

REPORTS OF THE COUNCIL ON MEDICAL SERVICE

The following reports were presented by Lynn Jeffers, MD, MBA, Chair:

1. INCENTIVES TO ENCOURAGE EFFICIENT USE OF EMERGENCY DEPARTMENTS

Reference committee hearing: see report of Reference Committee J.

HOUSE ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF REPORT FILED
See Policy TBD

At the 2022 Annual Meeting, the House of Delegates adopted Policy D-130.959, “Study of Incentives to Encourage Efficient Use of Emergency Departments,” which directs the American Medical Association (AMA) to study and report on the positive and negative experiences of programs in various states that provide Medicaid beneficiaries with incentives for choosing alternate sites of care, for physical and mental health conditions, when it is appropriate to their symptoms and/or conditions instead of hospital emergency departments (EDs). The Board of Trustees assigned this policy to the Council on Medical Service for a report back to the House of Delegates at the 2022 Interim Meeting. This report describes the positive and negative experiences of two commonly used incentives intended to reduce non-emergency ED use (increased patient cost-sharing and retrospective payment denials), summarizes relevant AMA policy, and makes policy recommendations.

BACKGROUND

Medicaid spending makes up an increasingly large share of most state budgets and continues to be a focus of policymakers seeking ways to contain costs without compromising care quality. EDs have been targeted for cost-savings in many states because, for a variety of complex reasons, Medicaid/Children’s Health Insurance Program (CHIP) enrollees have higher rates of ED use than Medicare, privately insured, and even uninsured individuals.^{1,2} Because services cost significantly more when provided in EDs than in other ambulatory care settings (e.g., physician offices and outpatient clinics), states—and managed care plans that enroll Medicaid patients—have long prioritized incentivizing more efficient ED use by Medicaid enrollees. Financial incentives, including increased patient cost-sharing and retrospective payment denials, are among the variety of strategies employed to try to reduce ED visits perceived to be non-emergency, nonurgent, or avoidable. Although there is no standard definition of what constitutes non-emergency, nonurgent, avoidable ED care, it is generally described as that which can be appropriately provided in a primary care or other outpatient setting at reduced cost.

Due to the lack of consensus around defining non-emergency, nonurgent, avoidable ED visits, researchers have employed an array of methodologies to assess the effectiveness of strategies to reduce those patient visits that could be effectively treated elsewhere. As a result, studies have produced a range of estimates of ED visits classified as non-emergency, nonurgent, or avoidable, depending on methodology and how these visits are defined. Importantly, a 2013 *JAMA* study revealed what many physicians already knew—that non-emergency visits cannot easily be discerned from patients’ presenting complaints and symptoms, since symptoms for many non-emergency conditions overlap with symptoms of conditions that require emergency care.³ This suggests that, in many cases, decisions about emergency versus non-emergency care are far from clear-cut and may not be evident at triage. Although exact percentages are not known, most estimates of non-emergency ED visits as a proportion of all ED visits are relatively small. Analyses by the Centers for Disease Control and Prevention (CDC) of ED data from the National Hospital Ambulatory Medical Care Survey found that 5.5 percent of all ED visits in 2015,⁴ 3.9 percent in 2017,⁵ and 3.1 percent in 2018,⁶ were classified as nonurgent. A 2015 report of the Washington Health Alliance found that nearly 12 percent of Medicaid enrollee ED visits in the Puget Sound region could be described as avoidable, compared to 8.5 percent of ED visits by privately insured individuals.⁷

Experts have long posited that a lack of regular access to primary care drives many patients to EDs for nonurgent reasons. Furthermore, Medicaid enrollees, and individuals dually eligible for Medicare and Medicaid, are known to experience added barriers to accessing health care, in part because they are more likely to experience inequities in social determinants of health (SDOH) that lead to complex and chronic health needs. Other factors that lower access to health care include a lack of available transportation, the distance one must travel to obtain care (especially in rural

areas), an inability to get needed specialty care, difficulties taking time off to attend medical appointments, cost concerns among patients, lack of community behavioral health resources, and inadequate Medicaid physician payment rates.

