Reversing Hospital Consolidation: The Promise Of Physician-Owned Hospitals

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Economic theory holds that competition drives innovation, improves the quality of goods and services, and lowers prices for consumers. Health care delivery is no exception. The COVID-19 pandemic and resulting operational challenges in hospital care delivery have stimulated policy makers' appetite to address longstanding problems in hospital market efficiency and consolidation. In large part because of mergers, the vast majority of US metropolitan residents now live in highly concentrated hospital markets.

As policy experts and researchers consider opportunities to engender flexibility, expand capacity, and promote competition in the nation's hospital industry, a sector plagued by 20 years without labor productivity growth, recent research has reaffirmed the challenges of hospital market consolidation. Hospital and physician consolidation into health systems results in the loss of both price and non-price competition. Well-documented, specific harms of provider consolidation are many, including a lack of quality benefits and decrement in patient experience, 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.

The COVID-19 pandemic has worsened the problem. While hospital mergers initially stabilized despite a pandemic recession, some experts have expressed concern regarding a new merger wave due to pandemic-induced financial distress driven by the temporary cessation of profitable elective care and decreased hospital use. Rural hospitals, already on the financial brink before COVID-19, are at risk of closure. Together, these same financial pressures are driving independent physicians to consider both horizontal and vertical mergers and transition to an employed model, compounding the challenge for policy makers.

A problem acknowledged by both Democrats and Republicans, hospital consolidation, regardless of its causes, presents a vexing stumbling block to better care for Americans. In this post, we review policy interventions available to policy makers to combat hospital consolidation, focusing on the history, challenges, and promise of physician-owned hospitals (POHs).

Hospital Consolidation: Tools For Policy Makers

Policy makers at the state and federal level have multiple potential strategies to choose from to promote a vibrant, competitive market for hospital care. State officials, for example, could explore a repeal or reform of certificate of need laws, currently enforced in 35 states, that often restrict or inhibit the introduction of new medical or hospital facilities. Such laws are anti-competitive, imposing barriers to market entry and simultaneously undercutting efforts at cost control (a recognized problem since at least 1988).

At the federal level, meaningful antitrust scrutiny of anti-competitive behavior, assertive merger control, and research on non-price competitive effects of health care mergers offer powerful means of addressing hospital market consolidation. While the recent election has reinvigorated the policy conversation centered on antitrust in health care, critics note that cases can take years to resolve and can suffer from poor optics when pursued in times of great economic distress.

Administrative agencies have attempted to promote price competition in hospital markets through mandated price transparency of both standardized and negotiated charges, a regulatory action subject to a (thus far) unsuccessful legal challenge; further federal price transparency efforts have targeted payers directly. Legal challenges have also been launched against attempts to encourage competition by establishing site-neutral Medicare payment, where clinically appropriate, for care that can be provided in either outpatient or inpatient settings. Targeting other levers of competition and value, both the Centers for Medicare and Medicaid Services (CMS) and the Office of Inspector General for the Department of Health and Human Services have attempted to reform regulations implementing the Stark self-referral laws—discussed in more detail below—to promote competition around coordinated, value-based care.

While rulemaking may ultimately serve to increase price competition and antitrust enforcement offers the potential to change hospital market structure, competition policy presents another lever for policy makers. Passed in 2010, the Affordable Care Act (ACA) had laudable goals of expanding insurance coverage, creating robust competitions in states' insurance markets, and reducing both health insurance costs and health care costs for typical families. Buried deep within the more than 1,000-page law, Section 6001 of the ACA placed new restrictions on the expansion of existing POHs and the creation of new ones, functionally prohibiting the growth of this Marketplace.

The History Of Physician-Owned Hospitals

POHs are equally split between community hospitals on the one hand and specialty surgical hospitals (cardiac, orthopedic, and surgical)—"focused factories"—on the other. POHs entered the scene in the early 1980s as a 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; these new institutions simultaneously facilitated patient-centered care redesign.

