REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 4-I-23

Subject: Physician-Owned Hospitals

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At the 2023 Annual Meeting, the House of Delegates adopted Policy D-215.983, Physician-Owned Hospitals, which asked the American Medical Association (AMA) to study and research the impact of the repeal of the ban on physician-owned hospitals (POHs) on the access to, cost, and quality of patient care and the impact on competition in highly concentrated hospital markets.

The Council presents this informational report, which provides background on POHs, and highlights extensive AMA policy and advocacy to repeal the ban on physician-owned hospitals.

BACKGROUND

There are more than 250 hospitals in the United States that are owned and operated by physicians, under various models: community hospitals, specialty hospitals, joint ventures, and rural hospitals. Community hospitals provide the services of a full-service hospital, such as labor and delivery, I]CU care, and surgery. Specialty hospitals focus on certain specialties, such as cardiac care, orthopedic care, or children's hospitals. Many nonprofit community hospital systems across the country choose to partner with physicians in joint venture models. In some cases, physicians own 100 percent of the hospital. In joint venture arrangements, a nonprofit community hospital system holds majority ownership and physicians have a minority stake. One in eight POHs serve rural communities in the United States.[1]

POHs first arose in the early 1980s in response to the rise of managed care and the corporatization of medical practice, as physicians sought to acquire control and ownership over their practice environment. Early health care services research highlighted concerns regarding physician self-referral in multiple markets, including physical therapy and radiological services. These findings, along with work of the General Accounting Office (GAO), led to the passage of the series of statutory reforms known as the "Stark Laws." These legislative provisions regulated and restricted physician self-referral in Medicare – and later Medicaid – for a variety of services in which physicians have a financial interest. Physician self-referral laws prohibit physicians from making referrals for certain services payable by Medicare to an entity with which the physician has a financial relationship. However, under the "whole hospital exception" a physician could refer a patient to a facility in which the physician was authorized to perform services only if he or she had an interest in the whole hospital, as opposed to a specific department.[2]

IMPACT OF THE AFFORDABLE CARE ACT

The Affordable Care Act (ACA) was passed in 2010 with a focus on expanding insurance coverage, creating robust competition in state insurance markets, and reducing both health insurance costs and health care costs. Section 6001 of the ACA placed new restrictions on the expansion of existing POHs and the creation of new ones; however, POHs established prior to the ACA being signed into law were given an exception and allowed to continue operations.[3] Section

6001 of the ACA amended section 1877 of the Social Security Act to impose additional requirements for POHs to qualify for the whole hospital and rural provider exceptions. After its passage, POHs were prohibited from expanding facility capacity. However, a POH that qualified as an applicable hospital or high Medicaid facility could request an exception to the prohibition from the Secretary of the Department of Health and Human Services.[4] As a result, the consequences of the ACA's virtual statutory ban on POHs were significant. More than $275 million of planned economic activity spread across 45 hospital expansion projects ceased. More than 75 new hospitals either planned or under development were prematurely terminated, representing more than $2.2 billion in economic losses. Non-financial losses include the loss of the "physician entrepreneur" and innovation in the face of increasing corporatization of medical practice, both likely contributing to the increase in physician professional dissatisfaction.[5]

Of the more than 250 POHs across 33 states, few, if any, could survive without Medicare or Medicaid funds. By contrast, there are approximately 5,000 public or for-profit hospitals in the United States.[6] According to the AMA's Physician Practice Benchmark Survey, the share of practicing physicians who owned their practices dropped below 50 percent for the first time in 2016.[7] The most recent data from the AMA's Physician Practice Benchmark Survey show that in 2022, 44 percent of physicians were owners of their practices, compared to 53.2 percent in 2012, and approximately 76 percent in the early 1980s. This shift represents more physicians opting to become employees at a hospital or practice instead of going into business themselves.[8]