MEDICAID PAYMENT RATES AND ENROLLEE ACCESS TO CARE

For decades, the AMA has highlighted the inadequacy of physician payment rates across state Medicaid programs—rates that are substantially below Medicare and private insurance fees and often do not come close to covering the cost of providing care. In enacting the equal access provision in section 1902(a)(30)(A) of the Social Security Act, Congress recognized that, “without adequate payment levels, it is simply unrealistic to expect physicians to participate in the [Medicaid] program.”⁸ While physicians have a strong sense of responsibility to provide care for Medicaid patients, physician practices cannot remain economically viable if they lose money on the care they provide. Without an adequate supply of participating physicians, Medicaid patients have coverage but may lack access to care. And without access to needed primary and specialty care, Medicaid enrollees tend to visit EDs more often for conditions that could be handled in alternate sites of service.

Because physicians participating in Medicaid remain sparse in many areas of the country, enrollees often experience lengthy wait times, travel long distances to access care, or may go without care altogether. Medicaid payment rates have been shown to significantly impact patient access to care, with increases in payments found to improve access to care.⁹ Accordingly, the AMA has long advocated at the federal and state levels that physicians be provided fair and reasonable Medicaid payment, defined in AMA policy as a minimum of 100 percent of Medicare rates. The AMA further advocates that the Centers for Medicare & Medicaid Services (CMS) ensure that states maintain Medicaid rate structures at levels that ensure there is sufficient physician participation, so that Medicaid patients can access care in a timely manner.

FACTORS CONTRIBUTING TO NON-EMERGENCY ED USE

EDs have historically served as an essential source of care for people struggling with economic marginalization, and research has shown an association between socioeconomic variables and potentially avoidable ED use.¹⁰ Medicaid enrollees experiencing inequities in SDOH—such as housing instability, food insecurity, or lack of transportation—may be more likely to use the ED for non-emergency care.

As previously noted, patients who do not have an established relationship with a primary care provider may be more likely to seek care at an ED for non-emergency conditions. Moreover, across some states, and especially in rural areas, it can be difficult for some Medicaid enrollees to obtain needed specialty care; in turn, these patients may visit EDs because alternative care sites are simply not available. Lack of access to behavioral health and substance use disorder services may be an additional barrier in some areas. Physician workforce shortages in certain specialties likely compound these access barriers that contribute to higher ED use among Medicaid enrollees.

Although some people may seek non-emergency care at EDs out of convenience, or on weekends or evenings when other outpatient care is not available, analyses have been mixed and some hospitals have found that non-emergency visits predominantly occur during regular hours when physician offices are open. A subset of Medicaid enrollees may turn to hospital EDs for services that cannot be accessed at primary care offices, while others may be motivated to have multiple health concerns addressed during a single ED visit. Patients who perceive that they cannot access timely or needed care in another setting, including individuals with mental health needs and/or substance use disorder, may also seek non-emergency ED care, as will patients who believe they are experiencing emergencies requiring immediate attention.

Insurer prior authorization (PA) requirements are also important drivers of non-emergency ED use, especially when they preclude patients from getting timely needed care. In some cases, patients may resort to EDs for certain medically indicated services that would otherwise be delayed while approval is sought from the patient’s insurer. PA rules that impede quick access to services ranging from mental health and substance use disorder treatment to imaging may lead some patients to seek care at EDs. According to one study, a new outpatient PA process for radiologic studies may have led to an increase in ED visits for outpatient MRI scans.¹¹

Lack of insurance, or limited insurance, also impacts ED use, although people with health insurance still experience time and access barriers to receiving regular care. Although the expansion of Medicaid under the Affordable Care Act

has been found to reduce the number of uninsured individuals and increase access to primary care,¹² research findings on the association between Medicaid expansion and ED use have been mixed, in part because newly insured patients may use more health care services.

STRATEGIES TO REDUCE NON-EMERGENCY ED USE

Beyond financial incentives, strategies to reduce non-emergency ED use are numerous and varied and have produced mixed results in the literature in terms of their impact. One strategy that is central to many state efforts is care coordination designed to connect Medicaid enrollees to services that address their physical and mental health needs as well as non-medical issues such as housing, nutrition, and transportation. To improve care coordination, many states have focused on enrolling Medicaid patients in patient-centered medical homes that use a physician-led team approach to coordinating and managing care for individuals. Consistent with value-based care, care coordination and the use of patient-centered medical homes assist patients in getting the right care at the right time in the appropriate setting. Many medical home programs have successfully reduced hospitalizations and ED use including, for example, Community Care of North Carolina, which was found to decrease ED visits among individuals enrolled compared to those not enrolled.¹³ In the Medicare population, enrollees with patient-centered medical homes have also been found to have slower growth in ED use than those not treated by medical homes.¹⁴

