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BUSINESS

The Hidden System That Explains How Your Doctor Makes Referrals

More primary-care doctors work directly for hospitals, and they are being pushed to keep lucrative referrals in-house

By Anna Wilde Mathews and Melanie Evans
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Phoebe Putney Health System doesn't want its doctors to send business to competitors. If they do, Phoebe makes sure their bosses know about it.

Doctors working for the Albany, Ga.-based hospital system's affiliated physician group get regular reports breaking down their referrals to specialists or services. One viewed by The Wall Street Journal included cardiology, colonoscopies and speech therapy, along with the share of each referred to Phoebe health-care providers.

If the share of in-house business wasn't viewed as adequate, administrators would press them to improve, doctors said.

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"They would let you know it wasn't high enough," said Thomas Hilsman, a primary-care doctor recently retired from the Phoebe medical group. He said he felt referrals should be based on which health-care provider was best for patients. "They keep the Phoebe physicians busy, they see more patients, they make more money."

Phoebe officials said they use referral policies to improve quality and reduce costs, and physicians weren't punished for their decisions.

Patients are often in the dark about why their doctors referred them to a particular physician or facility. Increasingly, those calls are being driven by pressure to keep business within a hospital system, even if an outside referral might benefit the patient, according to documents and interviews with doctors, current and former hospital executives and lawyers.

Losing patients to competitors is known as “leakage.” Hospitals, in response, use an array of strategies to encourage “keepage” within their systems, which in recent years have expanded their array of services.

The efforts at “keepage” can mean higher costs for patients and the employers that insure them —health-care services are often more expensive when provided by a hospital. Such price pressure and lack of transparency are helping drive rising costs in the $3.5 trillion U.S. health-care industry, where per capita spending is higher than any other developed nation.

St. Mary Medical Center in Langhorne, Pa., the Trinity Health hospital where Dr. Patel, who is now in private practice, once worked. PHOTO: MATT STANLEY FOR THE WALL STREET JOURNAL

For hospital systems, doctors’ referrals are a vital source of revenue. A hospital earns an average of $1.8 million annually in revenue from an internal-medicine physician’s admissions, referrals for tests and other services, plus practice revenue for employed doctors, a 2016 survey by recruiter Merritt Hawkins, a unit of AMN Healthcare Services Inc., found. The survey didn’t include hospital revenue from referrals by internal-medicine doctors to specialists, such as orthopedic surgeons or cardiologists.

Hospitals have gained more power over doctors with a wave of acquisitions of practices and hirings in recent years, and hospitals are getting more aggressive in directing how physicians refer for things such as surgeries, specialty care and magnetic resonance imaging scans, or MRIs.

> Insurers have been working to steer patients toward doctors’ offices and other non-hospital locations for many types of care, because they are generally less expensive. The

same service often costs twice as much or more when delivered in a hospital setting, compared with a doctor's office, according to an analysis of dozens of medical services performed for The Wall Street Journal by the nonprofit Health Care Cost Institute. Hospitals often have the clout to negotiate higher rates with insurance companies, including extra fees that they often receive.

For a patient with employer-provided insurance, the average cost of a complicated drug administration—such as chemotherapy—was $612 when performed in hospital-affiliated facilities, and $247 in a doctor's office in 2016, according to the analysis. The data include a small number of locations that aren't hospital-affiliated or doctors' offices.

Patients often pay more out-of-pocket as a result. A study released earlier this year by researchers at Yale University and elsewhere found that patients whose doctors worked for hospital systems were 27% more likely to get their lower-limb MRIs at a hospital, and their scans cost $277 more on average, with about $90 of that extra amount being added to the patient's out-of-pocket cost. The researchers suggested that the referring doctors "may be motivated to refer patients to specific providers for reasons other than quality or patient costs."

Jim Wood, a manufacturing-company executive, said his doctor, who worked for Rockford, Ill.'s SwedishAmerican, annually ordered his lab tests done by the hospital, with bills that amounted to $529.85 in 2015. The next year, Mr. Wood had the same tests done at an independent lab instead. The total cost: $57.83.

His doctor suggested he get a shoulder MRI from a mobile SwedishAmerican site, at a total cost of $2,507.36, including the radiologist's fee, of which he had to pay $626.85 out-of-pocket. When he later checked what the scan would have cost at a local imaging center, the estimate was under $300, not including the doctor's fee.

His doctor "works for them, so he's not necessarily going to tell me where to go to get it done cheaper," Mr. Wood said. "Any procedure done by a hospital is going to be marked up."