Early health care services research highlighted concerns regarding physician self-referral in multiple markets, including physical therapy and radiologic services. This work, along with that of the General Accounting Office (GAO), led to the passage of the series of statutory reforms known collectively 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. However, under the "whole hospital exception," a physician could refer a patient to a facility in which the physician was authorized to perform services even if he or she had an interest in the whole hospital, as opposed to a specific department.

Quickly, industry participants and some policy experts noted challenges, with full-service, for-profit hospitals asserting that surgical-specialty POHs select for low-acuity, high-revenue commercial patients, disfavoring higher-acuity patients with public insurance. A 2003 GAO study found that, while surgical-specialty POHs served fewer Medicaid patients than their community general hospital counterparts, cardiac hospitals served more Medicare patients than did general hospitals, while other surgical specialty POHs served roughly the same or slightly fewer Medicare patients than general hospitals. Notably, the GAO study did not compare physician-owned, surgical-specialty hospitals to corporate-owned or nonprofit surgical specialty hospitals—the latter market did not exist with scale.

Concerns regarding competitive harms to community hospitals led to a 2003 congressionally mandated 18-month study period and moratorium on new specialty POHs through temporary closure of the "whole hospital exception" for specialty POHs. Medicare Payment Advisory Commission studies in 2005 and 2006, along with CMS staff research, revealed complexity in the POH marketplace and an absence of negative financial impacts on competitor community hospitals. Medicare patients accounted for 67 percent of inpatient days at cardiac specialty hospitals, unsurprising given the natural history of

cardiac diseases. Patient severity was lower at some cardiac hospitals while patient satisfaction, quality of care, and efficiency were superior.

Orthopedic specialty hospitals demonstrated operational and financial similarity to ambulatory surgery centers, albeit with the addition of limited inpatient capacity for complex cases. While POHs provided less uncompensated care, their overall community benefit was higher than that of competitor general hospitals—surgical-specialty POHs paid real estate, property, income, and sales tax while their nonprofit counterparts did not; this finding was later replicated by academic researchers.

Implications Of ACA Section 6001

Consequences of the ACA's virtual statutory ban on POHs were and are significant. In the face of an initial statutory deadline of December 31, 2010, to have a Medicare provider agreement in place (that is, be a participating provider and "in-network" for the Medicare fee-for-service program), 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. Intangible losses include the loss of the "physician entrepreneur" and user-driven innovation in the face of increasing corporatization of medical practice, both likely contributing to the increase in physician professional dissatisfaction. Other, unforeseen consequences include loss of flexibility from increased hospital bed capacity in a country that faced pandemic-driven shortages of hospital and intensive care unit beds.

Premature foreclosure of the POH marketplace inhibited the development of the US version of the "focused factory" model of specialized hospitals or integrated practice units, a feature seen in other markets. In Canada, the famous Shouldice Hernia hospital, a longstanding subject of both management and medical research, created a focused factory for the repair of inguinal hernias, with increased quality as measured by a lower risk of recurrence. Still other models include the work of Devi Prasad Shetty, MD, who established Narayana Health as a model of low-cost, high-quality tertiary care, with a particular focus on cardiac care. Focused factories use a well-documented, positive quality-volume relationship for many procedures, resulting in lower in-hospital mortality for percutaneous coronary intervention, improved 30-day and one-year survival in mitral valve repair, decreased complication rates in total knee arthroplasty, and lower mortality rates with total hip arthroplasty.

Policy Recommendations To Address Concerns Regarding Physician-Owned Hospitals

Decades of focusing the policy lens on POHs highlight the importance of using "the right tools for the right problem." To address historical concerns of specialty POH overpayment and favorable patient selection, CMS in 2007 modified the fee-for-service Medicare program, updating the diagnosis-related group system for inpatient payment to better account for both patient severity and outlier cases. Further efforts addressing overpayment and favorable patient selection could focus on using structural tools, such as auto-enrollment of new beneficiaries into Medicare Advantage plans, to transition payment markets away from fee-for-service payment to risk-adjusted, capitated payment structures; this would empower health plans to apply the tools of managed care (site neutral payment, prior authorization, and so forth) to ensure that the right patient gets care in the right clinical setting at the right time.

