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Access to Urological Care for Medicaid-Insured Patients at Urology Practices Acquired by Private Equity Firms

Authors

Nie, James
Hsiang, Walter
Marks, Victoria
et al.

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Access to Urological Care for Medicaid-Insured Patients at Urology Practices Acquired by Private Equity Firms

James Nie, Walter Hsiang, Victoria Marks, Folawiyo Laditi, Adarsh Varghese, Waez Umer, Afash Haleem, David Mothy, Hannah Wang, Riya Patel, William Pan, Rishi Shah, Sophia Khan, Rohan Singh, Vishnukamal Golla, Jaime Cavallo, Benjamin N. Breyer, and Michael S. Leapman

OBJECTIVE To characterize appointment access for Medicaid-insured patients seeking care at urology practices affiliated with private equity firms in light of the recent national trends in practice consolidation.

METHODS We identified 214 urology offices affiliated with private equity firms that were geographically matched with 231 non-private equity affiliated urology offices. Using a standardized script, researchers posed as an adult patient with either Medicaid or commercial insurance in the clinical setting of new onset, painless hematuria. The primary outcome was whether the patient's insurance was accepted for an appointment. The secondary outcome was appointment wait time.

RESULTS We conducted 815 appointment inquiry calls to 214 private equity (PE) and 231 non-PE-affiliated urology offices across 12 states. Appointment availability was higher for commercially-insured patients (99.0%; 95% CI: 98.1%-99.9%) vs Medicaid-insured patients (59.8%; 95% confidence interval [CI]: 55.0%-64.6%) ($P < .0001$). Medicaid acceptance was higher at non-PE affiliated (66.8%; CI 60.4%-73.2%) than PE-affiliated practices (52.1%; 95% CI 45.0%-59.2%) ($P = .003$). On multivariable logistic regression analysis, state Medicaid expansion status (odds ratio [OR] 2.20; CI 1.14-4.28; $P = .020$) was independently associated with Medicaid appointment availability, whereas PE-affiliation (OR 0.55; CI 0.37-0.83; $P = .004$) was independently associated with lower Medicaid access. Appointment wait times did not differ significantly for commercially-insured vs Medicaid patients (19.2 vs 20.1 days; $p = .59$), but PE-affiliated practices offered shorter mean wait times than non-PE offices (17.5 vs 21.4 days; $P = .017$).

CONCLUSION Access disparities for urologic evaluation in patients with Medicaid insurance at urology practices and were more pronounced at private equity acquired practices. UROLOGY 164: 112–117, 2022. Published by Elsevier Inc.

Patients with medicaid have historically faced reduced access and longer wait times for urological care compared to privately insured patients.[1-4] Lower reimbursement and greater administrative burdens associated with Medicaid have often been cited as the major drivers for reduced access for Medicaid-insured.[2] Prior to implementation of Medicaid expansion associated with the Affordable Care Act (ACA) in 2014, it was estimated that 41.7% of urologists did not accept any form of Medicaid.[2] With a projected urology workforce shortage and growing need for urological services from a Medicare population, it is possible that Medicaid-insured patients may be crowded out and face even greater access disparities in the future.[5] On the heels of successful ventures in other healthcare specialties, private equity firms have begun investing in urology practices.[6] Over the last 5 years, private equity (PE) firms have begun to create large urology platforms with horizontal consolidation of local urology practices and vertical integration ancillary services, such as ambulatory surgery centers and diagnostic laboratories.[6] In general, the strategic horizon for a PE firm is to institute operational improvements, such as increases in patient volume that increase the valuation of acquired entities in a short time frame for future sale.[7,8] In line with this strategy, it would be expected that PE firms would institute revenue optimizing practices, such as

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From the Department of Urology, Yale University School of Medicine, New Haven, CT; the Yale University School of Medicine, New Haven, CT; the Department of Urology, University of California-San Francisco, San Francisco, CA; and the Department of Urology, Duke School of Medicine, Durham, NC

Address correspondence to: Michael S. Leapman, Department of Urology, Yale University School of Medicine, 310 Cedar St, BML 238c, New Haven, CT 06520. E-mail: michael.leapman@yale.edu

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limiting care provided to Medicaid-insured patients.[9] In this study, we sought to characterize rates of Medicaid acceptance and appointment wait times between offices with and without PE-affiliation.