In a statement, SwedishAmerican, which is part of the University of Wisconsin Health system, said that "patients have the final say in where they choose to receive care," and it accommodates referrals to outside groups. The statement also said "we also believe that there is benefit to patients receiving ancillary services within our health system as it provides opportunities for enhanced continuity of care."

Federal rules generally block hospitals from directly tying physicians' pay to referrals, because of worries that factors other than patient needs could impact physicians' decisions. Doctors and hospital officials said that hospitals make the goals clear in ways both subtle and overt.

Some hospitals have employment contracts that mandate doctors refer within their system,

Hospitals are getting more aggressive in directing how physicians refer for things such as surgeries, specialty care and MRIs, shown above. **PHOTO:** ISTOCK

with a few exceptions required by law. In electronic medical records, a system's own specialists and services are sometimes located in a convenient drop-down menu, while referring to an outsider requires additional steps. Hospitals may train doctors' staffs on where to direct referrals, since doctors often leave the final decision to them.

A 2016 survey of hospital executives by Nielsen Strategic Health Perspectives found 55% were actively managing, or planning to manage, referrals to keep them inside their systems.

Mrugesh B. Patel, a cardiologist in Langhorne, Pa., who worked for St. Mary Medical Center, owned by the large Trinity Health system, said hospital executives would talk in meetings with doctors about the need to maximize the system's market share.

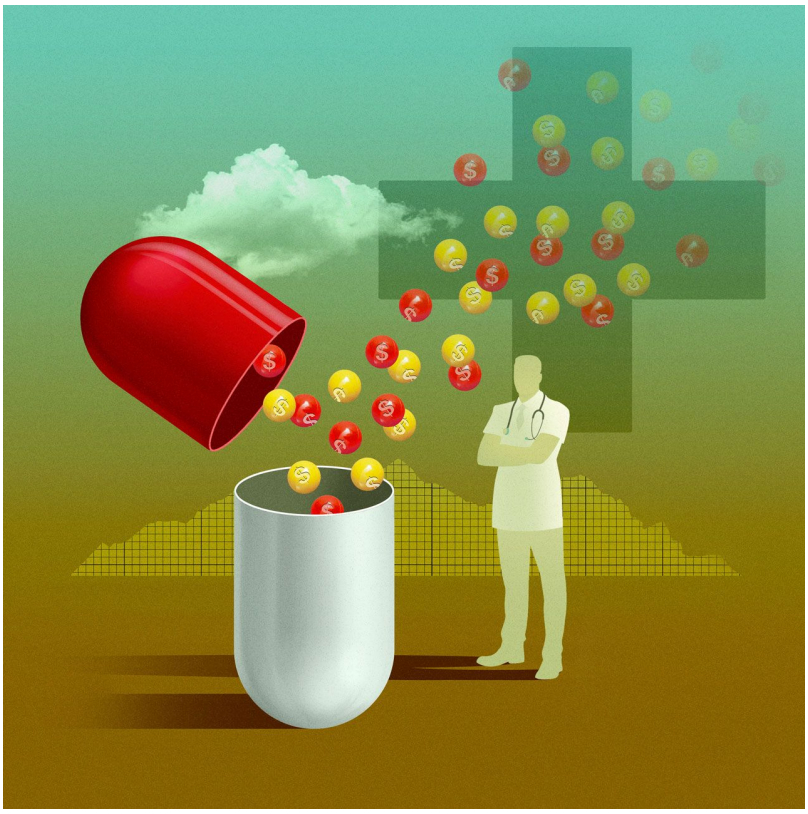
"There was strong, strong emphasis to keep our patients internal and not let them leak out to unaffiliated physicians," he said. "Big Brother was always watching because they had all these computers, so they knew who's sending patients out of the system."

Dr. Patel, who now has his own practice, said he would still refer patients outside if he thought that was the best option for them.

"Referral tracking within our network helps us confirm that our providers are creating and optimizing opportunities for coordinated care," Trinity said in a statement.

Hospital-system executives, including from the Phoebe medical group, said their referral policies are aimed at ensuring quality and reducing costs, partly through avoiding duplication and unnecessary procedures, efforts that some insurers are trying to encourage with financial incentives. A single electronic medical record, for example, means all of the health-care providers in the system can share findings easily, they said.

WHY AMERICANS SPEND SO MUCH ON HEALTH CARE



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Phoebe officials said another goal of tracking referrals is to bolster care by showing where Phoebe may need to add or improve services. Conversations with doctors about their referral patterns aren't common, and the process wasn't punitive toward physicians, they said. A Phoebe spokesman said the written referral summaries go to doctors based in its outpatient clinics.