Additional mechanisms employed to help reduce non-emergency ED use include integrating behavioral health care into primary care and expanding access to after-hours primary care, which have been implemented by some health systems along with expanded telehealth availability. In the Netherlands, linkages between primary care physician cooperatives and EDs have significantly reduced ED use.¹⁵ Rural health clinics, community health centers, and federally qualified health centers serving economically marginalized communities may also play a role in reducing non-emergency ED visits by providing accessible and timely care that would otherwise not be available. Research has shown that the availability of health centers lowers ED use, and that many centers actively work with local hospitals to further reduce ED visits.¹⁶

Ensuring the availability of community mental health resources is also key to addressing ED use by mental health and substance use disorder patients and enabling them to access treatment outside of EDs. Crisis response services and same-day access to treatment in one's community have also been cited as important mechanisms for reducing the use of EDs.¹⁷ Notably, some states, health plans, hospitals and health systems pursue cost-savings opportunities by targeting high-need, high-cost Medicaid patients who have the greatest number of ED visits. Case management/care management interventions of varying designs are often employed to help meet these patients' complex physical, behavioral, and social needs, thereby reducing their use of EDs. Extensivist clinics, employed by some hospitals and health systems to coordinate and manage care for patients with multiple complex health needs, have also been found to incur cost-savings by decreasing ED utilization and hospitalizations.¹⁸ Consistent with Policy D-130.959, this report summarizes the literature on two commonly used financial incentives—increased cost-sharing for non-emergency ED use and retrospective payment denials for non-emergency diagnoses.

INCREASED PATIENT COST-SHARING FOR NON-EMERGENCY ED VISITS

Although federal law prohibits the imposition of cost-sharing for certain services in Medicaid, including “emergency services,”¹⁹ the Deficit Reduction Act of 2005 (DRA) gave states the option to impose cost-sharing for “non-emergency services.”²⁰ In 2013, CMS established through rulemaking that a maximum eight dollars in cost-sharing for non-emergency use of the ED could be imposed by states without an approved waiver.²¹ Accordingly, over the ensuing years, many states have imposed limited cost-sharing amounts of eight dollars or less. Although the Kaiser Family Foundation reported in 2020 that 21 states had mandated cost-sharing requirements for non-emergency use of EDs,²² it is unclear how many states have waived those requirements for the duration of the COVID-19 public health emergency. Notably, South Dakota's Medicaid program informs enrollees that they will be responsible for paying the full cost of non-referred, non-emergency ED services.²³

A handful of states have used Section 1115 demonstration waivers to establish cost-sharing amounts exceeding the eight-dollar maximum, although most of these waivers—including those from Kentucky and New Mexico—are no longer in effect. Under Georgia's current waiver, \$30 can be retroactively deducted from enrollees' Member Rewards Accounts—used to deduct and deposit non-monetary dollar-value equivalent credits for healthy behavior activities—for non-emergency use of EDs. Because enrollees are not charged with any out-of-pocket costs, the \$30 deduction in Georgia is considered an incentive but is not true cost-sharing.²⁴ Other states have provided prepaid cards to cover

cost-sharing expenses that may allow enrollees to keep remaining amounts on the card at the end of the year; however, no analyses of such programs were located during the development of this report.

Relevant Research

The landmark RAND Health Insurance Experiment, conducted between 1971 and 1982, is frequently cited as the benchmark study of cost-sharing and its effects on health care utilization, quality of care, and health. This experiment found that cost-sharing reduced utilization of almost all services, whether needed or not, and that the sickest and lowest-income people had better outcomes under free plans, suggesting that cost-sharing should not be applied to them.²⁵ Prior to enactment of the DRA, research had found that even minimal cost-sharing could lead Medicaid enrollees to use fewer health care services.²⁶

More recent studies of cost-sharing requirements for ED visits labeled non-emergency or nonurgent have produced mixed results. A study of state ED cost-sharing requirements in the five years following DRA enactment found no differences in ED use between states with and without those cost-sharing requirements, and no increases in the use of alternative outpatient settings.²⁷ A 2010 study of data in nine states that had imposed cost-sharing for non-emergency ED visits also suggested that cost-sharing requirements did not reduce these visits and were therefore not effective.²⁸ However, a 2015 analysis of nine years of data (from 2001 to 2009) concluded that ED visits by Medicaid enrollees in states with cost-sharing requirements were less likely to be nonurgent.²⁹

