REPORT 7 OF THE COUNCIL ON MEDICAL SERVICE (A-19)
Hospital Consolidation
(Resolution 235-A-18)
(Reference Committee G)

EXECUTIVE SUMMARY

Most hospital markets are highly concentrated, largely due to consolidation. This report describes horizontal and vertical hospital consolidation and potential consequences for physicians and patients in highly concentrated hospital markets (e.g., increased prices, reduced choice, and fewer physician practice options).

Because hospital markets are predominantly local, states play a significant role in regulating them. States have their own antitrust laws, and state attorneys general and other regulators have access to the local market-level data needed to oversee and challenge proposed mergers in their states. In addition to challenging hospital mergers outright, state strategies to address consolidation include all-payer rate setting for hospitals (Maryland, Pennsylvania and Vermont) and the Massachusetts Health Policy Commission, which are discussed in this report.

The Council reviewed an abundance of relevant American Medical Association (AMA) policy and recommends affirming 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.

Because antitrust efforts may not be effective in hospital markets that are already highly concentrated, the Council also recommends that the AMA 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.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 7-A-19

Subject:	Hospital Consolidation (Resolution 235-A-18)
Presented by:	James G. Hinsdale, MD, Chair
Referred to:	Reference Committee G (Rodney Trytko, MD, Chair)

At the 2018 Annual Meeting, the House of Delegates referred Resolution 235-A-18, "Hospital Consolidation," which was introduced by the Washington Delegation. The Board of Trustees assigned this item to the Council on Medical Service for a report back at the 2019 Annual Meeting. Resolution 235-A-18 asked that our American Medical Association (AMA) actively oppose future hospital mergers and acquisitions in highly concentrated hospital markets, and study the benefits and risks of hospital rate setting commissions in states where highly concentrated hospital markets currently exist.

This report discusses horizontal and vertical hospital consolidation; outlines findings from a recent AMA analysis of hospital market concentration levels; highlights the role of states; describes alternative solutions that promote competition and choice in hospital markets; summarizes relevant AMA policy; and makes policy recommendations.

BACKGROUND

Consolidation in health care markets includes both horizontal and vertical mergers of physicians, hospitals, insurers, pharmaceutical companies, pharmaceutical benefit managers, and other entities. As stated in Council Report 5-A-17, "Hospital Consolidation," the AMA believes that health care entity mergers—including among hospitals—should be examined individually, taking into account the case-specific variables of market power and patient needs. The AMA strongly supports health care market competition as well as vigorous state and federal oversight of health care entity consolidation. Antitrust advocacy for physicians is a longstanding AMA priority, and close monitoring of health care markets is a key aspect of AMA antitrust activity.

Horizontal Hospital Consolidation

Although the AMA's most visible health care consolidation efforts have focused on health insurance markets, the AMA has also analyzed hospital market concentration using 2013 and 2016 data from the American Hospital Association. In a 2018 analysis, the AMA looked at 1,946 hospitals in 363 metropolitan statistical area (MSA)-level markets in 2013 and 2,028 hospitals in 387 MSAs in 2016 and found that, in most markets, hospitals (or systems) have large market shares.[1] In terms of hospital market shares, the AMA found that in 95 percent of MSAs, at least one hospital or hospital system had a market share of 30 percent or greater in both 2013 and 2016. In 2016, 72 percent of MSAs were found to have a single hospital or system with a market share of at least 50 percent, and 40 percent of MSAs had a single hospital or system with a market share of 70

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percent or more.[2] The AMA analysis also found that, in 2016, 92 percent of MSA-level markets were highly concentrated, and 75 percent of hospitals were members of hospital systems.[3]

Hospital markets are concentrated largely due to consolidation. There were 1,412 hospital mergers between 1998 and 2015—with 561 reported between 2010 and 2015—and an additional 102 and 115 mergers documented in 2016 and 2017, respectively.[4,5] Eleven of the transactions in 2017 were mega-deals involving sellers with net revenues of $1 billion or more.[6]