METHODS

We performed a national cross-sectional study using the secret shopper method, a widely used approach in health services and market research, whereby investigators pose as patients to gain understanding of real-world practices.[10] This study was exempted from IRB approval.

Identification of PE-Affiliated Offices

In March 2021, we systematically searched five financial databases and news aggregator sites, and conducted manual Google keyword search to identify urology practices that had been acquired by PE firms using a previously described method.[6] We identified five platform companies that acquired urology practices across 12 states between August 2016 and January 2021. We then searched the websites of the websites of each company to identify clinical locations and contact information. In total, we identified 239 patient facing office locations. These clinics represent 100% of the clinical sites with known PE affiliation as of March 2021.

Identification of Non PE-Affiliated Offices

For each PE-affiliated urology office, we identified two unique, geographically matched non-PE-affiliated private practice offices located within 25 miles using the Urology Care Foundation's "Find a Urologist" portal based on the zip code of each PE-affiliated office.[11] We reviewed results sequentially to identify unique urologists' practices that were not PE-affiliated, academic, federal, or belonging to a health maintainence organization. Of note, a proportion of PE-affiliated offices did not have any offices within 25 miles that met selection criteria.

Study Design

From May through July of 2021, trained investigators used a standardized script to call urology offices from a caller-ID blocked phone number (Fig. 1). Investigators posed as the family member of an adult patient with new onset, painless, gross hematuria to inquire about appointment availability. Researchers were randomly assigned to call PE-affiliated offices and the corresponding geographically matched, non-PE-affiliated offices. Each researcher called each clinical location twice, once for each insurance scenario (Medicaid and commercial insurance). Commercial insurance plans were identified for each state using a Silver or Gold level plan identified on the Center for Medicare and Medicaid Service's Health Insurance Marketplace.[12]

Researchers collected information on whether the office accepts new patients, whether the clinic accepted Medicaid, and the date of the earliest available in-person appointment. To prevent access disruptions, no appointments were booked. If the office required registration with patient details to discuss appointment availability (name, date of birth, address, phone number, etc), researchers were instructed to exit the call. Offices that required registration or a referral to make an appointment and those that would not allow booking over the phone were excluded from analysis.

Statistical Analysis

The primary endpoint was whether the patient's insurance was accepted for booking an appointment. Appointment availability was defined as the proportion of phone calls in which researchers were able to get a date of appointment. The secondary endpoint was appointment wait times. Student's *t* test was used to compare insurance acceptance and wait times. Univariable logistic regression was used to assess the impact of Medicaid Expansion and PE-affiliation on Medicaid appointment availability. Factors that approached significance ($P < .1$) were included in a multivariable model. We used 2-sided tests at an alpha level of 0.05 to determine statistical significance. All statistical analyses were performed using STATA 17 (College Station, TX). The geographic distribution of offices were visualized using ArcGIS

