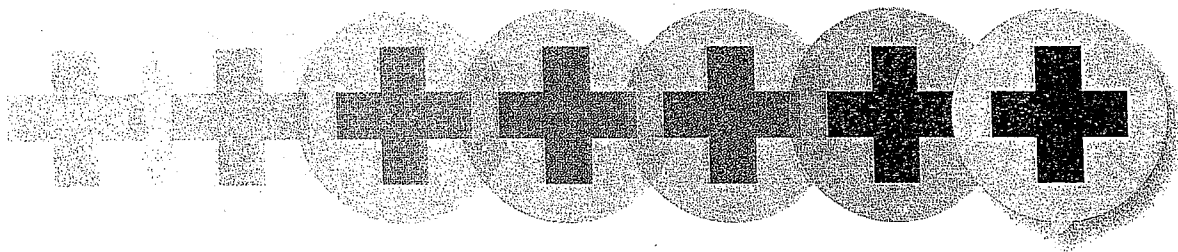


# farewell

## to the family doctor

BY ANGIE C. MAREK



**O**n tourist maps, it might get eclipsed by the nearby Abraham Lincoln Presidential Library. But St. John's Hospital, a tan, 11-story building, is beginning to cast a long shadow in Springfield, Ill. For several years most of the physicians in this town of 120,000 have been split into teams like kids in a summer-camp color war: SIU HealthCare and The Springfield Clinic, huge medical groups employing 450 doctors between them, have dominated the market for years. But recently, the Franciscan

nuns and executives behind St. John's have been trying to put together their own dream team and have bought up some of the few independent medical practices left in this pocket of the Midwest.

The effort is all being laid out in a cramped off-site conference room, where Kelly Ford and a dozen other executives huddle in a buzz of conversation, plotting the next steps in the expansion of Hospital Sisters Health System Medical Group, the network St. John's belongs to. A mosaic of pastel pink, yellow and blue Post-it notes covers one wall, each inscribed with

an item from what looks like the world's longest medical shopping list ("Order lab coats/business cards"; "Update insurance contracts"). It adds up to a lot of work for executives like Ford, the director of medical-staff affairs for Hospital Sisters. But the mood in the room is upbeat, and with good reason. In less than two years, the group has grown from just a handful of executives to become a squad of almost 200 doctors and nurse practitioners, recruiting the likes of a pulmonologist from Joliet, Ill., and an internist with hundreds of patients at a big,

**With health care reform taking hold, hospitals are buying up medical practices to boost their profits and get an edge. But what are the side effects when family doctors give up their independence?**

STYLING BY SUSAN GEORGE; DOCTOR AND DOLL ILLUSTRATION (C) SEPS LICENSED BY CURTIS LICENSING INDIANAPOLIS, IN. ALL RIGHTS RESERVED