There are potential benefits and harms resulting from horizontal hospital consolidation, with savings due to economies of scale and enhanced operational efficiencies cited as potential benefits. Hospitals acquiring market power through mergers may also increase prices for hospital care above competitive levels. Although not all hospital mergers impact competition, research has found that mergers in concentrated markets lead to price increases, and that the increases are significant when close competitors consolidate.[7,8] Studies have found little evidence of quality improvements post-merger, and lower quality in more concentrated hospital markets.[9,10] The evidence is more consistent for markets where prices are administered (e.g., Medicare). In markets where prices are market determined, consolidation can also lead to lower quality, but the evidence is more mixed.[11] Highly concentrated hospital markets may also lessen the practice options available to physicians in communities dominated by large hospital systems.

Vertical Hospital Consolidation

A hospital acquiring a physician practice is an example of vertical hospital consolidation. The AMA closely monitors trends in hospital acquisition of physician practices—which was the focus of Council on Medical Service Report 2-A-15, "Expanding AMA's Position on Healthcare Reform Options,"—via biennial Physician Practice Benchmark Surveys (Benchmark Surveys), which are nationally representative samples of non-federal physicians who provide care to patients at least 20 hours per week. In 2018, the share of physicians who worked in practices that were at least partially owned by a hospital was 26.7 percent, up from 25.4 percent in 2016, 25.6 percent in 2014 and 23.4 percent in 2012.[12] The share of physicians who were direct hospital employees in 2018 was 8.0 percent, up from 7.4 percent in 2016, 7.2 percent in 2014 and 5.6 percent in 2012.[13]

Vertical hospital consolidation has been found to increase prices and, in markets where prices are administered (e.g., Medicare), to increase total spending.[14,15] Recent steps taken by the Centers for Medicare & Medicaid Services (CMS) to level the site-of-service playing field between physician offices and off-campus hospital provider-based departments may have diminished a crucial incentive for hospitals to purchase physician practices in the future. For many years, higher payments to hospital outpatient departments likely incentivized the sale of physician practices and ambulatory surgical centers (ASCs) to hospitals because acquired facilities meeting certain criteria (e.g., located within 35 miles of the hospital) were routinely converted to hospital outpatient departments and allowed to charge higher rates for services performed at these off-campus facilities. However, a provision in the Bipartisan Budget Act of 2015 (BBA) disallowed provider-based billing by hospitals for newly acquired physician practices and ASCs. Beginning in 2017, off-campus entities acquired after enactment of the BBA—in November 2015—were no longer permitted to bill for services under Medicare's Outpatient Prospective Payment System (OPPS), and instead required to bill under the applicable payment system (Physician Fee Schedule). Since 2017, CMS has paid for services at non-excepted off-campus provider-based hospital departments using a Physician Fee Schedule relativity adjuster that is based on a percentage of the OPPS payment rate. CMS has since extended site-neutral payments to include clinic visits provided at off-campus provider-based hospital departments acquired prior to November 2015 that were

previously excepted from the BBA provision.[16] The AMA will continue to monitor the impact of these changes on hospital markets.

PROMOTING COMPETITION AND CHOICE

The AMA is aware of the potential effects of hospital consolidation on physicians and patients, including concerns about the loss of physician autonomy in clinical decision-making and preserving physician leadership in large systems, and also increased hospital prices in concentrated markets. 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.[17]

The AMA has long been a strong advocate for competitive health care markets and antitrust relief for physicians, and maintains that health care markets should be sufficiently competitive to allow physicians to have adequate choices and practice options. AMA efforts to obtain antitrust relief for physicians, maximize their practice options, and protect patient-physician relationships include legislative advocacy; advocacy at the Federal Trade Commission (FTC) and the US Department of Justice (DOJ); and the creation of practical physician resources.