Positive and Negative Experiences

Cost-sharing requirements are intended to incentivize appropriate health care utilization while discouraging unnecessary or inappropriate care. The DRA policy allowing limited cost-sharing requirements intended to incentivize Medicaid enrollees to reduce their reliance on EDs for services that can be provided in alternate settings at reduced costs. Cost-sharing requirements have also been touted for encouraging personal responsibility and incentivizing patients to make better health care choices, which could benefit both patients and the Medicaid program overall.

However, increased cost-sharing in state Medicaid programs has been somewhat controversial because of the risks that imposing even limited cost-sharing amounts will dissuade economically marginalized enrollees from seeking ED care in emergency situations. Critics of these cost-sharing requirements maintain that most Medicaid enrollees use EDs for actual emergencies and, as discussed earlier in this report, a relatively small percentage of enrollees turn to EDs for non-emergency services that could be provided elsewhere. Accordingly, on their own, cost-sharing requirements may not incur much cost-savings and could lead some patients to avoid seeking or delay needed care.

An additional drawback of cost-sharing increases for non-emergency ED visits is that it can be challenging for hospitals to administer since, in many cases, it is frequently not possible to determine at triage whether services will be considered non-emergency and thus subject to cost-sharing. Moreover, hospitals may be hesitant to request that cost-sharing be paid upfront due to potentially violating the Emergency Medical Treatment and Labor Act (EMTALA), which requires individuals to be stabilized and treated, regardless of insurance status or ability to pay. Lastly, the administrative burden on hospitals of collecting cost-sharing amounts after care is provided may be higher than any savings incurred from the minimal cost-sharing that is collected.³⁰

RETROSPECTIVE PAYMENT DENIALS FOR NON-EMERGENCY ED SERVICES

Some states and insurers have attempted to rein in Medicaid costs by reducing or denying payment and coverage for ED services when the diagnosis is retrospectively determined to be non-emergency. One state using a variation of this incentive is Indiana, where the Indiana Health Coverage Program (IHCP) will pay hospitals for emergency services only if a screening determines that the patient has an emergency condition. Although the IHCP does not deny payment for non-emergency services, a site-of-service payment reduction is applied to those services so that payment is based on office visit rates.³¹

In 2011, the Washington State Health Care Authority made headlines by announcing its intention to limit non-emergency ED visits to three per year and to deny payment to physicians and hospitals for services related to a lengthy list of diagnoses labeled non-emergent.³² Facing significant opposition from physicians and hospitals, this policy was nixed at the last minute and replaced by an alternative plan that arose from a partnership between the Washington State Medical Association, the Washington Chapter of the American College of Emergency Physicians, the

Washington State Hospital Association, and the Health Care Authority. This multifaceted effort to reduce nonurgent ED visits coalesced around a series of best practices that saved nearly \$34 million in the program's first year, during which ED visits by Medicaid enrollees declined by 10 percent.³³ The following "ER is for Emergencies" best practices became integral to Washington State's efforts to reduce avoidable ED visits:

1. Adoption and use of an interoperable health information exchange;
2. Dissemination of materials intended to educate patients about appropriate care utilization and the difference between emergencies and non-emergencies;
3. Identification by hospitals of frequent ED users;
4. Development of care management plans for frequent ED users that incorporate information on social determinants of health;
5. Implementation of state guidelines for prescribing opioids;
6. Implementation of the state's prescription monitoring program; and
7. Engaging ED and care management staff to track ED utilization data and provide feedback.³⁴

While not specifically targeting Medicaid, large private insurers have periodically proposed coverage denials that limit payment for ED services retrospectively determined to have non-emergency ED discharge diagnoses. The AMA has advocated against such policies, as it did in 2017, when Anthem implemented policies in several states that denied coverage for many ED services and shifted the cost burden onto patients.³⁵