As the federal government reviewed clinical information in the years following the passage of the ACA, it was clear that POHs were high-performing facilities. Nine of the top 10 performing hospitals were physician-owned, as were 48 of the top 100. This information was released by the Centers for Medicare & Medicaid Services (CMS) nearly three years after the ACA effectively banned these facilities from expanding and prohibited new majority physician-owned facilities from opening their doors. To date, efforts to lift the 2010 restrictions have proven unsuccessful. A lawsuit challenging that portion of the ACA was dismissed by the 5th U.S. Circuit Court of Appeals in August 2012, citing a lack of jurisdiction. Efforts to have Congress repeal Section 6001 of the ACA also have been unsuccessful.[9]

CONSOLIDATION AND MARKET IMPACT

Hospital consolidation results in the loss of both price and non-price competition. Hospital acquisition of physician practices can lead to higher prices without improvements in quality. Well-documented, specific harms of provider consolidation are many, including a lack of quality improvement and a decrease in patient satisfaction, physician burnout due to a loss of control over the practice environment, and higher hospital prices driving rising insurance premiums and ultimately rising costs to consumers.[10] A September 2022 review of the Health Care Cost Institute Hospital Concentration Index, which measured market concentration in 182 metro areas across the U.S., summarized its findings as follows:

> "…areas with physician-led hospitals have higher competition and lower market concentration. Only four percent of areas with physician-led hospitals were classified as very highly concentrated markets (compared to 13 percent without physician-led hospitals)."[11]

Current market entry requirements are strict: ACA Section 6001 prohibits participation in Medicare for both new or expanded pre-existing POHs unless they meet pre-specified exceptions as a rural facility or a "high Medicaid" facility. Nonprofit and for-profit hospitals do not face this restriction. Since the passage of the ACA in 2010, only seven hospitals nationwide have been granted an exception.[12]

It is also important to note the impact of consolidation on prices. Allowing POH entrants into a market would increase competition and as a result would likely have a positive impact on price. From a competition perspective, the potential entry of additional POHs reduces the ability of incumbents to exercise market power and applies competitive pressure on price, quality, and innovation. Even the threat of such entry can improve market outcomes as incumbent hospitals keep prices and quality more competitive to avoid inviting a new entrant.[13]

COST AND QUALITY IMPLICATIONS

CMS studied physician-owned specialty hospitals and found a number of factors account for their high performance, including specialization, improved nursing staff ratios and expertise, patient amenities, patient communication and education, emphasis on quality monitoring, and clinical staff perspectives on physician ownership. Additionally, CMS found that perhaps the most essential POH efficiency is created by physician ownership itself:

> "In our site visits, staff at specialty hospitals described the physician owners as being very involved in every aspect of patient care. The physicians monitored patient satisfaction data, established a culture that focused on patient satisfaction and were viewed by the staff as being very approachable and amenable to suggestions that would improve care processes."[14]

Regarding costs, opponents of POHs claim that physician-owned facilities both "cherry-pick" only the healthiest patients and over-order on tests and treatments to drive up costs and increase profits. Neither of these claims have been proven to be true. Either a cherry-picking theory or a provider-induced demand theory presumes that physician owners have perverse incentives that nonprofit and investor-owned hospitals lack. Several reviews have found the claim of cherry-picking lacks consistent support in research. One review found that after controlling for a variety of factors, such as case mix, disease severity, and volume of procedures, research results on quality metrics were highly favorable for specialty POHs and neutral for general acute care POHs. In contrast, cost evidence was neutral to favorable, suggesting that specialty POHs tended to have lower or similar costs, while general acute care POHs tended to be similar in costs.[15]

AMA POLICY AND ADVOCACY

Policy H-215.960, established by Council on Medical Service Report 7-A-19, states that the AMA will continue to support actions that promote competition and choice including repealing the ban on physician-owned hospitals, and the AMA has been active in implementing this policy. Policy H-215.960 also states that the AMA strongly supports and encourages competition in all health care markets.

