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Growth Of Single-Specialty Medical Groups

Can single-specialty groups match multispecialty groups for high-quality, cost-efficient care?

by Lawrence P. Casalino, Hoangmai Pham, and Gloria Bazzoli

ABSTRACT: Using site-visit data from the Community Tracking Study, we show that specialists are increasingly forming large single-specialty medical groups, particularly in orthopedics and cardiology, where new technologies have increased the number of diagnostic imaging and surgical services that can be provided in outpatient settings. Specialists are also forming large groups to gain negotiating leverage with health plans; the decline of managed care and the fading of the perception of a specialist surplus has made single- rather than multispecialty groups an attractive means to gain leverage. We explore possible consequences of this shift in physician practice organization and its policy implications.

Throughout the twentieth century most U.S. physicians chose to work in solo or small-group practices. During much of the 1990s the growth of “tight” managed care gave physicians incentives to create or join large multispecialty, primary care–based medical groups to secure a patient base through primary care physician (PCP) gatekeepers, to gain negotiating leverage with health plans, and to manage costs and spread financial risk under the capitated contracting that was expected to become prevalent.1

The perceptions that tightly managed care would become the dominant model in the United States and that there was a surplus of specialists placed PCPs in a critical position.2 They were viewed as critical not only for gaining access to patients, but also for making it possible to profit from capitated contracts. Such contracts, which gave physicians and hospitals a fixed sum of money to care for patients, threatened to turn the historical role of specialists and hospitals on its head. Instead of being the prime revenue generators and profit centers in the delivery of health care, specialists and hospitals would be cost centers, whose use was to be avoided as much as possible. Revenue would come from monthly capitation payments, which were tied to the PCPs with whom patients enrolled. Because their services were less expensive, because utilization management began with...
them, and because it was thought that they would coordinate patients’ care, PCPs were considered essential to containing costs. Under these circumstances, many specialists joined multispecialty, primary care–based medical groups; independent practice associations (IPAs); and physician-hospital organizations (PHOs). The growth of such groups was welcomed by many. Medical care reformers had long believed that primary care–based multispecialty groups were an efficient way to provide high-quality care.

But by the late 1990s it was clear that tightly managed care was not becoming the prevalent model in the United States and that, in fact, health plans were retreating from it. Patients began shifting from health maintenance organizations (HMOs) to preferred provider organizations (PPOs). HMOs themselves began to look more like PPOs, as employers chose health insurance products that met employees’ demands for open access to specialists, broad provider networks, and less utilization management. Predictions of a specialist surplus failed to materialize. The development of new technologies made it possible to provide expensive imaging and surgical services on an outpatient basis, while the decline of tightly managed care made it easier to profit from investing in these services.

Under these circumstances, specialist physicians (and hospitals) have the opportunity to once again become the prime revenue/profit generators in medical care delivery. It seems reasonable to hypothesize that specialists now have incentives to form single-specialty groups both to gain negotiating leverage with health plans and to profit from imaging and surgical services without having to share governance and revenues with PCPs in a multispecialty group.

In reviewing the literature, we were struck by the almost complete absence of research into the organization of specialist practice. In previous work we used data from Community Tracking Study (CTS) site visits to describe hospitals’ move toward a “new medical arms race” and specialists’ efforts to own ambulatory surgery centers (ASCs) and even specialty hospitals. In this paper we use data from the CTS site visits and Physician Survey, as well as secondary data, to investigate the extent to which specialists are moving into specialty-only medical groups and to explore reasons for creation of these groups, barriers to their success, and policy issues they raise.

**Study Methods**

Since 1996 the CTS has conducted four rounds of site visits to the same twelve metropolitan areas—more than 2,600 interviews with leaders of the largest health plans, hospitals, and physician groups in each area, as well as with employers and government officials. Here we use information from the first three rounds of the CTS as background and focus on 417 interviews conducted with health plan, hospital, and physician group leaders during Round Four (September 2002–May 2003). These three respondent categories are well positioned to know what is happening with specialists. By comparing their responses, we can minimize the
possibility of accepting a view of the situation offered by one (self-interested) set of respondents.\textsuperscript{10} We also use data from brief written surveys given to specialist-group leaders and hospital executives at the end of their interviews. We obtained completed surveys from thirty-nine (87 percent) of the medical group leaders and twenty-six (79 percent) of the hospital executives.


