REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 2-A-15

Subject: Physician Payment by Medicare

Presented by: Jack McIntyre, MD, Chair

At the 2014 Annual Meeting, the House of Delegates adopted Policy D-285.964, which states:

> That our American Medical Association (AMA) will study the impact of hospital acquisition of physician practices on health care costs, patient access to health care and physician practice.

Policy D-285.964 was established after the House of Delegates adopted Substitute Resolution 104-A-14, which originally asked the AMA to examine the methodology behind Medicare fee schedules and also examine why Medicare payments are higher for hospital-based facilities than for private practice physicians. This report, which is provided for the information of the House of Delegates, reviews the literature on consolidation between hospitals and physician practices; describes the current empirical understanding of the effects of such consolidation on health care costs and other metrics; provides information on Medicare payment and hospital-based facilities; and summarizes relevant AMA policy and advocacy.

BACKGROUND

Policy discussions of consolidation in the health care sector, including hospital acquisition of physician practices, are not new to the AMA but have reignited in recent years, fueled by hospital employment of physicians, incentives for developing integrated health care delivery systems and higher Medicare payments to hospital-acquired, provider-based facilities performing outpatient procedures. Consolidation among hospitals, health insurers and physician practices is closely monitored by the AMA. For example, the AMA's Physician Practice Benchmark Survey produces highly regarded data on physician practice arrangements from which shifts toward hospital employment of physicians can be ascertained.

Consolidation between physicians and hospitals, a type of vertical integration, has been subject to fewer empirical investigations than mergers among hospitals, and therefore less can be generalized about its effects on health care costs and other variables. Current economic theory also does not provide clear predictions of what should be expected from such vertical integration.

Most studies of hospital mergers have found that the price of hospital care increases post-merger at consolidated facilities and, in some cases, their competitors. Research conducted on consolidation between physicians and hospitals has generally found that such consolidation has not led to lower health care costs or improved quality, possibly because consolidation did not lead to meaningful integration. Two recent studies on that type of vertical integration, coupled with key findings on mergers and acquisitions in the health care industry during 2013 and AMA/RAND field research on physician satisfaction, offer additional insights.

A study by Laurence Baker, M. Kate Bundorf and Daniel Kessler, published last year in *Health Affairs*, examined data from 2001 through 2007 and found increases in hospital ownership of

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physician practices were associated with increases in hospital prices and hospital spending.[1] No significant effect on hospital volume was found.[2]

A study by James Robinson and Kelly Miller, published last year in *JAMA*, examined health care cost data for 4.5 million HMO-covered patients in California. Expenditures per patient were found to be higher in physician organizations owned by local hospitals and multihospital systems than organizations owned by member physicians.[3]

Key findings from the 2014 edition of the Health Care Services Acquisition Report, published by Irvin Levin Associates, show what may be a downward trend in mergers and acquisitions involving physician groups overall and, in particular, acquisitions of physician practices by hospitals.[4] There were 41 merger and acquisition transactions involving physician groups in 2009 and 67 in 2010. After peaking in 2011 at 108, the number of deals involving physician practices fell to 70 in 2012 and 65 in 2013. Of the 65 deals announced in 2013, only six were acquisitions by hospitals.[5]

Data from the AMA's 2014 Physician Practice Benchmark Survey—a nationally representative sample of non-federal physicians who provide care to patients at least 20 hours per week—confirms a shift toward hospital employment of physicians, but indicates that this shift has not been as seismic as some articles have suggested. The AMA survey found that 26 percent of physicians worked in practices that were at least partially owned by a hospital and another 7 percent were directly employed by a hospital. In contrast, 57 percent of physicians worked in practices that were wholly owned by physicians.

The 2013 AMA-RAND study on professional satisfaction found that physicians in physician-owned practices were more satisfied than physicians in other ownership models (hospital, corporate), although work controls and opportunities to participate in strategic decisions were found to mediate the effect of practice ownership on overall professional satisfaction.[6]

MEDICARE PAYMENT AND PROVIDER-BASED STATUS

Council on Medical Service (CMS) Report 3-A-13, "Payment Variations Across Outpatient Sites of Service," and CMS Report 3-A-14, "Medicare Update Formulas Across Outpatient Sites of Service," provide detailed information on the disparity in payments and patient cost-sharing for outpatient procedures performed at different sites of service. CMS Report 3-A-13 established Policy D-240.994, which directs the AMA to work with states to advocate that third party payers be required to: assess equal or lower facility coinsurance for lower-cost sites of service; publish and routinely update pertinent information related to patient cost-sharing; and allow their plan's participating physicians to perform outpatient procedures at an appropriate site of service as chosen by the physician and the patient. In CMS 3-A-14, the Council expressed concern regarding the effect of hospital acquisition of physician practices and ambulatory surgical centers (ASCs) on costs incurred by the Medicare program. An increase in payments to hospital-acquired ASCs and practices is suspected because, under the Medicare program, hospital-acquired ASCs and practices can be granted provider-based status by the Centers for Medicare & Medicaid Services (CMS) and subsequently bill for services as hospital outpatient departments (HOPDs).