**BY THE NUMBERS**  
**Bozeman, Mont.**

**55**

NUMBER OF DOCTORS HIRED BY  
BOZEMAN DEACONESS HOSPITAL

**0**

NUMBER OF INTERNISTS AND  
ONCOLOGISTS IN TOWN WHO ARE  
INDEPENDENT OF THE HOSPITAL

**83%**

AMOUNT BY WHICH THE PRICE OF  
A CHEST X-RAY AT BOZEMAN  
DEACONESS HOSPITAL EXCEEDS  
THE STATE AVERAGE

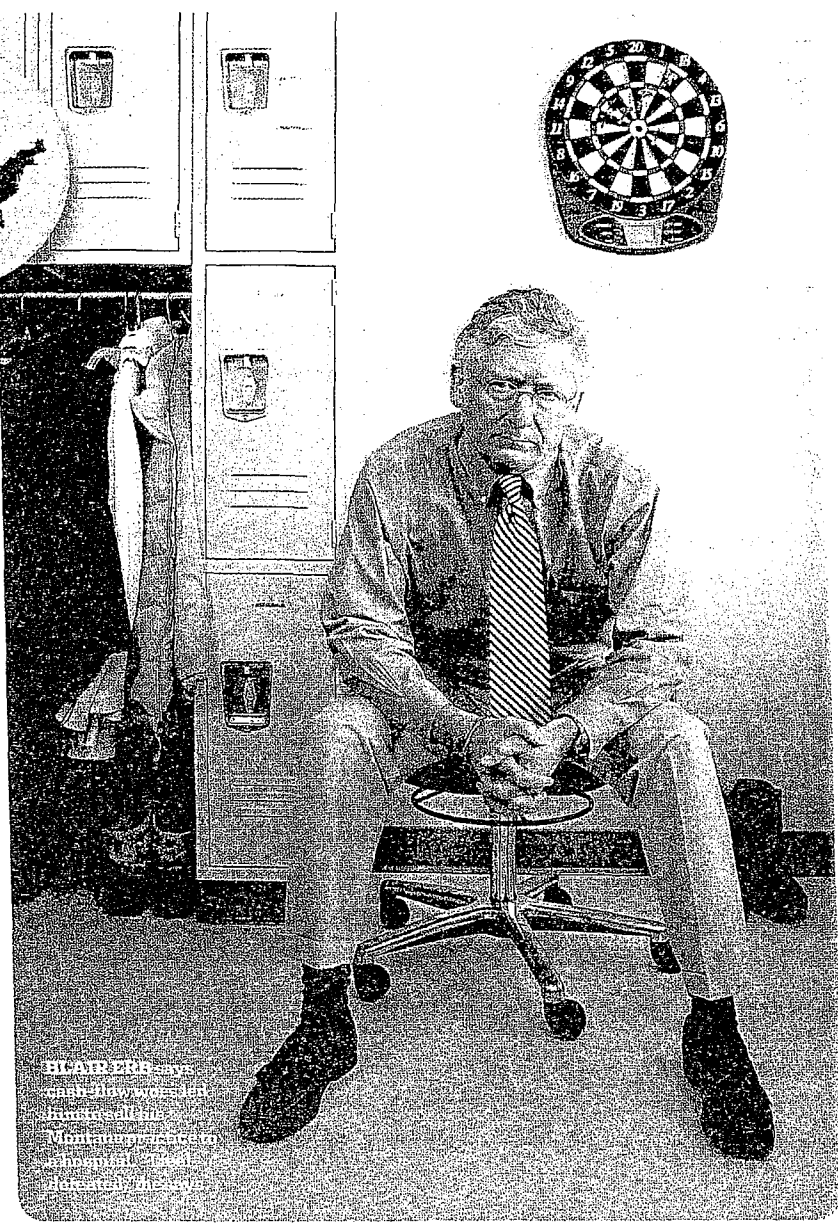
**2**

BILLS PATIENTS GET AFTER A  
VISIT TO A DEACONESS DOCTOR  
(ONE FROM THE HOSPITAL, ONE  
FROM THE DOCTOR)

**7,187**

NUMBER OF BILLS DEACONESS  
SENT TO COLLECTIONS IN 2008

SOURCES: BOZEMAN DEACONESS HOSPITAL;  
MONTANA DEPARTMENT OF JUSTICE



**HICAP ERG** says many doctors left their practices to work for hospitals. ERG says that's a trend that's spreading across the country.

independent practice across town. "We like to think of ourselves as a fast-moving start-up," says Ford.

Remember the solo family doctor? In places like Springfield, it has become increasingly likely that she's collecting a paycheck from a large regional hospital—and practicing medicine according to the hospital's strict playbook. The experience in Springfield is just a needle prick compared with what's going on nationwide. At least one in six doctors—more than 150,000 nationwide—now works as an employee of a hospital system. And with about half of recent medical school graduates deciding to work for hospitals and many established doctors looking to unload their practices amid the tough economic climate, what was a trickle of change has turned into a torrent. Jim Pizzo, a Chicago-area hospital consultant, says the blistering pace of these mergers is leading some colleagues to joke that there are two types of physicians today: "Those employed by hospitals and

those about to be."