In June 2023, the AMA sent a letter to the U.S. House of Representatives and U.S. Senate in support of H.R. 977 and S. 470 – The Patient Access to Higher Quality Health Care Act of 2023. This bipartisan legislation would repeal limits to the whole hospital exception of the Stark physician self-referral law, which essentially bans physician ownership of hospitals and places restrictions on expansion of already existing POHs.[16,17]

The AMA also submitted comments in June 2023 on the 2024 Inpatient Prospective Payment System proposed rules. CMS proposes to reinstate restrictions on POHs that both qualify as high Medicaid facilities and are seeking exceptions to the prohibition on expanding facility capacity. In addition, the agency proposed to expand its authority regarding approval of exceptions to the prohibition on expanhding facility capacity and to increase the type of relevant community input, as well as to double the length of the community input period. The AMA strongly opposes the

proposals to revoke the flexibilities for POHs that service greater numbers of Medicaid patients, to increase the agency's regulatory authority to grant or deny exceptions to expansion, and to expand the scope of community input. The AMA believes these proposals limit the capacity of POHs to increase competition and choice in communities throughout the country and more significantly, limit patients' access to high-quality care. The AMA believes that in the proposed rule, CMS provides a one-sided rationale to support its proposals restricting POHs. CMS' own study in 2003 found a number of factors that account for the high performance of POHs, including specialization, improved nursing staff ratios and expertise, patient amenities, patient communication and education, an emphasis on quality monitoring, and clinical staff perspectives on physician ownership.[18] Unfortunately, CMS published the Final Rule in August 2023 and moved forward with enacting restrictions on POHs. An excerpt from the Final Rule states:

> "As we have stated in previous rulemakings, we are concerned that, when physicians have a financial incentive to refer a patient to a particular entity, that incentive can affect utilization, patient choice and competition. Physicians can overutilize by ordering items and services for patients that absent a profit motive, they would not have ordered. A patient's choice is diminished when physicians steer patients to less convenient, lower quality, or more expensive providers of health care just because the physicians are sharing profits with, or receiving renumeration from, the quality, service, or price." (80 FR 41926 and 81 FR 80533)[19]

The AMA has recently provided comments to the U.S. Senate Finance Committee,[20] the U.S. House Committee on Ways and Means,[21] and the U.S. House Committee on Energy and Commerce[22] all in support of physician-owned hospitals and repealing the existing ban. Additionally, in July 2023, the AMA supported a sign-on letter to Congress in support of the Patient Access to Higher Quality Health Care Act (S. 470/H.R. 977) which supports repealing the ban on physician-owned hospitals.[23]

CONCLUSION

Longstanding AMA policy supports the repeal of the ban on POHs, and the AMA has been actively advocating for the repeal as recently as 2023. The AMA's June 2023 letter of support for the Patient Access to Higher Quality Care Act of 2023 underscores that POHs have been shown to provide high-quality care to the patients they serve. The Council believes that not only does limiting the viability of the POHs reduce access to quality medical care, but it also reduces competition in hospital markets to the detriment of the communities these hospitals serve.

One of the strongest opponents of POHs is the American Hospital Association (AHA). In a comment letter to Congress on H.R. 977/S.470, the AHA claims that POHs "provide limited or no emergency services, relying instead on publicly funded 911 services when their patients need emergency care." However, the majority of POHs are generally equipped with several hundred beds and large emergency departments similar to community hospitals. A report by CMS in 2005 found that physician-owned cardiac hospitals resembled full-service hospitals with emergency departments, whereas orthopedic hospitals and general surgical specialty hospitals more closely resemble Ambulatory Surgery Centers (ASCs) which focus on outpatient services or cases with a reasonable expectation of limited hospitalizations. For example, POHs with specialty care, like cardiac care, closely resemble full-service hospitals with emergency departments, while POHs that specialize in orthopedic care closely resemble other outpatient facilities or ASCs. The differences are driven by services provided to patients and are not driven by the ownership structure of the hospital.[24]

Additionally, in their comment letter, the AHA claims that "physician self-referral also leads to greater utilization of services and higher costs." The Council believes that this is also a misrepresentation. CMS studied referral patterns associated with specialty hospitals among physician owners relative to their peers and ultimately stated: "We are unable to conclude that referrals were driven primarily based on incentives for financial gain." Several studies looking at the effect of hospital ownership on health care utilization have concluded that physician ownership does not lead to an increased volume of surgeries being performed, suggesting that any evidence of increased utilization is at best mixed.[25]