"We do not use our referral tracking data to put pressure on our physicians to refer to their partners within our system," said Suresh Lakhanpal, president of Phoebe Physicians, the medical group. "However, if an employed physician routinely refers patients outside of our group without good reasons to do so, then that physician is not demonstrating commitment to the best interest of the patients and may not fit well within our team of outstanding health-care professionals."

Phoebe created its referral-tracking system, which draws on doctors' electronic medical records, a few years ago, according to people with knowledge of the matter. Data from an outside vendor had shown that outsiders were getting a substantial share of the referrals made by doctors employed by the Phoebe medical group, including in lucrative fields such as orthopedics and cardiology, according to these people. Executives internally worried about the lost revenue and pushed for efforts to keep more business in the system. The new tracking, including the regular reports given to doctors, worked, according to the people, and the share of referrals kept in the system rose.

Southern Illinois Healthcare, a three-hospital system based in Carbondale, Ill., has used employment contracts to restrict referrals. Language from two physician contracts at the system's doctor group, viewed by the Journal, said the doctor "shall be required to refer all patients to an SIH facility." The contracts allowed exceptions carved out by federal law, such as patient preference.

Documents that emerged in an antitrust case filed against Southern Illinois Healthcare by a local surgery center showed the system going further. In a 2014 letter to doctors and managers of the SIH Medical Group, a Southern Illinois Healthcare executive said the group "will no longer refer patients" to two surgeons because "they regularly take patients" to a rival hospital to do procedures after being referred by SIH physicians. The letter noted exceptions such as patient preference that would allow for referrals to those physicians.

"I was kind of shocked the hospital system felt it could do this," said Brian Daines, an orthopedic surgeon who was one of the subjects of the letter. He said the letter went out after he had begun working with the rival hospital on a new special joint-surgery center, though he used both hospitals for operations.

Kevin Koth, the other surgeon named in the letter, said that he typically did operations at whichever hospital could schedule the surgery soonest because that was better for patients.

"I don't conform to what the hospital wants, I do what's best for the patient," he said.

A spokeswoman for Southern Illinois Healthcare declined to comment.

The referral policies of Orlando Health, an eight-hospital system in Florida, contributed to the operator's failed bid to take over a public hospital in Vero Beach, Fla., that hospital said.

The public hospital's officials pressed bidders about their potential referral mandates, said Marybeth Cunningham, one of the public officials who oversaw the hospital transaction. "You'd like to know that they are going to refer to whoever is the best," she said.

Orlando Health's policy to prioritize its own hospitals over competitors was one factor in the decision to reject its bid, Ms. Cunningham said.

David Strong, Orlando Health's chief executive, said the system doesn't mandate doctors send patients in-house, but instead analyzes referral data to identify physicians who send patients elsewhere and then approaches them to learn why, to make changes that will bring in their business. "We want the referral," he said, but added the system's doctors have the right to refer patients wherever they believe is best.

Orlando Health, which has more than doubled its physician employees since 2010 to more than 550 doctors, acquired local outpatient imaging centers in late 2014. Patients visit imaging

The Phoebe Putney Memorial Hospital in Albany, Ga. PHOTO: JENNIFER PARKS/THE ALBANY HERALD

centers for diagnostic and screening tests that require ultrasounds, MRIs or CT scans.

Soon after, David Panzer, the former president of the radiology group that jointly owns the imaging centers with Orlando Health, went to an Orlando Health primary-care group to press for more referrals. Dr. Panzer said he made his pitch at a meeting that included Mr. Strong.

The primary-care doctors weren't happy with slow service at the radiology centers, according to doctors at the meeting. "We had a frank conversation," said Martin Derrow, an internal-medicine physician who was present.

Ultimately the primary-care group switched many referrals to the new radiology group after Dr. Panzer and his colleagues made requested changes, Dr. Derrow said. In some cases that shifted patients away from doctors the primary-care group previously "felt did the best job," Dr. Derrow said. Patients who ask to go elsewhere can do so, and he always asks, he said. "Nothing is more important than patient advocacy," he said.

For the newly acquired radiology centers, Orlando Health waived extra fees that typically drive up prices for hospital-affiliated locations. Add-on charges for care at such locations are known as "facility fees" that hospitals say offset typically higher costs associated with their operations. Other Orlando Health-affiliated imaging locations continue to charge the fees.

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