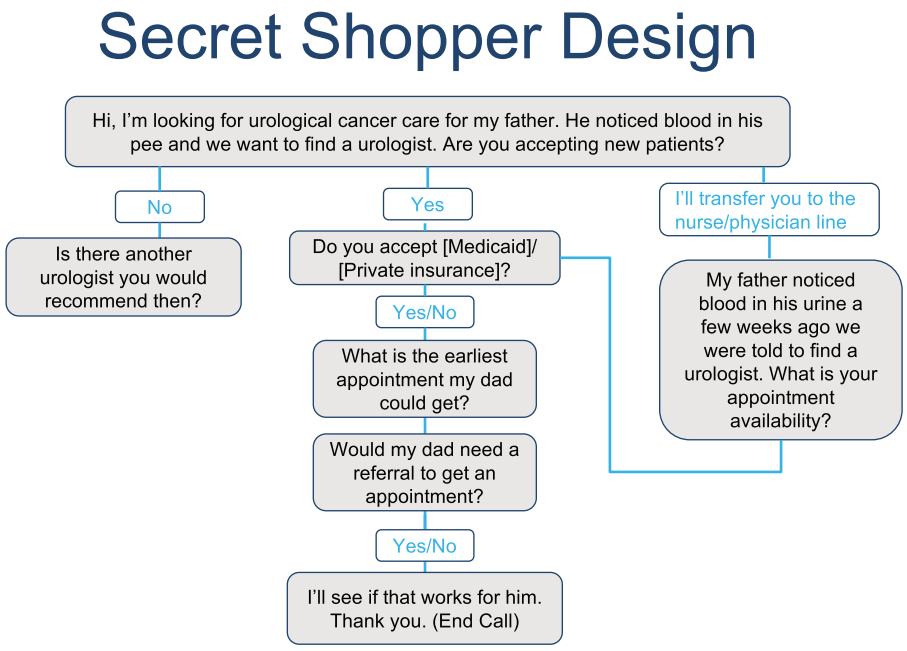

Figure 1. Standardized call script used for secret shopper calls. (Color version available online.)

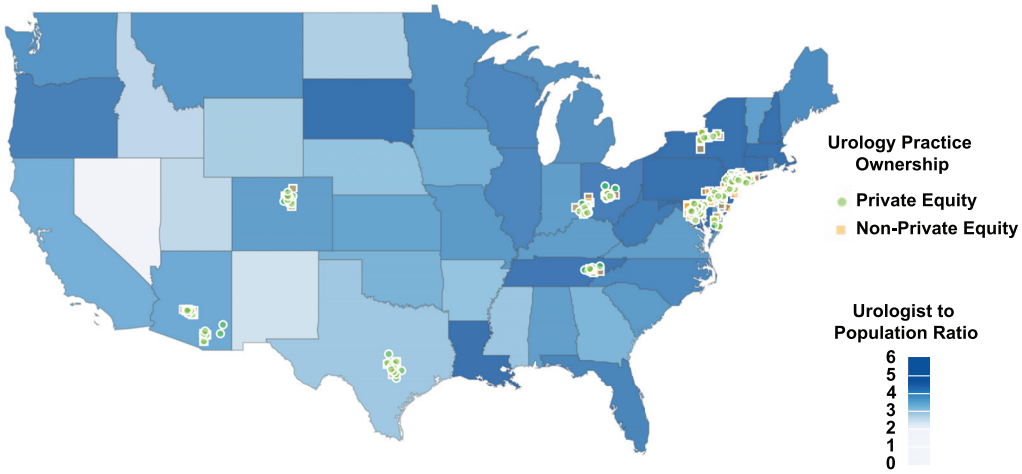

Figure 2. Geographic distribution of contacted PE-affiliated and non-PE-affiliated practices. (Color version available online.)

software version 10.6.1 (Environmental Systems Research Institute, Redlands, CA).

RESULTS

Investigators made 927 phone calls to 473 unique urology offices. After excluding offices that were not accepting new patients, those that would not allow for appointment availability estimation without patient registration, and those that would not allow booking over the telephone, the final dataset included 815 calls calls made to 445 offices (214 PE-affiliated offices, 231 non-PE-affiliated offices) across 12 states (Fig. 2).

