REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 5-A-17

Subject: Hospital Consolidation
(Resolution 216-A-16)

Presented by: Peter S. Lund, MD, Chair

Referred to: Reference Committee G
(J. Clay Hays, MD, Chair)

At the 2016 Annual Meeting, the House of Delegates referred Resolution 216, "Hospital Consolidation," which was sponsored by the Washington Delegation and assigned to the Council on Medical Service for study. Resolution 216-A-16 asked the American Medical Association (AMA) to:

> (1) study the current market power of hospitals and hospital conglomerates in the largest state metropolitan statistical areas; (2) compare the market power of hospitals and hospital conglomerates and health plans; (3) study the effects of hospital consolidation on price, availability of services, physician satisfaction, and quality; and (4) develop an action plan to manage adverse effects of the current consolidation of hospitals and hospital conglomerates.

This report describes AMA efforts to promote competition in health care markets and address health care entity consolidation; outlines findings from a recent AMA analysis of hospital market concentration levels; summarizes relevant AMA policy; and makes policy recommendations.

BACKGROUND

Consolidation among health care entities (e.g., hospitals, health insurers, and physician practices), and the consequences that mergers may have on patients, physicians, and health care prices, continue to be closely monitored by the AMA. At the same time, new health care payment and delivery models have led many physicians to engage in pioneering practice transformations that involve integrating a variety of delivery partners, including hospitals. The AMA promotes physician leadership in integrated structures and develops policy and resources intended to help safeguard physicians employed by large systems.

The AMA believes that specific instances of health care entity consolidation must be examined individually, taking into account the case-specific variables of market power and patient needs as determined, in part, by physician input. That said, the AMA strongly supports and encourages competition in all health care markets in order to provide patients with more choices while improving care and lowering the costs of that care. The AMA further maintains that markets should be sufficiently competitive to allow physicians to have adequate practice options.

The most visible AMA competitive analyses have focused on health insurance markets, because the anticompetitive effects of dominant insurers in highly concentrated health insurance markets pose substantial risk of harm to consumers. Analyses prepared by the AMA—based on data from the AMA's *Competition in Insurance: A Comprehensive Study of US Markets*—provide the

foundation for the AMA's merger advocacy, which achieved two significant victories this year when a federal judge issued a ruling blocking the proposed merger between Aetna and Humana on January 23 and another federal judge blocked the proposed Anthem-Cigna merger on February 8. AMA analyses had determined that the proposed mergers would significantly diminish market competition. The AMA has been publishing its analyses of health insurance markets for fifteen years, and has long cautioned about the negative consequences of anticompetitive health insurer mergers.

Although the Federal Trade Commission (FTC) has successfully blocked several hospital mergers, many hospital markets are highly concentrated and noncompetitive.[1] In 2016, the AMA conducted its own analysis of hospitals' market shares and market concentration levels using 2013 data from the American Hospital Association (AHA). The AMA looked at 1922 hospitals in 362 metropolitan statistical area-level markets and found that the vast majority (90 percent) of hospital markets are highly concentrated. The analysis also found that 70 percent of hospitals are members of hospital systems.[2]

The AMA also monitors trends in hospital acquisition of physician practices (vertical hospital consolidation) and physician employment. Data from the AMA's 2012, 2014 and 2016 Physician Practice Benchmark Surveys (Benchmark Surveys), which yield nationally representative samples of non-federal physicians who provide care to patients at least 20 hours per week, demonstrate recent stability in the ownership structure of physician practices. Analyses of the surveys found that the share of physicians who worked directly for a hospital or in practices that were at least partially owned by a hospital remained unchanged between 2014 and 2016 at 33 percent both years.[3] This percentage represented an increase from 29 percent in 2012. In 2016, 56 percent of physicians worked in practices that were wholly owned by physicians, compared to 57 percent in 2014 and 60 percent in 2012. Although detailed information on practice ownership structure is not available for years prior to 2012, research suggests that in 2007-2008, only 16 percent of physicians worked directly for a hospital or in practices that were at least partially owned by a hospital.[4]

Because the Centers for Medicare & Medicaid Services has taken steps to level the site-of-service playing field between physician offices and off-campus provider-based departments acquired after November 2015, the incentive for hospitals to purchase physician practices in the future has likely been reduced. Vertical consolidation between hospitals and physician practices was the focus of Council on Medical Service Report 2-A-15 (https://www.ama-assn.org/sites/default/files/media-browser/public/about-ama/councils/Council%20Reports/council-on-medical-service/a15-cms-report2.pdf), which described potential benefits of such consolidation, such as increased patient care coordination and operational efficiencies, as well as the potential for increased provider market concentration that could lead to higher prices.