State and federal antitrust enforcement for hospital consolidation has been somewhat limited and has had mixed results over the years, with some successes and also periods of intense merger activity.[18] Many mergers have proceeded unchallenged. Experts have also asserted that in hospital markets that are already highly concentrated, antitrust provides no remedy.[19] Accordingly, in addition to antitrust activities, the AMA has pursued alternative solutions that promote competition and choice, including: eliminating state certificate of need (CON) laws; repealing the ban on physician-owned hospitals; reducing the administrative burden to enable physicians to compete with hospitals; and achieving meaningful price transparency.

Eliminating State CON Laws: The AMA supports the elimination of state CON laws, which are barriers to market entry that harm competition, and supports state medical associations in their advocacy efforts to repeal them. CON laws require state boards to review all entities seeking to enter a health care market to provide care, including existing facilities seeking to offer new services or services in new locations. Thirty-five states and the District of Columbia currently administer CON programs.[20] As stated in Policy H-205.999, the AMA believes that there is little evidence to suggest that CON programs are effective in restraining health care costs or in limiting capital investment. In the absence of such evidence, AMA policy also opposes CON laws and the extension of CON regulations to private physician offices.

Repealing the Ban on Physician-Owned Hospitals: The AMA strongly advocates that Congress 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 expansions of already existing physician-owned hospitals. Repealing the ban would allow new entrants into hospital markets, thereby increasing competition. Because physician-owned hospitals have been shown to provide the highest quality of care to patients, limiting their viability reduces access to high-quality care. The AMA firmly believes that physician-owned hospitals should be allowed to compete equally with other hospitals, and that the federal ban restricts competition and choice.

Reducing Administrative Burdens: Physicians are increasingly burdened by administrative tasks that are extremely costly to practices and reduce time with patients, yet increase the work necessary to provide medical services. Examples of these burdens include abiding by state and federal rules and regulations, meeting quality reporting requirements, managing electronic health records, and navigating a plethora of payer protocols and utilization management programs. Utilization management has become so burdensome that in 2018 the average physician reported completing 31 prior authorizations per week, a process that required 14.9 hours of work or the equivalent of two business days.[21] Taken together, these burdens make it difficult for physician practices—particularly smaller practices—to compete, which may lead physicians to consolidate with larger groups or hospitals.[22] The AMA conducts widespread prior authorization advocacy and outreach, including promoting Prior Authorization and Utilization Management Reform Principles, the Consensus Statement on Improving the Prior Authorization Process, model state legislation, the Prior Authorization Physician Survey, and the AMA Prior Authorization toolkit.

Price Transparency: The lack of complete, accurate and timely information about the cost of health care services prevents health care markets from operating efficiently. Patients are increasingly becoming active consumers of health care services rather than passive recipients of care in a market where price is often unknown until after the service is delivered. The AMA supports price transparency and recognizes that achieving meaningful price transparency may help lower health care costs and empower patients to choose low-cost, high-quality care. The AMA supports measures that expand the availability of health care pricing information, enabling patients and their physicians to make value-based decisions when patients have a choice of provider or facility.

ROLE OF STATES

While it is recognized that most hospital markets are highly concentrated and do not work as well as they could, it is also recognized that hospital markets are local and that states play a significant role in regulating them. States have their own antitrust laws, and state attorneys general and other regulators have better access to the local market-level data needed to oversee and challenge proposed mergers in their states. States can take on mergers themselves or join federal antitrust efforts. Some states have approved mergers but established conditions that must be met, such as requiring merged hospitals to maintain charity care programs or capping price increases for a certain number of years. As discussed previously, states can also reduce barriers to new competitors in hospital markets by eliminating CON laws.