Insurance Acceptance

Overall, appointment availability was significantly higher for commercially-insured patients (99.0%; 95% confidence interval [CI]: 98.1%-99.9%) than for Medicaid patients (59.8%; 95% CI: 55.0%-64.6%) ($P < .001$) (Fig. 3). Appointment availability for patients with Medicaid was higher at non-PE affiliated practices (66.8%; CI 60.4%-73.2%) than at PE-affiliated offices (52.1%; 95% CI 45.0%-59.2%) ($p = .003$), whereas for commercially insured patients, appointment availability was greater at PE-affiliated offices (100.0%; 95% CI 100.0%-100.0%) than non-PE-affiliated practices (98.1%; 95% CI 96.2%-99.9%) ($P = .047$). Notably, appointment availability for patients with Medicaid was significantly higher in states that had expanded Medicaid (61.9%; 95% CI 56.9%-66.9%) than those that had not (41.4%; 95% CI 25.7%-57.2%) ($P = .011$). Among PE-affiliated offices, Medicaid acceptance was greater in expansion states (55.0%; 95% CI 47.5%-62.6%) than in non-expansion states (30.4%; CI 10.1% - 50.8%) ($P = .027$). On multivariable logistic regression, state Medicaid expansion status (odds ratio [OR] 2.20; CI 1.14-4.28; $P = .020$) was independently associated with Medicaid appointment availability, whereas PE-affiliation (OR 0.55; CI 0.37-0.83; $P = .004$) was independently associated with

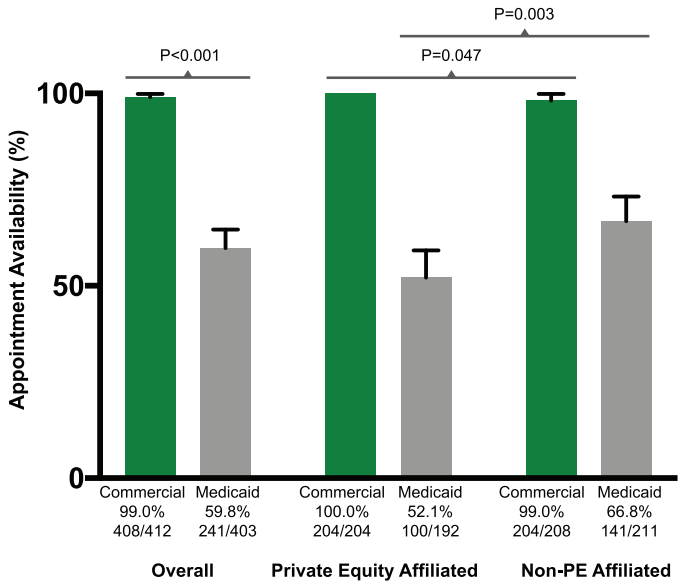

Figure 3. Representation of the proportion of private equity (PE)-affiliated and geographically matched non-PE-affiliated clinics that accepted commercial and Medicaid insurance. The *P*-value threshold for statistical significance is 0.05. (Color version available online.)

lower odds of of Medicaid appointment availability. Among practices that did not offer appointments availability to patients with Medicaid, 87.7% did not accept any form of Medicaid and 12.3% cited a full Medicaid panel.

Appointment Wait Times

Overall, appointment wait times did not differ significantly for commercially insured patients or patients with Medicaid (19.2 vs 20.1 days; $P = .591$), however PE-affiliated practices reported shorter mean wait times than non-PE-affiliated offices (17.5 vs 21.4 days; $P = .017$). In examining wait times within PE-affiliated (Medicaid 18.2 days vs Commercial 17.1 days; $P = .592$) and non PE-affiliated practices (Medicaid 21.5 days vs Commercial 21.3 days; $P = .945$), there were no statistically significant differences in wait times by insurance status.

DISCUSSION

We performed a cross-sectional, national secret shopper study to evaluate insurance acceptance practices for urologic evaluation across a national sample of PE-affiliated and non-PE-affiliated urology offices. We found that Medicaid-insured patients face persistent barriers in accessing urologic care, with only 59.8% offices offering appointment availability for patients with Medicaid compared to 99.0% of offices for commercially insured patients. Appointment access disparities were more pronounced for for Medicaid-insured patients at PE-affiliated practices compared with geographically matched practices. In the context of major recent national increases in insurance achieved through Medicaid expansion associated with the ACA, our findings highlight evolving barriers to accessing urologic care. Furthermore, as initial hematuria evaluation serves as a common initial entry point for related conditions, including nephrolithiasis, benign prostatic hyperplasia, and urologic cancer, this study can provide an updated evaluation of possible proximate sources of disparity in healthcare access and outcome.[13] Given accelerating trends of healthcare consolidation, including nationally-scaled PE associated acquisitions, these findings have implications for enhancing equitable access to urologic care.[6]