**Single-Specialty Medical Groups**

Moderate to large-size single-specialty groups have become more common, at least in certain specialties, since the late 1990s.\textsuperscript{11} During Rounds Three (2000–01) and Four of the CTS site visits, we identified fifty-five specialist groups of ten or more physicians in the twelve CTS communities.\textsuperscript{12} Approximately half of these groups, with a mean size of thirty-seven physicians (range = 11–135 physicians; median = 24 physicians), had been created since 1996, usually through the merger of small existing groups, or had recently embarked on rapid growth. The remainder were created prior to 1997 and have grown slowly since, without any recent rapid increase in size. We identified only one large single-specialty group that had disappeared since 1997. Of the fifty-five specialist groups, cardiovascular (17 groups) and orthopedic (10) groups were the most common, followed by neurology (6), ophthalmology (5), oncology (5), and several other specialties.

The number of large specialty groups identified through site visits represents a minimum estimate of those that exist. Recent AMA physician surveys support the CTS site-visit findings: During the past few years physicians in certain specialties have been moving into larger groups, while PCPs and physicians in other specialties, such as gastroenterology, have not (Exhibit 1). More than 80 percent of family physicians and general internists practiced in groups of seven or fewer in 2001. In contrast, approximately one-third of cardiologists and orthopedists practiced in groups of eight or more, and these specialists moved rapidly into larger groups between 1999 and 2001. Although the AMA data do not specify whether these groups are single- or multispecialty, the findings from the CTS site visits suggest that most of this movement was into single-specialty groups.

**Why Single-Specialty Groups, And Why Now?**

The medical group, hospital, and health plan leaders interviewed during CTS site visits consistently cited four main reasons for specialists to join large groups: (1) to have the capital and scale economies to invest in expensive equipment and facilities to provide imaging and surgical services; (2) to gain negotiating leverage with health plans; (3) to gain a reputation as a high-quality group; and (4) to gain
professional management to deal with an increasingly complex business and regulatory environment. Group leaders and hospital executives also frequently stated that groups provided lifestyle benefits, such as collegiality and sharing night and weekend calls. We do not emphasize lifestyle benefits in this paper, because they have always been available in small groups as well as large ones.

In surveys completed at the end of interviews, specialty-group leaders and hospital executives gave responses that were generally consistent with our interview findings (Exhibit 2). However, disagreements concerning the importance of negotiating leverage and the importance of improving quality should be noted.

■ Negotiating leverage. Although both specialty-group leaders and hospital executives frequently emphasized the importance of negotiating leverage with health plans, gaining negotiating leverage is ranked relatively low in the group leader survey, because the survey included leaders of smaller single-specialty groups (around ten physicians), who generally reported having little or no ability to negoti-
...ate higher payment rates from health plans. Leverage was very important, however, to leaders in the larger groups. “Fear of managed care was what drove us together,” said the medical director of one large group, who continued, “Success in contracting is what has held us together.” The executive of the same group stated that “if there were a single-payer system we would die—there would be no need for us.”

**Quality of care.** Virtually without exception, physician leaders of specialty groups spoke enthusiastically about their group’s reputation for quality. However, they had little to say when asked specifically what organized processes their group uses to improve quality, although some of the larger groups have electronic medical records (EMRs), and some of the cardiology groups have coumadin clinics and lipid clinics. Hospital and health plan executives, while not denying the good reputation of the groups, generally reported that they saw little evidence that they are making organized efforts to improve quality. Hospital and health plan interviewees focused more on negotiating leverage and investment in surgical and ancillary diagnostic facilities as the prime reasons for specialty-group formation.