Whether they wear suits or scrubs, many medical pros think they're doing the right thing. Hospital executives say they're adapting to the rapid evolution of the health care business, while physicians, fed up with running businesses during the recession, are drawn to the safety of a salary and regular hours. What's less clear is how the fever to buy up local doctors' offices will affect the paper-gowned patients caught in the middle, with many saying they've already seen costs rise or treatment choices dwindle. Consumer advocates say the demise of the neighborhood doctor could turn out to be as big a change for medicine as anything happening at the national level with health care reform. "The story of how well these collaborations will actually work, day after day, hasn't been written yet," says Roland Goertz, president of the American Academy of Family Physicians.

**R**UTH TAYLOR, A 44-YEAR-OLD WOMAN IN Bozeman, Mont., started seeing Robert Hathaway as her doctor during college, and she stuck with him through everything from routine blood tests to a kidney transplant. Taylor, a professional nurse with warm blue eyes, describes Hathaway as a “classic small-town doctor” who knew all his patients by name and socialized with them at local basketball games; he was accessible and thorough—even catching a health problem of hers that other doctors had missed. But after Hathaway sold his practice to the local hospital, Taylor says, things began to sour. She was more likely to be assigned to see the physician assistant rather than Hathaway himself. And when she went in for a comprehensive physical (also run by the assistant) in late 2008, she was charged \$360, more than double what she’d paid for a workup in previous years. Her insurance covered very little of the higher tab; now, fearful of the cost, Taylor is putting off a mammogram. “When a nurse is skipping out on care she knows she needs,” Taylor says, “you know there are problems.”

Stories like Taylor’s aren’t uncommon in Bozeman, a funky, college-kid and retiree paradise surrounded by soaring mountains. Bozeman Deaconess Hospital sits high on a hill outside town, cross-country ski trails circling it like lassos. Five years ago Deaconess, the lone hospital here, didn’t own any medical practices. Since then it has gone on such a buying binge that more than half the doctors in town are on its payroll. Hathaway says the arrangement was eventually a godsend for him, letting him avoid the evening ritual of wondering whether his office could eke out enough funds to pay its overhead, and he disputes the notion that he saw his patients less. He acknowledges, however, that rising costs for patients were a troubling side effect. “It was the one thing I lost control of,” Hathaway says wistfully.

Gordon Davidson, chief financial officer at Bozeman Deaconess, says that some price increases have been related to Medicare billing rules; he also says that the hospital’s pricing has helped keep doctors from leaving Bozeman. While this isn’t the first time that hospitals have tried to buy up doctors’ offices, Bozeman’s merger drama sheds some light on why the trend is picking up again now. Davidson says that Deaconess first started buying practices when cash-strapped

doctors turned to the hospital for help; they did so largely because of Medicare, whose payments have been criticized by doctors for not keeping up with medical inflation. With the 2010 health care reform law aiming to trim \$500 billion from projected Medicare spending levels, many doctors’ economic anxiety is increasing.

But hospital executives also believe that buying doctors’ practices could yield a big payday, thanks to a different provision in the health care law. The law will encourage doctors and hospitals to share some payments when treating each patient; as collaborative teams, they could earn bonuses for holding down costs and meeting quality markers. “The real question for everyone is how that pie—that money—is going to get split up,” Goertz

**RUTH TAYLOR** says quality of service declined and some prices rose after a hospital bought her doctor's family practice.

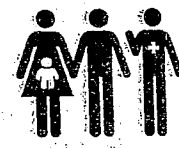


## Your Doctor's New Boss

In dozens of cities, big hospital medical groups are buying up doctors' practices, reshaping the landscape of local medicine. Here's a look at five cities.

Note: Prices reflect the reimbursement rates negotiated by providers with Aetna.

SOURCES: HOSPITAL BOND FILINGS; AETNA REIMBURSEMENT DATABASE



### UNIV. OF WASHINGTON MEDICINE (SEATTLE)

DOCTORS ON STAFF  
 ■ TODAY ■ 2007

1,740

1,500

MATERNITY CARE PLUS CAESAREAN SECTION  
 ■ HOSPITAL ■ INDEPENDENT

\$2,700

The University of Washington is one of a few fast-growing hospital groups in the Seattle area. Frustrated consumers have raised objections about facility fees added to their bills by the expanding hospital chains; in some cases, those fees raised the cost by 65 percent or more. (The University declined to comment.)