Finally, the AHA claims that "physician-owned hospitals tend to cherry-pick the most profitable patients, jeopardizing communities' access to full-service care." To the contrary, evidence indicates that physician-owned hospitals do not "cherry-pick" patients. For example, CMS studied referral patterns associated with specialty hospitals among physician owners relative to their peers and were unable to conclude that referrals were driven primarily based on incentives for financial gain. Importantly, new economic research also finds strong evidence against "cherry-picking" in POHs.[26]

While the Council recognizes the challenges of a partnership with POHs, we believe there are potential benefits to collaborating with interested stakeholders to promote the benefits that POHs can provide to a community.

The IPPS Final Rule issued by CMS in August 2023 will make it more difficult for existing POHs to expand and will not allow for new POHs to open. Even facilities deemed high Medicaid facilities will not be able to expand beyond 200 percent of their baseline facility capacity, must locate all approved expansion facility capacity on their main campus, and may not request an expansion exception earlier than two calendar years from the date of the most recent decision by CMS approving or denying the hospital's most recent expansion request. The Final Rule changes the process for community input when considering a POH's request to expand, including doubling the length of time for initial community input, as well as doubling the length of time for hospital rebuttal if a request is denied.[27]

The AMA believes that POHs provide high-quality care to patients and needed competition in hospital markets. The AMA supports competition between health care providers and facilities as a means of promoting the delivery of high-quality, cost-effective health care. Providing patients with more choices for health care services stimulates innovation and incentivizes improved care, lower costs, and expanded access.

The CMS Final Rule mischaracterizes physicians and POHs by incorrectly assuming that physicians misuse resources and steer patients to use excess services and are solely driven by profit motives. In contrast, POHs would increase competition and provide valuable resources to many communities, including those in rural areas. CMS' own study of physician referral patterns found no evidence of "cherry-picking" or steering patients. Lifting the ban on POHs could allow physicians to acquire hospitals and better enable them to implement alternative delivery and payment models in an effort to control hospital costs and supervise the overall health care product.

The Council believes the AMA has clear policy to advocate for the repeal of the ban on physician-owned hospitals as evidenced by recent AMA advocacy activities. The Council presents this report for the information of the House and will continue to monitor this issue.

Fiscal Note: Less than $500.