All-Payer Rate Setting for Hospitals (Maryland, Pennsylvania and Vermont)

The approach to fostering competition cited in referred Resolution 235-A-18 is all-payer rate setting for hospitals, under which all payers (e.g., Medicare, Medicaid, private insurers and employer self-insured plans) pay hospitals the same price for services. Although-payer rate setting was popular in the 1970s, Maryland is the only state where it remains. Building on its all-payer rate setting approach, Maryland began implementing an all-payer global budgeting model for hospitals in 2014, while Pennsylvania began a similar model for rural hospitals in 2017. Vermont has developed an all-payer model for accountable care organizations (ACOs) that enables Medicare, Medicaid and private insurers to pay ACOs differently than through fee-for-service. These more recent all-payer payment models are still in the early stages of implementation and continue to undergo refinements and ongoing evaluation. Hospitals under this model are exempt from Medicare's inpatient and outpatient prospective payment systems and instead are paid based on fixed annual budget amounts for inpatient and outpatient hospital services that are established in advance.

A federally-funded evaluation of the first three years of Maryland's all-payer model found that it reduced total expenditures and hospital expenditures for Medicare patients but did not impact total expenditures or hospital expenditures for privately insured patients.[23] The evaluation further found that hospitals have adapted to global budgets without being adversely impacted financially. Other studies have looked at hospitals in eight urban counties in Maryland and the state's earlier rural pilot program, and research is ongoing. Accordingly, the Council believes that it may be premature to draw meaningful conclusions about the potential impact of hospital rate-setting in states with highly concentrated hospital markets.

All-payer rate setting for hospitals is intended to increase price competition and lessen the bargaining power of dominant hospitals, and it moves hospitals away from fee-for-service. However, appropriate payment rates can be challenging to establish and the model can be costly for states to administer.[24] Strong state leadership as well as an established information technology infrastructure are needed for all-payer global budgeting to be successful.[25]

Massachusetts Health Policy Commission

The Massachusetts Health Policy Commission (HPC) is an independent state agency that monitors health care spending growth and makes policy recommendations regarding health care payment and delivery reforms. Among other responsibilities, the HPC—established in 2012—is charged with monitoring changes in the health care market. Massachusetts regulations stipulate that health care provider organizations with more than $25 million in revenue must notify the HPC before consummating transactions for the purpose of enabling the state watchdog to conduct a "cost and market impact review."[26] The HPC has conducted several such reviews of proposed hospital mergers over the years and made them available to stakeholders as well as the public, thereby increasing transparency surrounding these transactions. Notably, mergers may be allowed to move forward despite criticisms from the HPC.

AMA RESOURCES

Recognizing that physicians are increasingly becoming employed by hospitals and health systems, the AMA has developed several practical tools for physicians, including the Annotated Model Co-Management Service Line Agreement, Annotated Model Physician-Hospital Employment Agreement and the Annotated Model Physician-Group Practice Employment Agreement which assist in the negotiation of employment contracts. For physicians considering a practice setting change or looking for an alignment strategy with an integrated health system, the AMA developed Joining or Aligning with a Physician-led Integrated Health System. The AMA has also made available a set of resources called "Unwinding Existing Arrangements" that guides employed physicians on how to "unwind" from their organization, factoring in operational, financial, and strategic considerations.

AMA principles for physician employment (Policy H-225.950) have been 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. The AMA has also developed a series of model state bills, available from the AMA's Advocacy Resource Center, that are intended to address concerns expressed by employed physicians. Through these resources, the AMA is well-positioned to help employed physicians and those considering employment by hospitals or other corporations to preserve physician autonomy and independent decision-making and protect patient-physician relationships. The inviolability of the patient-physician relationship is a recurrent theme throughout the AMA Code of Medical Ethics, which also addresses mergers of secular and religiously affiliated health care institutions

(Code of Medical Ethics Opinion11.2.6). AMA staff are available to provide guidance and consultation on a range of issues related to employment and consolidation.

Working Toward Integrated Leadership Structures

Importantly, the AMA has always supported the ability of physicians to choose their mode of practice. The AMA promotes physician leadership in integrated structures and develops policy and resources intended to help safeguard physicians employed by large systems. The AMA has collaborated with hospitals, independent physician associations, large integrated health care systems' leaders and payers to cultivate successful physician leadership that improves the value of care for patients. Working with these stakeholders to bring clinical skills and business insights together at the leadership level, the AMA is fostering a more cohesive and integrative decision-making process within hospitals and health care systems. To help hospitals and health care systems institute that kind of decision-making process, the American Hospital Association (AHA) and the AMA released "Integrated Leadership for Hospitals and Health Systems: Principles for Success" in June 2015. The "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.