### SUTTER HEALTH (NORTHERN CALIFORNIA)

DOCTORS ON STAFF  
 ■ TODAY ■ 2007

3,500

1,700

A YEAR'S WORTH OF WEEKLY ALLERGY SHOTS  
 ■ HOSPITAL ■ INDEPENDENT

\$850

\$770

Sutter Health, which recently absorbed a 900-doctor practice in San Francisco, holds considerable bargaining power: One study found that a stay at a Sutter hospital costs 37 percent more than the state average. A spokesperson says Sutter's prices reflect "other obligations and commitments," like building facilities to withstand earthquakes.

### FLORIDA HOSPITALS AND MEDICAL CENTERS (ORLANDO)

DOCTORS ON STAFF  
 ■ TODAY ■ 2007

240

180

SLEEP STUDY WITH NEUROLOGIST  
 ■ HOSPITAL ■ INDEPENDENT

\$1,150

\$780

This eight-hospital chain has recently gotten involved in contract tangles with major insurers in the area over its attempts to negotiate higher fees. A hospital spokesperson attributed the sleep-study discrepancy to the higher overall costs of inpatient care; the hospital declined to comment further.



says; hospitals think they'll have the upper hand if they employ the doctors that they're sharing their banana crème with. And that's touched off a flurry of mergers everywhere—from Seattle to Roanoke, Va.

Hospitals are also scrambling to get a bigger share of one of the most lucrative arenas of medicine: outpatient surgeries. These options have become popular with patients because they're often cheaper and faster than hospital surgeries and boast lower infection rates (and often, better parking). Timothy Eckels, vice president for government relations at Hospital Sisters in Springfield, says the outpatient-care trend is one factor that jump-started his institution's acquisition boom: "We really could see the writing on the wall." One recent study by health care consultancy Sg2 predicted demand for outpatient surgeries will grow by 22 percent from 2010 to 2019, while growth for hospital-based

surgeries will remain flat; another study showed profit margins at outpatient centers are five or six times as high as at hospitals.

Now that the acquisition spree is in full swing, some experts worry that price increases could become the dominant narrative for patients. When hospitals run medical practices, federal law allows them to add substantial "facility fees" to patients' bills to cover overhead expenses. The new bosses also often rip equipment like X-ray machines and MRIs out of the physician's office, preferring to have patients get those tests from radiologists at the hospital. That, too, can cost patients. A consumer with a high-deductible Aetna plan, for instance, would pay up to \$1,400 for an MRI of her back at the University Medical Center at Princeton, N.J., according to data that the insurer makes available to its members. The same scan would cost about a third as much at near-

## AURORA HEALTH CARE (MILWAUKEE)

DOCTORS ON STAFF  
■ TODAY ■ 2007

1,400

750

Aurora is one of a few health systems that provide most of the health care in Milwaukee. According to independent research, insurers pay doctors here about double what they pay for the same care in Miami or Los Angeles, where large health groups aren't as prominent. Aurora says the system ultimately saves money by coordinating care.

STRESS TEST WITH  
A CARDIOLOGIST  
■ HOSPITAL ■ INDEPENDENT

\$170



## UNIV. OF NORTH CAROLINA HEALTHCARE (CHAPEL HILL, N.C.)

DOCTORS ON STAFF  
■ TODAY ■ 2007

110

48

With only 65 independent practices remaining in the area, doctors are being heavily wooed. One high-profile signing by UNC subsidiary Rex Healthcare: a 23-doctor cardiology practice. Rex executive director Bob Ricker says the expansion will save consumers money by creating efficiencies, like having doctors share billing staff.

RAPID THROAT CULTURE  
WITH A PEDIATRICIAN  
■ HOSPITAL ■ INDEPENDENT

\$12



sary care and duplicate tests. But Robert Berenson, a fellow with the Urban Institute, a think tank, says the new relationship sets up a vicious cycle: Hospitals become emboldened to ask for 60 or 75 percent price increases one year, and then insurers have to step up premiums to cover costs. "Unless something major changes in how we pay for care," Berenson says, "this could be the Achilles' heel of our health care system."