REFERENCES

[1]Physician-Led Healthcare for America. Physician-Led Hospitals: The Patient-Physician Relationship. Accessed: July 21, 2023. https://physiciansled.com/physician-owned-hospitals/#:~:text=Beginning%20in%20the%20early%202000s,owned%20and%20operated%20by%20physicians
[2]Miller, Brian J., et al. Reversing Hospital Consolidation. Health Affairs. April 12, 2021. https://www.healthaffairs.org/content/forefront/reversing-hospital-consolidation-promise-physician-owned-hospitals
[3]*Ibid*
[4]CMS.gov. Physician-Owned Hospitals. Accessed: July 20, 2023. https://www.cms.gov/medicare/fraud-and-abuse/physicianselfreferral/physician_owned_hospitals
[5]*Supra*. Note 2.
[6]Bryant, Meg. ACA is taking a toll on physician-owned hospitals. Healthcare Dive. July 11, 2017. https://www.healthcaredive.com/news/aca-is-taking-a-toll-on-physician-owned-hospitals/446761/
[7]Kane, Carol K. Recent Changes in Physician Practice Arrangements: Shifts Away from Private Practice Towards Larger Practice Size Continue through 2022. American Medical Association. 2023. https://www.ama-assn.org/system/files/2022-prp-practice-arrangement.pdf
[8]*Ibid*
[9]Henry, Tanya Albert. Physician-Owned Hospitals Seize their Moment. Journal of the Missouri Medical Association. July-August 2013. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6179879/
[10]*Supra*. Note 2.
[11]NDP Analytics. The Economic and Social Benefits of Physician-Led Hospitals. September 2022. https://physiciansled.com/wp-content/uploads/2022/09/Economic-Impact-Report-2022-1.pdf
[12]*Supra*. Note 2.
[13]Mandelberg, Matthew C., et. al. Hospital Competition and Restrictions on Physician-Owned Hospitals. February 5, 2023. https://ssm.com/abstract=4350105
[14]AMA Comment Letter to Centers for Medicare & Medicaid Services in Response to 2024 Inpatient Prospective Payment Systems Proposed Rule. June 9, 2023. https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2Flfcmt.zip%2F2023-6-9-Letter-to-Brooks-LaSure-re-2024-IPPS-Comments-v4.pdf
[15]*Supra.* Note 13.
[16]AMA Comment Letter to U.S. House of Representatives in Support of H.R. 977. June 1, 2023. https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2Flfcsot.zip%2F2023-6-1-Letter-to-House-re-PAHQHCA-Physician-Owned-Hospitals-Bill.pdf
[16]AMA Comment Letter to U.S. Senate in Support of S. 470. June 1, 2023. https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2Flfcsot.zip%2F2023-6-1-Letter-to-Senate-re-PAHQHCA-Physician-Owned-Hospitals-Bill.pdf
[17]Department of Health and Human Services – Centers for Medicare & Medicaid Services. Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2024 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Rural Emergency Hospital and Physician-Owned Hospital Requirements; and Provider and Supplier Disclosure of Ownership; and Medicare Disproportionate Share Hospital (DSH) Payments: Counting Certain Days Associated with Section 1115 Demonstrations in the Medicaid Fraction. Federal Register. 42 CFR Parts 411, 412, 419, 489, and 495. August 1, 2023. https://public-inspection.federalregister.gov/2023-16252.pdf
[18]*Supra.* Note 13.
[19]AMA Statement to the U.S. Senate Finance Committee. Consolidation and Corporate Ownership in Health Care: Trends and Impacts on Access, Quality, and Costs. June 8, 2023. https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2Flfcsot.zip%2F2023-6-8-Senate-Finance-Comm-Statement-for-the-Record-Testimony-on-Consolidation-Corp.pdf
[20]AMA Statement to the U.S. House Committee on Ways and Means – Subcommittee on Health. Why Health Care is Unaffordable: Anticompetitive and Consolidated Markets. May 17, 2023. https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2Flfcsot.zip

%2F2023-5-17-WMs-Health-SubCmt-Statement-for-the-Record-on-Anticompetitive-and-Consolidated-Markets-v2.pdf

[21]AMA Statement to the U.S. House Committee on Energy and Commerce – Subcommittee on Health. Lowering Unaffordable Costs: Examining Transparency and Competition in Health Care. March 28, 2023. https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2Fstmnt.zip%2FEC-Statement-For-the-Record-on-Transparency-and-Competition-X.pdf

[22]Sign-on Letter – Physician-Led Hospitals Coalition. July 27, 2023. https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2Flfsolg.zip%2F2023-7-27-Sigend-On-Coalition-Letter-re-Physician-Led-Hospitals.pdf.

[23]Swanson, A. "Physician investment in hospitals: Specialization, selection, and quality in cardiac care." Journal of Health Economics 80. 2021.

[24]*Supra*. Note 14.

[25]*Supra*. Note 13.

[26]*Supra* Note 13.

[27]*Supra*. Note 17.

Policy Appendix

Hospital Consolidation H-215.960
Our AMA: (1) affirms that: (a) health care entity mergers should be examined individually, taking into account case-specific variables of market power and patient needs; (b) the AMA strongly supports and encourages competition in all health care markets; (c) the AMA supports rigorous review and scrutiny of proposed mergers to determine their effects on patients and providers; and (d) antitrust relief for physicians remains a top AMA priority; (2) will continue to support actions that promote competition and choice, including: (a) eliminating state certificate of need laws; (b) repealing the ban on physician-owned hospitals; (c) reducing administrative burdens that make it difficult for physician practices to compete; and (d) achieving meaningful price transparency; and (3) will work with interested state medical associations to monitor hospital markets, including rural, state, and regional markets, and review the impact of horizontal and vertical health system integration on patients, physicians and hospital prices.
(CMS Report 7, A-19; Reaffirmation: I-22)