RELEVANT AMA POLICY

Policy H-215.968 supports and encourages competition between and among health facilities as a means of promoting the delivery of high-quality, cost-effective health care. 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 ACO. Policy D-385.962 directs the AMA to support antitrust relief for physician-led accountable care organizations. Policy H-225.950 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.

The AMA has substantial policy intended to protect medical staffs, including Policy H-220.937, which states that geographic disparities or differences in patient populations may warrant multiple medical staffs within a single hospital corporation, and that each medical staff shall develop and adopt bylaws and rules and regulations to establish a framework for self-governance of medical activities and accountability to the governing body. 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 at least the following issues: (a) medical staff representation on the board of directors; (b) clinical services to be offered by the institutions; (c) process for approving and amending medical staff bylaws; (d) selection of the medical staff officers, medical executive committee, and clinical department chairs; (e) credentialing and recredentialing of physicians and limited licensed providers; (f) quality improvement; (g) utilization and peer review activities; (h) presence of exclusive contracts for physician services and their impact on physicians' clinical privileges; (i) conflict resolution mechanisms; (j) the role, if any, of medical directors and physicians in joint ventures; (k) control of medical staff funds; (l) successor-in-interest rights; and (m) that the medical staff bylaws be viewed as binding contracts between the medical staffs and the hospitals. Policy H-215.969 also states that the AMA will 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. Under Policy H-235.991, medical staff bylaws should include

successor-in-interest provisions to protect medical staffs from a hospital ignoring existing bylaws and establishing new bylaws to apply post-merger, acquisition, affiliation or consolidation.

Policy H-225.947, which was established via Council on Medical Service Report 5-A-15, "Hospital Incentives for Admission, Testing and Procedures," encourages physicians who seek employment as their mode of practice to strive for employment arrangements consistent with a series of principles including that: (a) physician clinical autonomy is preserved; (b) physicians are included and actively involved in integrated leadership opportunities; (c) physicians are encouraged and guaranteed the ability to organize under a formal self-governance and management structure; (d) physicians are encouraged and expected to work with others to deliver effective, efficient and appropriate care; (e) a mechanism is provided for the open and transparent sharing of clinical and business information by all parties to improve care; and (f) a clinical information system infrastructure exists that allows capture and reporting of key clinical quality and efficiency performance data for all participants and accountability across the system to those measures. Policy H-225.947 also encourages continued research on the effects of integrated health care delivery models that employ physicians on patients and the medical profession. Policy H-285.931 adopts principles for physician involvement in integrated delivery systems and health plans. Policy D-225.977 directs the AMA to continue to assess the needs of employed physicians and promote physician collaboration, teamwork, partnership, and leadership in emerging health care organizational structures.

AMA policy does not prohibit the application of restrictive covenants in the physician employment context generally, although Policy H-225.950, "Principles for Physician Employment," discourages physicians from entering into agreements that restrict the physician's right to practice medicine for a specified period of time or in a specified area upon termination of employment. AMA Code of Medical Ethics Opinion 11.2.3.1 states that covenants-not-to-compete restrict competition, can disrupt continuity of care, and may limit access to care. Accordingly, physicians should not enter into covenants that: (a) unreasonably restrict the right of a physician to practice medicine for a specified period of time or in a specified geographic area on termination of a contractual relationship; and (b) do not make reasonable accommodation for patients' choice of physician. This opinion also states that physicians in training should not be asked to sign covenants not to compete as a condition of entry into any residency or fellowship program. Under Policy H-140.984, the AMA opposes an across-the-board ban on self-referrals, because of benefits to patients including increased access and competition.