Reduced access for patients with Medicaid likely reflect practice strategies to limit exposure to the lower reimbursement and increased administrative burdens associated with Medicaid.[9,14] We have previously demonstrated that PE investment in urology has preferentially been directed at higher-volume and higher-reimbursement practices.[15] Therefore, the present findings may reflect the existing Medicaid acceptance practices favoring higher reimbursing payors that predated PE acquisition. However, organization restructuring and distinct financial strategies associated with the PE model may also promote practices focused on short-term investment windows.[7,16] Notably, Medicaid appointment availability at PE-affiliated urology practices was approximately three times higher than in a recent study of PE-affiliated dermatology practices, which may reflect the more mature PE model in dermatology, where PE investment has been present for approximately 15 years.[9] The majority of offices that did not offer care to Medicaid-insured patients in this study reported that they did not see any Medicaid patients, however, 12.3% indicated that they maintained a limited panel of Medicaid patients. In comparison, academic urology practices have been shown to have an ~90% rate of Medicaid acceptance, possibly due to differences in strategic missions and having greater scale to absorb lower reimbursement.[4] However, other studies have shown that academic practices also invoke strategies to limit Medicaid patient access as evidenced by longer wait times for Medicaid patients compared to Medicare patients.[4]

The magnitude of Medicaid access disparities observed in this study are consistent with estimates conducted in the era prior to sweeping expansions of the program associated with the ACA.[2] Although access for Medicaid-insured patients residing in states that elected to expand Medicaid was higher than in nonexpansion states, overall appointment denial rate matched pre-expansion levels of approximately 40%. However, these estimates should be viewed in the context of a larger number of Medicaid insured Americans, suggesting that increased access following Medicaid expansion has not overwhelmed urological care delivery. By quantifying the extent to which explicit efforts remain in place to restrict access for Medicaid-insured patients, our study provides critical perspective when estimating the effects of Medicaid expansion. For example, hospital-registry based studies of patients with genitourinary cancers derived from the National Cancer Database largely show declines in the rate of uninsurance following Medicaid expansion, but report variations in changes to stage of diagnosis and time to treatment.[13,17-20] Appreciating the persistence of barriers to access elevates the importance of conducting studies at the level of the Medicaid insured population.

Our findings highlight the potential for trends in favor of greater healthcare consolidation to increase access disparities for Medicaid-insured patients. Several PE-backed urology platforms have established large, regionally powerful practices, with some employing over 25% of the urologists within a state.[6] Horizontal consolidation strategies may have resulted in a greater number of urologists within a practice, translating into the decreased overall appointment wait time and increased appointment availability for commercially insured patients found in this study.[6] The construction of geographically-dominant practices might accentuate accessibility challenges, resulting in fragmented or inconvenient care associated with travel for patients who are already more likely to be resource-strained.[21]

This study has several limitations. As we could not assess insurance access rates prior to PE-affiliation, we cannot directly assess how PE investment affected access. While we attempted to capture all PE-affiliated offices as of March 2021, given the pace of PE investment, additional acquisitions during the course of this study have likely occurred. However, given that we contacted all of the known PE-affiliated offices as of March 2021, our

findings are likely to be represenative of PE-affiliated practices despite subsequent acquisitions. We were unable to identify a geographically matched non-PE-affiliated practice for approximately one-third of PE-affiliated offices in this study, limiting comparions in some regions. However, the inability to locate parallel non-PE affiliated practices is itself notable, and reflects significant geographic dominance in some markets. To reduce the volume of calls and potential disruptions to clinical practices we did not include assessments of all insurance types, or uninsured patients. However, prior studies have indicated that access is similar for Medicare and commercially-insured patients.[9,10] Furthermore, based on the secret shopper methodology, we could not control for variation in provider availability or timing of the phone calls, which may have impacted appointment availability.