There is also the potential for benefits and harms resulting from hospital mergers (horizontal hospital consolidation). Consolidated hospitals may incur some savings due to economies of scale, and may also increase the volume of specialized services, which may in turn improve quality.[5] However, hospitals acquiring market power through mergers may also increase prices for hospital care.[6] Furthermore, highly concentrated hospital markets may lessen the practice options available to physicians in communities dominated by large hospital systems. The AMA is cognizant of the effects of hospital consolidation on physicians and patients, including concerns about loss of physician autonomy in clinical decision-making and also preserving physician leadership in large systems.

The AMA also recognizes that employment preferences vary greatly among physicians, and that employment by large hospital systems or hospital-owned practices remains an attractive practice

option for some physicians. A 2013 AMA-RAND study on professional satisfaction found that physicians in physician-owned practices were more satisfied than physicians in other ownership models (e.g., hospital or corporate ownership), but that work controls and opportunities to participate in strategic decisions mediate the effect of practice ownership on overall professional satisfaction.[7]

AMA ACTIVITY

The AMA strongly supports and encourages competition among all health care entities (e.g., hospitals, health insurers and physician practices) as a means of promoting high-quality, cost-effective health care. A competitive marketplace provides more choices to physicians and patients, and stimulates innovation in health care. The AMA also supports rigorous review and greater scrutiny of proposed health care entity mergers to determine their effects on patients and providers, and has urged Congress and the Administration to take steps to foster competition in health care markets. The AMA has further advocated for clear and commonsense antitrust rules concerning the formation of innovative delivery models so that physicians can pursue integration options that are not necessarily hospital driven.

Physician-Owned Hospitals: The AMA strongly advocates that Congress repeal the ban on expansion and new construction of physician-owned hospitals, which could increase competition in hospital markets. Under current law, physician-owned hospitals are not allowed to expand capacity unless certain restrictive exceptions can be met. The AMA supports HR 1156, "Patient Access to Higher Quality Health Care Act of 2017," which would repeal limits to the whole hospital exception of the Stark physician self-referral law that essentially bans physician ownership of hospitals and places restrictions on expansion of existing physician-owned hospitals. Because physician-owned hospitals have been shown to provide the highest quality care to patients, limiting their viability reduces access to high-quality care. Limits on existing physician-owned hospitals also put them at a competitive disadvantage, making it difficult for them to respond to their communities' health care needs.

Working Toward Integrated Leadership Structures: The AMA has always supported the ability of physicians to choose their mode of practice. As greater numbers of physicians became employed by hospitals and health systems, the AMA developed resources for employed physicians and promoted their autonomy and leadership within integrated structures. AMA resources include a new Guide to Selecting a Physician-Led Integrated System, the Annotated Model Physician-Hospital Employment Agreement and the Annotated Model Physician-Group Practice Employment Agreement to assist members in the negotiation of employment contracts. AMA Principles for Physician Employment (Policy H-225.950) were codified to address some of the more complex issues related to employer-employee relationships, and the AMA Physician's Guide to Medical Staff Bylaws is a useful reference manual for drafting and amending hospital medical staff bylaws.

Notably, the AMA has been working with the American Hospital Association (AHA) to create collaborative and integrated leadership structures for physicians, health care executives, hospitals and health systems. In October 2013, the AMA and the AHA held a joint leadership conference on new models of care to initiate discussions about integrating the administrative and clinical aspects of health care delivery. The conference, which was the first formal meeting between these two organizations in more than 35 years, was an opportunity to better understand how physicians and hospitals interact and the ways in which they can become more collaborative. Conversations centered on the need for greater physician-hospital collaboration to achieve the Triple Aim through new payment and delivery models. These discussions laid the foundation for identifying solutions

to aid physicians and hospital executives in working together and in adapting to an ever-changing health care environment.