DISCUSSION

The Council shares the concerns among physicians regarding potential negative consequences for physicians and patients in highly concentrated hospital markets (e.g., increased prices, reduced choice, and fewer physician practice options). In addition to reviewing the literature, the Council received input from AMA antitrust experts during the development of this report, and notes that AMA staff are readily available to assist and advise AMA members and state medical associations with questions or concerns about physician-hospital relations or hospital consolidation. Nonetheless, the AMA does not have the resources to actively oppose all future hospital mergers in highly concentrated markets, as requested by Resolution 235-A-18. Attempting to address hospital mergers in the same manner that the AMA has addressed major health insurance mergers would place an undue burden on the organization's resources and may alienate many valued AMA members who work for hospitals and hospital systems.

Having prepared two reports on hospital consolidation in a two-year time period, the Council has a clear understanding of ongoing AMA efforts to monitor and respond to health care consolidation,

including engaging with the FTC and the DOJ as well as state attorneys general and insurance commissioners. The Council further appreciates the abundance of AMA policy embracing competition and choice, and concludes that hospital consolidation is sufficiently addressed (and not prohibited) by existing policy. Accordingly, the Council developed a new policy recommendation that brings together existing AMA policy to affirm 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.

The Council also recognizes that most hospital markets are highly concentrated, and that hospital markets are predominantly local. The Council's review of the literature found that antitrust efforts may not be effective in hospital markets that are already highly concentrated, and that alternative solutions are warranted. Accordingly, the Council recommends that the AMA continue to support actions that promote competition and choice, including: (a) eliminating state CON 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.

Because hospital markets are local, the Council further recommends encouraging state medical associations to monitor hospital markets and review the impact of horizontal and vertical health system integration on patients, physicians and hospital prices.

Having discussed the potential impact of hospital consolidation on medical staffs, and the need to protect affected medical staffs post-merger, the Council recommends reaffirmation of four policies intended to help guide medical staffs and physicians experiencing consolidation: Policy H-215.969, which 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 critical issues; Policy H-220.937, which states that geographic disparities or differences in patient populations may warrant multiple medical staffs within a single hospital corporation; Policy H-225.950, which outlines AMA Principles for Physician Employment; and 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.

The Council is intrigued by state efforts to promote competition, including Maryland's all-payer rate setting model and Massachusetts' HPC. The AMA will continue to monitor these and other models but, at this time, does not make recommendations regarding their widespread adoption.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 235-A-18, and the remainder of the report be filed:

1. That our American Medical Association (AMA) affirm 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. (New HOD Policy)

2. That our AMA 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. (New HOD Policy)

3. That our AMA 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. (New HOD Policy)

4. That our AMA reaffirm Policy H-215.969, which 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 at least the following issues: (a) medical staff representation on the board of directors; (b) clinical services to be offered by the institutions; (c) process for approving and amending medical staff bylaws; (d) selection of the medical staff officers, medical executive committee, and clinical department chairs; (e) credentialing and recredentialing of physicians and limited licensed providers; (f) quality improvement; (g) utilization and peer review activities; (h) presence of exclusive contracts for physician services and their impact on physicians' clinical privileges; (i) conflict resolution mechanisms; (j) the role, if any, of medical directors and physicians in joint ventures; (k) control of medical staff funds; (l) successor-in-interest rights; and (m) that the medical staff bylaws be viewed as binding contracts between the medical staffs and the hospitals. (Reaffirm HOD Policy)

5. That our AMA reaffirm Policy H-220.937, which states that geographic disparities or differences in patient populations may warrant multiple medical staffs within a single hospital corporation, and that each medical staff shall develop and adopt bylaws and rules and regulations to establish a framework for self-governance of medical activities and accountability to the governing body. (Reaffirm HOD Policy)

6. 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, and that discourage physicians from entering into agreements that restrict their right to practice medicine for a specified period of time or in a specified area upon termination of employment. (Reaffirm HOD Policy) and

7. 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. (Reaffirm HOD Policy)

Fiscal Note: Less than $500.

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