Physician specialty societies can also participate by supporting appropriate procedure eligibility and site-of-care selection, convening experts to update and promulgate clinical practice guidelines and offering consensus statements and appropriate use criteria. Many medical specialties already do this in other areas, such as the nearly decade-old Choosing Wisely Campaign against more than 500 low-value care practices or joint guidelines from the American College of Cardiology and the American Hospital Association for evaluation and management of cardiac conditions, dating back to 1991. Physicians can partner with both industry and government to design and support standards for cost-effective and efficient clinical practice.

Other concerns have centered on surgical specialty POHs' ability to manage medical emergencies. In an industry where medical errors are estimated to be responsible for more than 250,000 deaths annually, patient safety is a joint responsibility of all stakeholders. Errors are not unique to any one hospital market, and they highlight opportunities for both operational and regulatory improvement. Government-supported regulators and accreditors have long struggled with hospital oversight, underscoring the need to develop either meaningful government-developed and promulgated safety standards for the hospital industry akin to National Highway and Traffic Safety Administration's Federal Motor Vehicle Safety Standards or an industry-driven alternative.

Current market entry requirements are strict and originate with the best of intentions: 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 (meaning they treat a relatively high proportion of Medicaid patients). Nonprofit and for-profit hospitals do not face this restriction. While purported POH disfavoring of public-payer patients did not hold up in subsequent research, there exist general and well-founded hospital access concerns for public-payer patients. Increasing transition of both the Medicare and Medicaid programs to managed care models and away from "any willing provider" fee-for-service networks facilitates both network tiering and preferential payment, expanding access for public-payer patients to high-quality, low-cost care delivery while sacrificing access to lower-quality or high-cost providers.

Finally, self-referral presents important questions for care delivery regardless of ownership: for-profit, nonprofit, physician, or government. While the individual weighting of motivations differs among market actors, both profit and market share drive behavior. The ACA's virtual statutory prohibition on physician self-referral to new POHs forecloses the benefits of integrated, coordinated care delivery seen with vertically oriented, corporate-owned and operated, self-referral models.

Benefits of self-referral in integrated ambulatory-hospital care delivery and payer-provider models include "one-stop shopping," improved sharing of clinical information, and an improved consumer experience of care delivery; harms center primarily on inappropriate use and referral, commonly known as physician-induced demand. As confirmed by CMS, unsurprisingly both physicians and corporations respond to market incentives, modifying volume and intensity in response to changes in price.

At its core, self-referral and accompanying physician-induced demand represents a regulatory problem, emphasizing the need for time and attention to a long-neglected health plan function: program integrity. By partnering with Silicon Valley technology companies, both public and private payers could unleash artificial intelligence and deploy algorithmic claims screening to identify problematic claims or even provider referral behavior prior to payment, obviating the need for a statutory ban. Health plan network credentialing requirements could drive improved transparency of organizational relationships, with provider participation in preferred networks contingent upon consumer-friendly, timely disclosure of self-referral relationships.

Lastly, recognizing that a payer's fraudulent or wasteful claim is a physician's or corporation's revenue, individual legislators should respect enhanced

program integrity efforts and refrain from interfering on the behalf of specific parties.

The Need To Repeal Section 6001

Previous policy concerns regarding physician-owned hospitals used competition policy to address broader issues in payment policy, hospital safety, and access to care. Rather than banning a business model that offers the potential for both price and non-price competition in an increasingly concentrated hospital and health system sector, policy makers should address the specific programmatic and policy concerns outlined above. With a pandemic underscoring the need for flexible, dynamic hospital capacity, now is the time for congressional correction of Section 6001, a provision contrary to the ACA's goals of expanding access to care, improving quality, and promoting innovation.

Authors' Note

These views are those of the authors and do not necessarily represent those of their employers or professional societies. Dr. Ehrenfeld is a member of the Board of Trustees of the American Medical Association. Dr. Ficke is a member of the Board of Directors of the American Academy of Orthopaedic Surgeons. Dr. Marine is a member of the Board of Governors of the American College of Cardiology.