**F**OR SOME PATIENTS, THERE MAY BE AN even bigger headache that comes from all of this consolidation—potentially much less choice in which doctors they see. By their own admission, most hospitals are eager to keep patient referrals under the same corporate umbrella, to save on costs and share medical records but also to boost revenue. The hospitals say they wouldn't force an internist, for example, to refer a patient with heart problems to their own cardiologists, but critics say there's certainly financial pressure. Under a little-noticed regulation that took effect in 2007, hospitals are allowed to pay doctors less if they don't do enough internal referrals.

Doctors in Bozeman and Springfield who granted interviews said they didn't feel pressure to be "team players" with referrals. But some of those who've left large health systems tell a different story, including Mark Callenberger, an orthopedist in Merritt Island, Fla. Callenberger says that the hospital group where he used to work urged him to direct more patients to the MRI machine owned by the hospital. The doctor preferred a more advanced machine at a private practice that he says offered clearer pictures. But after he ignored the recommendations, Callenberger says, the hospital told his office manager to schedule patients at the hospital's MRI anyway, leaving him to perform surgery using "crummy images." (The hospital declined to comment on Callenberger's case but says its doctors can use whatever facilities they choose.) Patients may never know about these power struggles, because doctors aren't required to disclose how they choose specialists. And while patients who ask can always see a specialist outside the network, in practice few are likely to challenge their doctors' judgment, says Bruce A. Johnson, a Denver health care lawyer. "Face it, when we're really sick," says Johnson, "if the doctor tells us to jump off a roof, we'll probably consider doing it."

Sometimes the hospital and its doctor jump ship on the patient. As hospital groups get more clout and demand more money in negotiations with insurers, some employers and insurers are now showing a willingness to ax them out of their networks. When Kaiser Permanente went through contract negotiations for 2010, it couldn't reach an agreement with one hospital-owned, 400-doctor network in the Atlanta area, so it dropped them. For Stephanie Owen, a 42-year-old mother of

by Radiology Affiliates of New Jersey, a nonhospital facility. Based on a review of insurance databases and state regulatory records, that's a fairly typical price gap. (Barry Rabner, president and CEO of the Princeton system, says the hospital's fees cover expenses like 24-hour staffing and caring for uninsured patients.)

Price increases also have the potential to bleed outward—affecting not only the patients of the absorbed doctor, but also the cost of health care citywide. That's because when hospitals sit down at the bargaining table with insurers, they're almost always able to negotiate higher payment rates for their big groups of doctors than a lone physician with little bargaining power. Fast-growing hospital systems, including Hospital Sisters and Bozeman Deaconess, say that their growth will eventually make care more efficient and bring costs back down, since they'll be able to cut back on unneces-

two, that meant losing access to all her family's doctors. Owen, who was being treated for suspected breast cancer, says her primary-care doctor and breast-care clinic refused to keep seeing her, fearful that she'd be unable to pay her higher, out-of-network bills. "It was like they cut ties altogether," she says. "I was really upset and scared." Kaiser Permanente says it opened more clinics in the Atlanta area so consumers could see Kaiser physicians instead, but for Owen, that created some awkward moments. At one point, she says, she wound up being treated in an office in a strip mall.

As more patients face such disruptions, regulators are taking notice. In October, the Federal Trade Commission and the Department of Health and Human Services met with doctors, insurers and other health officials to discuss the referral and pricing problems that could arise from "accountable-care organizations"—those new groups of hospitals and doctors that will share financial incentives. The Federal Trade Commission will offer guidelines on what's permissible by mid-year. But hospitals are already lobbying for accountable-care groups to be exempt from antitrust and antitrust rules, even as they scoop up more and more medical practices. Under current regulations, officials in Washington must green-light all mergers involving companies valued at more than \$63 million. But by buying up tiny medical practices one at a time, critics say, hospitals stay below the threshold and avoid getting much attention. And by the time regulators settle on more-formal legal guidelines, those mergers may be hard to undo, says Cory Capps, a Washington economist specializing in health care antitrust issues.

**W**ITH THEIR EXPANSION A SENSITIVE topic, many hospitals have kept a low profile, declining to discuss their plans and encouraging their doctors to do the same.