**Profitability.** Why are specialists seeking the advantages of membership in a large group in specialty-only groups, rather than in multispecialty groups that include PCPs? Interviewees stated that with the retreat from tightly managed care, specialist-only groups have become much more attractive to specialists than primary care–based multispecialty groups. They stated that with fee-for-service rather than capitated payment from health plans to medical groups, specialists generate far more profit than PCPs do. This is particularly true for medical groups that own their own high-end imaging and surgical services (such as magnetic resonance imaging, or MRI, scanners, nuclear cardiac cameras, and ambulatory surgical centers, or ASCs), which under fee-for-service payment are more profitable than cognitive services. Specialists are able to generate more gross revenue while using the same number of or fewer staff than PCPs use. In a multispecialty group, PCPs are likely to pressure specialists to share some of that profit. Some interviewees stated that the case for sharing is strengthened by recent additions to laws regulating physician self-referral (Stark II), which make it illegal for a physician in a group to be paid according to the volume of ancillary services he or she orders.

**Organizational factors.** Respondents also stated that single-specialty groups have two other advantages over multispecialty, primary care–based groups. First, they avoid the complicated governance and operational issues engendered by having primary care and specialty physicians in the same organization—issues that were tolerated as a necessary evil when it appeared that PCPs were essential for access to patients and for assistance with controlling use. Second, a number of respondents suggested that single-specialty groups can gain negotiating leverage with health plans with far fewer physicians than a multispecialty group can.

If attempting to gain negotiating leverage were a sufficient reason for the creation of large single-specialty medical groups, we would expect to see such groups in all specialties. The fact that these groups are being created in certain special-
ties—notably cardiology and orthopedics—and not in others (for example, dermatology, psychiatry, or infectious disease)—suggests that gaining the size to invest profitably in outpatient imaging and surgical facilities is a key factor driving large specialty-group formation. Medical group and hospital interviewees stated that cardiology and orthopedics are specialties in which outpatient imaging and surgical services have become increasingly technologically possible, are particularly well reimbursed by Medicare and commercial health plans, and require a group of sufficient size to have the capital to invest in the necessary equipment and facilities. Health plan and hospital interviewees pointed out that the retreat from tightly managed care contributes to the growth of groups that can profit from these facilities. This retreat makes it possible for specialists to move a high volume of patients through their facilities without much need to deal with primary care gatekeepers or preauthorization of services. Given the decline of capitated contracting and the relatively high rates that Medicare and commercial health plans pay for imaging and surgical services, these facilities are now attractive as profit centers, not the cost centers they would be under capitation.

Decline Of Multispecialty Physician Groups

Large multispecialty medical groups never became as numerous as many expected. During the past three years the number appears to be declining: Not a single large multispecialty group was created in any of the twelve CTS metropolitan areas, and several large and prominent groups broke apart.

CTS survey data confirm this decline. Between Rounds Two (1998–99) and Three of the survey, the percentage of physicians practicing in multispecialty groups with PCPs increased slightly, from 8.4 percent to 9.9 percent (these data were not collected during Round One). However, for physicians in such groups, the percentage practicing in groups of fifty or more decreased from 46 percent to 27 percent and for groups of twenty to forty-nine, from 25 percent to 19 percent (Exhibit 3). Similarly, the number of IPAs and PHOs began to decrease beginning in the late 1990s as it became evident that gatekeeping and risk contracting were

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NOTE: Percentages are the proportion of nonfederal physicians in private practice (not group/staff health maintenance organizations, hospital, or medical school practices) practicing in groups of varying sizes.
becoming less, not more, common. All three of these forms of organization were prominent in interviews during the Round One (1996–97), but by Round Two enthusiasm had diminished. By Round Four, IPAs were important only in one of the twelve metropolitan areas (Orange County, where risk contracting and gatekeeping remained common), although a handful persisted in other sites. With rare exceptions, interviewees indicated that hospitals and physicians in their area had abandoned PHOs as a strategy.

Conclusions And Policy Implications

Even with the retreat from tightly managed care, physicians continue to have an incentive to form groups to gain negotiating leverage with health plans. Nevertheless, most physicians still do not practice in large groups, perhaps because of the costs (in money, time, and loss of independence) involved in creating such groups. The emergence of new imaging and surgical technologies, the decline of capitation, the relatively favorable fee-for-service payment rates for services using these technologies, and the retreat from utilization management that might limit the use of these technologies all favor the formation of groups including specialists, such as orthopedists and cardiologists, who can jointly invest in these technologies. The move away from primary care gatekeeping, the disappearance of the perception of a specialist surplus, and the Stark II regulations all favor creation of single-specialty rather than multispecialty groups.