In 2015, the AMA and AHA jointly released "Integrated Leadership for Hospitals and Health Systems: Principles for Success." These principles provide a guiding framework for physicians and hospitals that choose to create an integrated leadership structure but are unsure how to best achieve the engagement and alignment necessary to collaboratively prioritize patient care and resource management. A series of collaborative conferences have been held to promote the principles and the AMA's vision of successful integrated leadership, which requires functional partnership between organized physicians, health care executives, and hospitals.

The structure and function of physician-led health care teams were addressed by the Council in Reports 1-I-13 (https://www.ama-assn.org/sites/default/files/media-browser/public/about-ama/councils/Council%20Reports/council-on-medical-service/i13-cms-report1.pdf), and 1-I-15 (https://www.ama-assn.org/sites/default/files/media-browser/public/about-ama/councils/Council%20Reports/council-on-medical-service/i15-cms-report1.pdf), and Council on Medical Education and Council on Medical Service Joint Report I-12 (https://www.ama-assn.org/sites/default/files/media-browser/public/about-ama/councils/Council%20Reports/council-on-medical-service/i12-cmecms-jointreport.pdf).

AMA POLICY

The AMA's strong support of health care market competitiveness has been reaffirmed by several policies (e.g., Policies H-215.968, H-285.998[1], H-165.985, and H-385.990). The AMA also has longstanding policy on pluralism (Policy H-165.844) and the freedom of physicians to choose their method of earning a living (Policy H-385.926[2]). Policy D-225.995 directs the AMA to continue to monitor hospital mergers. Under Policy H-140.984, the AMA opposes the ban on physician self-referrals because of benefits to patients, including increased access and competition.

Policy H-225.947, which was established with Council on Medical Service Report 5-I-15 (https://www.ama-assn.org/sites/default/files/media-browser/public/about-ama/councils/Council%20Reports/council-on-medical-service/i15-cms-report5.pdf), encourages physicians who seek employment as their mode of practice to strive for employment arrangements consistent with a series of principles that actively involve physicians in integrated leadership and preserve clinical autonomy. Policy H-225.947 also encourages continued research on the effects of integrated health care delivery models on patients and the medical profession. Policy H-285.931 adopts principles for physician involvement in integrated delivery systems and health plans, while Policy H-225.957 outlines principles for strengthening physician-hospital relationships. Policy D-225.977 directs the AMA to continue assessing the needs of employed physicians and promote physician collaboration, teamwork, partnership, and leadership in emerging health care organizational structures.

Policy H-215.969 provides that, in the event of a hospital merger, acquisition, consolidation or affiliation, a joint committee with merging medical staffs should be established to resolve certain issues. Policy H-215.969 further directs the AMA to work to ensure, through appropriate state oversight agencies, that where hospital mergers and acquisitions may lead to restrictions on reproductive health care services, the merging entity shall be responsible for ensuring continuing community access to these services.

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 without being employed by a hospital or accountable care organization. Policy H-160.906 defines "physician-led" in the context of team-based health care and outlines guidelines for physician-led health care teams.

DISCUSSION

The Council understands the concerns regarding potential negative consequences for physicians and patients in highly concentrated hospital markets (e.g., increased prices, reduced choice, and fewer physician practice options). More broadly, the Council believes that highly concentrated markets dominated by any type of health care entity (including a physician practice) may be harmful and, conversely, that competition in the marketplace is essential to a well-functioning health care system.

The Council recognizes that the AMA is a strong advocate for competitive health care markets and antitrust relief for physicians and that existing policy sufficiently supports AMA activity in this regard. The Council recommends reaffirming Policy H-215.968, which supports and encourages competition between and among health facilities as a means of promoting the delivery of high-quality, cost-effective health care, and Policy H-380.987, which maintains antitrust relief as a top AMA priority. The Council also recognizes ongoing AMA efforts to monitor and respond to health care consolidation, including engaging with the FTC and the US Department of Justice as well as state attorneys general and insurance commissioners. AMA advocacy to ensure competitive health care markets is predominantly based on the AMA's own studies, which include the AMA's annual analyses of competition in health insurance markets; biennial Physician Practice Benchmark Surveys; and the 2016 analysis of hospital market concentration. Additionally, the Council values the AMA's strong advocacy to repeal the ban on expansion and new construction of physician-owned hospitals, which could increase competition in hospital markets, and recommends reaffirming the AMA's longstanding policy opposing the ban on self-referrals (Policy H-140.984).