CONCLUSIONS

In this secret shopper study, we identified significant Medicaid-access disparities for patients seeking urologic care. Although appointment availability was considerably lower compared with commercial insurance, access for Medicaid-insured patients was lower in private equity affiliated urology practices compared with geographically matched practices. Access for Medicaid insured patients was higher among practices located in states that elected to expand Medicaid associated with the Affordable Care Act. These findings highlight persistent barriers to healthcare for the large and growing number of Americans who have gained healthcare insurance through Medicaid.

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EDITORIAL COMMENT

The landscape of urologic employment has changed dramatically over the past 10 years. Older models of employment, such as independent practice and academic practice have given way to new models of employment, such as hospital-based employment, multispecialty group practice, and private equity (PE) acquired practices. Nie et al demonstrated that private equity acquisitions have become a dominant form of urology practice consolidation.[1] They estimate that 7.2% of private practice urologists were employed by private equity backed firms and 25% of urologists in New Jersy and Maryland are employed by private equity firms. This trend is concerning on many levels.

PE firms acquire physician owned practices and restructure the practice administration, serving as a "management services organization." They purchase the financial assets of the physician practice, increase the valuation of the practice in a few years and then sell the practice to another entity. This may be another PE firm, or it may be a hospital organization. The benefits to the practice of PE acquisition include reduced administrative burden, greater reimbursement, and higher short-term salaries. Drawbacks include increased pressure to generate revenue and

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reduced physician autonomy. The authors state that it is vital that physicians understand the impact the PE acquisition may have on patient care as the PE firm can influence physician behavior.[2]

The current manuscript provides an example of how PE acquired practices may limit patient's access to urologic care. In their study overall appointment availability for commercially insured patients was 99% vs 59.8% for Medicaid insured patients, but for PE backed practices the disparity was worse with 100% of commercially insured patients offered appointment and only 52.1% of Medicaid patients offered appointments. This is a problem. The burden of urologic disease may be mitigated by early detection and prompt treatment. By placing profit ahead of patient care, some patients may miss a window of opportunity for curative treatment. Our most vulnerable patients may experience worsening inequality in urologic care if PE backed firms begin to dominate urologic practice landscape.

Damara Kaplan, Cedar Urology, Albuquerque, NM

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AUTHOR REPLY

We thank the author for highlighting the significance of access for early detection and prompt treatment of urologic disease. Healthcare access for Medicaid-insured patients will be important to monitor as private equity acquisitions continue to reshape the urology landscape. In the year since our initial study, at least 1 additional private equity backed platform company has formed and numerous practices have been acquired in roll-up acquisitions.[1,2] In addition, the first known "exit" by a private equity firm has occurred with the sale of northeast urology platform to a for-profit, multispecialty physician group.[3] Changes in ownership should underscore to readers that private equity acquisitions are not intended as longitudinal partnerships with physicians or communities but are instead, by design, short-term investment opportunities.

We would like to emphasize that the findings in the present study do not imply that private equity acquisition has led to lower access for patients with Medicaid. A more plausible explanation is that private equity firms target higher revenue practices which also have more restrictive Medicaid policies. Our work also highlights the challenges that still exist in increasing healthcare access for the large number of Americans who are now insured through Medicaid. The overall rate of Medicaid acceptance in our study was similar to a 2013 estimate conducted just prior to Medicaid expansion, underscoring the large gap between healthcare insurance and health care access.[4] These findings should redouble advocacy efforts behind actions that can increase the financial viability of serving patients with Medicaid such as increasing reimbursement to levels at least on par with cost.[5] Consolidation across multiple physician specialties by a small number of private equity firms also presents challenges and opportunities. Increasing access to Medicaid-insured patients appears at odds with short-term revenue goals. However, as they scale, larger platforms can be approached with greater oversight across issues of competition, quality, value, and access.[6]

James Nie, Benjamin N. Breyer, Michael S. Leapman, Department of Urology, Yale University School of Medicine, New Haven, CT; Yale University School of Medicine, New Haven, CT; Department of Urology, University of California-San Francisco, San Francisco, CA

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