Relevant Research

Some studies have questioned the accuracy of retrospective payment denial policies for nonurgent ED services, which are based on claims data and assume there is a clear association between presenting symptoms and discharge diagnoses. The findings from the 2013 *JAMA* study, cited earlier in this report, cast doubt on this association and further suggest that policies that deny or limit payment based on diagnosis at discharge are not appropriate and may put some patients at risk of not getting emergency care that they need. According to the *JAMA* study:

Among ED visits with the same presenting complaint as those ultimately given a primary care-treatable diagnosis based on ED discharge diagnosis, a substantial proportion required immediate emergency care or hospital admission. The limited correspondence between presenting complaint and ED discharge diagnosis suggests that these discharge diagnoses are unable to accurately identify nonemergency ED visits.³⁶

Similar results were found in a 2018 study of a large private insurer's policy to deny coverage for ED visits when the ED discharge diagnosis is determined to be nonurgent.³⁷ This analysis of ED visits of privately insured patients between 2011 and 2015 found that nearly 40 percent of the more than 15 percent of visits with non-emergency diagnoses were in fact urgent, as evidenced by the fact that patients received emergency care. Furthermore, the presenting symptoms of patients in nearly 90 percent of the ED visits were the same as symptoms of those patients with diagnoses labeled nonemergency.³⁸

Positive and Negative Experiences

Although retrospective payment denials are likely to save money, they also violate important patient protections and undercut the practice of emergency medicine. Federal law requires insurance coverage of emergency services as defined using a prudent layperson standard that is based on symptoms, not eventual diagnoses.³⁹ Retrospective payment denial policies run the risk of violating the prudent layperson standard and also disregard patients' perceptions of their own symptoms and whether they need emergency care. Patients make care decisions based on symptoms and they should be neither encouraged to second guess their instincts that emergency care is needed nor expected to self-diagnose to determine whether, for example, chest pain is a heart attack or indigestion. Finally, the impact of policies that deny coverage and payment for emergency services based on diagnoses risks leading Medicaid patients, who may be seriously ill, to either not seek or delay seeking needed emergency medical care.

AMA POLICY

The AMA has long-standing policy supporting the prudent layperson standard (Policy H-130.970). Accordingly, this policy states that emergency services should be defined as those services provided in a hospital emergency facility after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe

pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in: (1) placing the patient's health in serious jeopardy; (2) serious impairment to bodily function; or (3) serious dysfunction of any bodily organ or part. Policy H-130.970 also directs the AMA to work with state insurance regulators, insurance companies and other stakeholders to take action to halt the implementation of policies that violate the prudent layperson standard of determining when to seek emergency care. Policy H-290.965 supports the use of ED best practices that are evidence-based to reduce avoidable ED visits.

Policy H-290.982 supports modest copays or income-adjusted premiums in Medicaid for non-emergent, non-preventive services. Policy H-165.855 states that children qualified for Medicaid should have no cost-sharing obligations. Under Policy H-290.985, the AMA advocates that enrollees in Medicaid managed care plans be educated about appropriate use of services, including at the emergency department, and availability of off-hours, walk-in primary care. This policy also maintains that Medicaid managed care plans should be responsive to cultural, language and transportation barriers to access, and provide intensive case management for high utilizers and realistic financial disincentives for beneficiary misuse of services.

Policy H-450.941 supports initiatives that protect patient access and that do not contain requirements that permit third-party interference in the patient-physician relationship, and it strongly opposes attempts to steer patients towards certain physicians primarily based on cost. Policy H-450.938 states that physicians should encourage their patients to participate in making value-based health care decisions, while Policy H-155.960 supports value-based decision-making and broad strategies for addressing rising health care costs. Policy H-155.960 also encourages third-party payers to use targeted benefit design, whereby patient cost-sharing requirements are determined based on the clinical value of a health care service or treatment, and tailoring cost-sharing requirements to patient income and other factors known to impact compliance. Policy H-185.939 supports value-based insurance design (VBID), consistent with several principles including that coverage and cost-sharing policies must be transparent and that VBID should not restrict access to care. Policy D-185.979 encourages national medical specialty societies to collaborate with payers to promote alignment of patient financial incentives with utilization of high-value services.

Under Policies H-385.921 and H-290.976, the AMA advocates for reasonable physician payments within Medicaid/CHIP, defined as a minimum of 100 percent of Medicare rates. Policy H-400.957 encourages CMS to expand the extent and amount of payment for procedures performed in the physician's office, to shift more procedures from the hospital to the office setting, which is more cost effective. Policy D-240.994 advocates that third-party payers be required to assess equal or lower facility cost-sharing for lower-cost sites of service.