Many hospital markets are already highly concentrated. Accordingly, the Council affirms its support for AMA activity and policy, summarized in this report, which is meant to help mitigate the effects of consolidation. In particular, the Council views active involvement by physicians in integrated leadership structures as an intrinsic countervailing force to dominant hospital systems. The AMA's strategic focus on physician satisfaction and its collaborative work to foster physician leadership further demonstrate AMA commitment to the needs of physicians working in large systems. The Council recommends reaffirmation of three AMA policies intended to help guide and protect these physicians: Policy H-225.947, which encourages physicians who seek employment as their mode of practice to strive for employment arrangements that actively involve physicians in integrated leadership and preserve clinical autonomy, and also encourages continued research on the effects of integrated health care delivery models on patients and the medical profession; Policy H-225.950, which outlines AMA principles for physician employment intended to assist physicians in addressing some of the unique challenges employment presents to the practice of medicine, including conflicts of interest, contracting, and hospital medical staff relations; and Policy H-160.906, which defines "physician-led" in the context of team-based health care and outlines guidelines for physician-led health care teams.

The Council points to the AMA and state medical associations as resources that AMA members can turn to for information on anticompetitive health care entity mergers as well as assistance with matters related to physician-hospital relations. The Council observed during its deliberations that health system mergers may have positive or negative effects on the availability of graduate medical education positions, depending on the merger. The importance of business education to physicians,

which would help ensure that physician leaders have requisite business and management skills, was also discussed. Finally, the Council notes that the impact on patient access to services resulting from consolidation between secular and religiously-affiliated hospital systems is currently under study by the AMA Council on Ethics and Judicial Affairs.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 216-A-16 and the remainder of the report be filed:

1. That our American Medical Association (AMA) reaffirm Policy H-215.968, which supports and encourages competition between and among health facilities as a means of promoting the delivery of high-quality, cost-effective health care. (Reaffirm HOD Policy)

2. That our AMA reaffirm Policy H-380.987, which maintains antitrust relief as a top AMA priority. (Reaffirm HOD Policy)

3. That our AMA reaffirm Policy H-140.984, under which the AMA opposes an across-the-board ban on self-referrals, because of benefits to patients including increased access and competition. (Reaffirm HOD Policy)

4. That our AMA reaffirm Policy H-225.947, which encourages physicians who seek employment as their mode of practice to strive for employment arrangements consistent with a series of principles that actively involve physicians in integrated leadership and preserve clinical autonomy, and also encourages continued research on the effects of integrated health care delivery models (that employ physicians) on patients and the medical profession. (Reaffirm HOD Policy)

5. That our AMA reaffirm Policy H-225.950, which outlines AMA Principles for Physician Employment intended to assist physicians in addressing some of the unique challenges employment presents to the practice of medicine, including conflicts of interest, contracting, and hospital medical staff relations. (Reaffirm HOD Policy)

6. That our AMA reaffirm Policy H-160.906, which defines “physician-led” in the context of team-based health care and outlines guidelines for physician-led health care teams. (Reaffirm HOD Policy)

Fiscal Note: Less than $500.

REFERENCES

[1] Gaynor M and Town R. The impact of hospital consolidation-Update. The Robert Wood Johnson Foundation: The Synthesis Project, Policy Brief No. 9, June 2013.
[2] Unpublished Analysis. Hospital Market Competition: Analysis of Hospitals' Market Shares and Market Concentration. American Medical Association. July 2016.
[3] Kane C. Physician Practice Benchmark Survey. American Medical Association. 2016, and Updated data on physician practice arrangements: Inching toward hospital ownership. AMA: Policy Research Perspectives, 2015.
[4] Kane C. Updated data on physician practice arrangements: Inching toward hospital ownership. AMA: Policy Research Perspectives, 2015.
[5] Cutler D and Morton FS. Hospitals, Market Share, and Consolidation. *JAMA*. 2013;310(18):1964-1970.
[6] Ibid.
[7] RAND Corporation and American Medical Association. Research Report: Factors Affecting Physician Professional Satisfaction and Their Implications for Care, Health Systems, and Health Policy. 2013.