Those who hold the traditional view that multispecialty, primary care–based groups are the best way to coordinate high-quality, cost-efficient care will not be pleased with the shift to single-specialty groups. But should policymakers be concerned?

Cost and quality issues. The simple response to this question is that we do not know nearly enough about the effects of large single-specialty groups to provide an answer. No systematic information on the costs or quality of care provided by such groups is available. Proponents of “focused factories” would expect quality to be higher and costs lower in these groups than in multispecialty groups. However, proponents of multispecialty group practice have long argued that the coordination essential to high-quality, cost-effective care will be better in the multispecialty group setting.

If specialty groups can operate as focused factories, and if they have incentives to contain costs, they could lower the overall cost of care through increased efficiency of operation and through providing only care that is appropriate. CTS site visits have provided little evidence that single-specialty groups, to date, are developing many of the organized quality-improving and cost-reducing processes to be expected in a focused factory. The current system pays specialists for increasing, not decreasing, the quantity and complexity of services provided and does not pay them for improving quality. Previous research has shown that physicians who own ancillary facilities tend to increase the amount of ancillary services they pro-
Health plan executives at many CTS sites believe that increased specialist use of ancillary services is increasing health care costs.

Large, single-specialty groups may also increase health care costs to the extent that they attain the negotiating leverage to gain higher payment rates from health plans. In general, plan executives interviewed during Round Four of the CTS did not appear greatly concerned at this time about the rates paid to most single-specialty groups, although they did express concern about the largest groups.

Payers and policymakers could increase the likelihood that specialty groups will function as beneficial focused factories by rewarding groups that provide high-quality care and control costs. Even if this occurs, however, concerns about coordination of care for patients with multiple chronic illnesses are likely to persist unless research shows that patients cared for in focused factories have better outcomes overall, and not just for specialty-specific diseases.

■ **Regulatory and purchasing issues.** Whether the number of large medical groups increases, and whether these groups will be single or multispecialty, will depend on government regulatory and corporate/government health insurance purchasing decisions, including decisions involving payment rates, Stark, antitrust enforcement, and the types of health insurance plans offered.

If Medicare and commercial health plan payment rates are sufficient for specialists to earn high incomes without the negotiating leverage and ancillary revenues that may be gained by joining a large group, most probably will not join. Specialists will also be less likely to join large groups if federal or state laws are enacted that would permit them to negotiate jointly with health plans while remaining in solo and small-group practices.

■ **Payment rates.** The attractiveness of single-specialty groups compared with multispecialty, primary care–based groups would be reduced if payment rates for cognitive services were raised relative to payments for surgical procedures and ancillary services, if the Stark II rules were repealed, or, at the other extreme, if referral by physicians to surgical and ancillary facilities that they own were prohibited.

■ **Types of plans available.** Finally, the degree to which physicians join single-specialty versus multispecialty groups will be strongly influenced by the types of health plan products that prevail in the market. If these plans emphasize fee-for-service payment and direct access to specialists, specialty groups will be favored. If they emphasize control of medical care costs through methods adapted from tightly managed care, multispecialty groups will be favored. If the plans reward coordination of care, it remains to be seen whether a system based on single-specialty or multispecialty groups will best be able to accomplish this objective.

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NOTES


2. Governance Committee, Grand Alliance II: Capitation Strategy (Washington: Governance Committee, 1994).


4. Committee on the Costs of Medical Care, Medical Care for the American People (Chicago: University of Chicago Press, 1932).


10. M.B. Miles and M. Huberman, Qualitative Data Analysis (Newbury Park, Calif.: Sage, 1994).

11. There is no accepted definition of “large,” “moderate-size,” and “small” single-specialty groups. Size may be considered in terms of the number of specialists in a group or the number of specialists in a group relative to the number of physicians in a geographic area.

12. We did not study academic physicians or the very common groups of hospital-based physicians (radiologists, anesthesiologists, pathologists, and emergency physicians).


17. Casalino et al., “Benefits of and Barriers to Large Medical Group Practice.”