A provider-based facility is defined as one that is either created by or acquired by a main provider (e.g., hospital) of health care services under the ownership and administrative and financial control of the main provider. To be granted provider-based status, hospitals must attest that their facilities are located within 35 miles of the hospital campus; operate under the main provider's license (unless a separate license is required by the state); are financially integrated with the main provider; and meet the other requirements outlined at 42 CFR § 413.65. Provider-based facilities, including

those off campus, are paid the same rate for outpatient services as hospitals, including a facility fee that is not included in Medicare payments for services performed in physician offices under the Medicare Physician Fee Schedule. In CMS Report 3-A-14, the Council highlighted its concern for patients who may reasonably assume they are receiving services at physician office rates and be taken aback by facility fees and higher cost-sharing amounts associated with hospital-based facilities.

As of January 1, 2015, CMS began collecting data on services furnished in off-campus, provider-based departments by requiring hospitals to report a modifier for these services furnished by the department and by requiring physicians and other eligible practitioners to report these services using a new place-of-service code on professional claims. Provision of this data is voluntary in 2015 and will be a requirement beginning in 2016.

RELEVANT AMA POLICY

The AMA strongly supports equitable Medicare payments across outpatient sites of service. Policy H-330.925 encourages CMS to fairly pay physicians for office-based procedures; adopt a single facility payment schedule for HOPDs and ASCs; and use valid and reliable data to develop payment methodologies for the provision of ambulatory services.

Policy D-330.997 supports defining Medicare services consistently across settings and encouraging CMS to adopt payment methodologies that assist in leveling the playing field across all sites of service. This policy also encourages CMS to collect data on the frequency, type and cost of services furnished in off-campus, provider-based departments. Policy H-240.993 further supports equity of payment between services provided in the HOPD and similar services furnished in physician offices.

Antitrust relief for physicians that enables physicians to negotiate adequate payment remains a top priority of the AMA under Policies H-380.987, D-383.989, D-383.990 and H-383.992. Under Policy H-160.915, antitrust laws should be flexible to allow physicians to engage in clinically integrated delivery models, such as accountable care organizations (ACO), without being employed by a hospital or ACO. Policy D-385.962 further directs the AMA to support antitrust relief for physician-led ACOs.

AMA ADVOCACY

AMA advocacy on antitrust policy encourages federal agencies to strike the right balance between allowing innovative integration among physicians and other providers, and monitoring market developments that may preclude physician engagement in new delivery models. The AMA has advocated that physicians be able to engage in integrated delivery models without being acquired or employed by a health care system. Similarly, the AMA has asked the Federal Trade Commission (FTC) to take a flexible approach in its evaluation of physician-driven collaborations. Because physician delivery models are often smaller and more vulnerable to anticompetitive market forces than hospitals, the competition generated by physician-driven clinical integrations may require additional antitrust protection.

The AMA has urged the FTC to examine health care entity mergers individually, taking into account the case-specific variables of market power and patient needs as determined, in part, by physician input. The AMA believes that health care markets should be sufficiently competitive to allow physicians to have adequate choices and practice options.

1 DISCUSSION
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3 In response to Policy D-285.964, which directs the AMA to study the impact of hospital acquisition
4 of physician practices on health care costs, patient access to health care and physician practices, the
5 Council reviewed recently published literature on the subject and consulted with the AMA's
6 economic and health policy research unit, which monitors and analyzes consolidation in health care
7 markets. The Council notes that there is limited understanding of whether, overall,
8 hospital/physician practice consolidation is beneficial or harmful to physicians and patients or
9 whether the consequences vary substantially by market. Furthermore, there is a paucity of data on
10 how such consolidation impacts critical quality of care and patient outcome variables.
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12 The Council recognizes that vertical integration between hospitals and physicians can have both
13 positive and negative effects. Increased patient care coordination and operational efficiencies are
14 possible favorable consequences, while increased provider market concentration could lead to
15 higher prices. The empirical findings described in this report are limited and do not merit either
16 generalizable conclusions by the Council or new AMA policy. Nevertheless, the well-documented
17 effects of highly concentrated hospital and health insurer markets suggest the possibility that
18 consolidation between hospitals and physicians may, in some instances, threaten competition in the
19 market. Additional study is warranted. Accordingly, the Council will continue to actively monitor
20 the impact of hospital/physician practice consolidation on costs, quality and access, and report back
21 to the House of Delegates as appropriate.

REFERENCES

[1] Baker, L.C., Bundorf, M. K, and Kessler, D. P. Vertical Integration: Hospital Ownership of Physician Practices Is Associated With Higher Prices and Spending. Health Affairs 2014;33(5):756-763.
[2] Ibid.
[3] Robinson, J.C. and Miller, K. Total Expenditures per Patient in Hospital-Owned and Physician-Owned Physician Organizations in California. JAMA 2014;312(16):1663-1669.
[4] The Health Care Services Acquisition Report, Twentieth Edition, 2014.
[5] Ibid.
[6] RAND Corporation and American Medical Association. Research Report: Factors Affecting Physician Professional Satisfaction and Their Implications for Patient Care, Health Systems, and Health Policy. 2013.