But in Springfield, the Hospital Sisters system is willing to give us a long, if somewhat stage-managed, tour. A brisk young executive who manages PR is glued to our side as we visit the office of Michael Nenaber, a primary-care doctor who made the switch a year ago. After he signed on, Hospital Sisters quickly moved Nenaber to this new facility. Outside, we find a giant blue sign that identifies the clinic as St. John's Health Center: Prairie Crossing—without mentioning Nenaber's name. Inside, the office is gleaming new, with a TV playing the History Channel in one corner of the waiting area and a crucifix in another. "I'd follow Dr. Nenaber anywhere," says Hazel Jenne, a 90-year-old patient waiting for her husband to be called in for an appointment. In a few months Jenne will get to test that theory again. Across the street a green and white construction trailer and a torn-up plot mark the clinic where Nenaber will be moving in March. Designed by the same architect, the PR manager tells



**BY THE NUMBERS**  
**Springfield, Ill.**

**911**

**DOCTORS WITH ACTIVE LICENSES  
IN SPRINGFIELD**

**52%**

**SHARE OF THOSE DOCTORS  
EMPLOYED AT THE CITY'S FOUR  
LARGEST HEALTH SYSTEMS**

**191**

**DOCTORS WHO'VE JOINED  
HOSPITAL SISTERS SINCE 2009**

**45%**

**AMOUNT BY WHICH PRICE OF A  
SKIN LESION PROCEDURE AT ONE  
HOSPITAL SISTERS FACILITY  
EXCEEDS THE STATE AVERAGE**

**\$170-\$400**

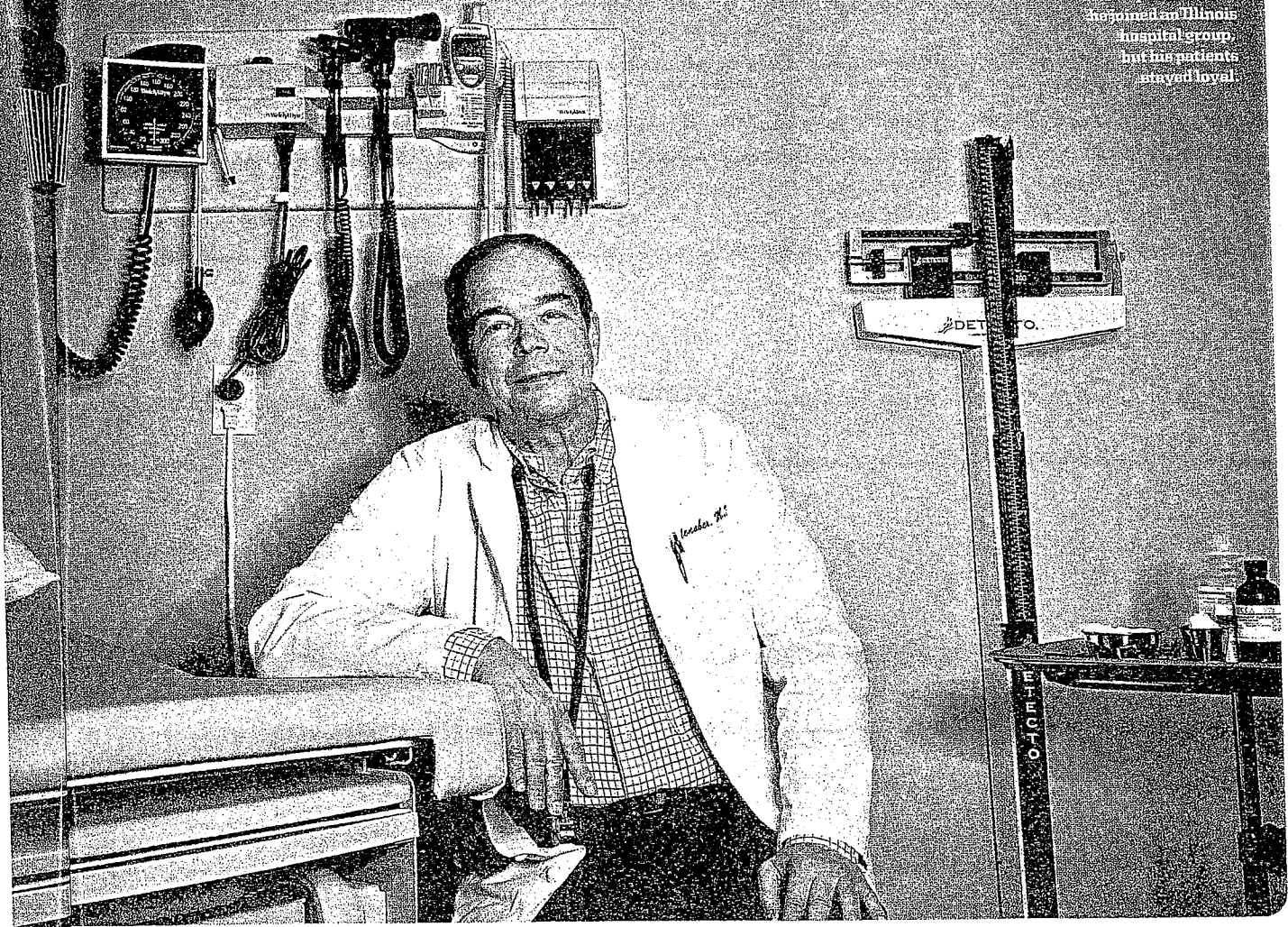
**AMOUNT A MAJOR MEDICAL  
GROUP IN SPRINGFIELD CHARGES  
FOR A STREP THROAT EXAM**

SOURCES: ILLINOIS DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION; ILLINOIS DEPARTMENT OF PUBLIC HEALTH; SPRINGFIELD CLINIC

us, it'll be a lot like this office—"but bigger!"

It's clear that transitions like these are sometimes rocky. Last spring Hospital Sisters tried to shift all of its Springfield medical offices to electronic medical records simultaneously. But there wasn't enough tech support to deal with all the problems physicians ran into on day one, and wait times spiked at the system's walk-in locations. Nenaber, a soft-spoken 64-year-old with wire-rim glasses, sounds acquiescent about the situation. "We're getting the hang of these things," he says slowly, sitting at his desk overlooking a gas station and a strip-mall parking lot. But his practice is still waiting for its electronic payoff: While other Hospital Sisters' doctors enthusiastically show off the iPads and iPhones they can use to access and share patient files, Nenaber has a sign tacked to the back of each exam room door urging visitors to "be patient" while he upgrades technology.

**MICHAEL  
NENABER** saw  
some upheaval after  
he joined an Illinois  
hospital group,  
but his patients  
stayed loyal.



PHOTOGRAPH BY BOB STERKO FOR SMARTMONEY

At Hospital Sisters, the role model everyone wants to emulate is the Advocate Health Care System in Chicago, a four-hour drive north of here on Interstate 55. That 13-hospital behemoth has been buying doctors' practices for more than a decade, and today it says its patients are healthier, thanks in part to efforts to get doctors to follow uniform guidelines when treating common ailments. Frank Mikell, chief physician executive for Hospital Sisters, says standardization can "make the patient experience dramatically better" through collaboration and a plethora of checklists. Executives here are also hoping to push the needle further—standardizing everything from how long patients wait on hold to the ease of parking at the doctor's office (valets, luxury-restaurant style, are one solution under consideration).

Still, Mikell acknowledges, "doctors don't want follow-the-directions, cookbook medicine." And for many physicians, the idea of following new rules triggers a

much larger unease at giving up their independence—a feeling of loss, both for the businesses they built and for their patients. Back in Bozeman, Blair Erb, the sole cardiologist in town, is a picture of resignation as he prepares to sign a contract with Deaconess. "I feel defeated," Erb says, looking around at the office furniture he and his wife, Liz, chose from a catalog years ago. The weathered ranchers and bundled-up women that come through his door mostly express disbelief when they hear that this frank-talking Tennessee native will sell his practice. His staffers say they're not looking forward to the questions the hospital's medical records system will soon prompt them to ask patients. (Do you wear a bike helmet regularly? Do you have a smoke detector?) "We'll try to retain as much professional independence as possible," Erb says, gazing at the hospital building, whose bulk he can see through his window. "But the fact of the matter is, we'll have a new master." ☺