The AMA has adopted principles for patient-centered medical homes, including that each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care (Policy H-160.919). These principles also maintain that enhanced access to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff. ED boarding and overcrowding are addressed by Policies H-130.940 and H-130.945. The latter policy encourages hospitals to use appropriate criteria to triage patients so those with simpler medical needs can be redirected to other appropriate ambulatory facilities. EMTALA is addressed by Policy D-130.982.

Policy H-165.822 (1) encourages new and continued partnerships to address non-medical, yet critical health needs and the underlying social determinants of health; (2) supports continued efforts by public and private health plans to address social determinants of health in health insurance benefit designs; and (3) encourages public and private health plans to examine implicit bias and the role of racism and social determinants of health. Policy H-185.920 supports continuity of care principles for financial incentive programs, including that these programs never interfere with a patient-physician relationship, and that only treating physicians can determine whether a lower-cost care option is medically appropriate. This policy also supports objective studies of the impacts of financial incentive programs.

Policy H-373.994 recognizes the increasing use of patient navigator and patient advocacy services to help improve access to care and help patients manage complex aspects of the health care system. Policy H-290.995 supports primary care case management programs for Medicaid enrollees: on a voluntary basis with incentives provided toward a prudent choice of care source; and on a mandatory basis only for those identified as overutilizers or mis-utilizers of services; and comparative analyses of these programs to determine their relative effectiveness regarding patient access, quality of and satisfaction with care, and cost reduction.

DISCUSSION

Policies aimed at reducing ED use for services that could be provided elsewhere, and at lower cost, have been debated for decades and are worthy of continued monitoring and testing. Since many states incorporate such policies into Section 1115 demonstration waivers and state Medicaid plan amendments, the Council recommends support for continued monitoring and pilot testing, by CMS and other stakeholders, of strategies and best practices for reducing non-emergency ED use among Medicaid/CHIP enrollees, particularly among patients with the highest number of ED visits. The Council believes that ongoing study of state approaches to reducing ED use, and dissemination of study results, will greatly benefit state Medicaid programs as they strive to manage health care costs without compromising care quality.

State Medicaid programs, hospitals and health systems have employed a variety of strategies to reduce non-emergency ED use, and the Council supports state flexibility in this regard since best practices will depend in part on the health needs of a state's Medicaid population. Recognizing the abundance of AMA policy that is relevant to this topic, the Council recommends support for state efforts to encourage appropriate ED use among Medicaid/CHIP enrollees that are consistent with the standards and safeguards outlined in AMA policy on ED services.

The Council understands that a complex mix of factors influences ED use and that the share of visits that are non-emergency, while difficult to discern, is relatively low. We also recognize that modest cost-sharing for non-emergency ED visits for adult Medicaid enrollees, but not for children, is consistent with AMA policy (Policies H-290.982 and H-165.855) and may incentivize some patients to make better health care choices. Although we do not recommend changes to existing policy, we conclude from the literature that modest cost-sharing requirements, on their own, may not be very effective at either reducing nonurgent ED services or generating significant cost-savings. We further question whether the cost of administering nominal cost-sharing requirements may, in some cases, be higher than any savings they generate.

Although diagnosis-based payment and coverage denials for non-emergency ED services may effectively contain costs, the Council affirms that these policies risk violating important patient protections and may potentially harm some patients—by dissuading them from seeking emergency care when needed—as well as physicians and hospitals, when payment is denied. Accordingly, the Council recommends reaffirming Policy H-130.970, which supports the prudent layperson standard for determining the need for emergency services and directs the AMA to work with state insurance regulators, insurers, and other stakeholders to halt the implementation of policies that violate this standard.

The Council believes that most Medicaid enrollees turn to EDs when they do not have access to primary care or needed specialty care—including mental health and substance use disorder treatment—and when few or no other care options are available. We further believe that strategies may be more effective if they specifically target individuals with the highest numbers of ED visits, generally a small percentage of enrollees who account for a disproportionately high amount of ED utilization. Facilitating these patients' treatment for non-emergency services in alternate settings and linking them with primary care, mental health care, and other needed services, are more likely to significantly reduce ED use and incur some cost-savings. The Council emphasizes that strategies targeting frequent ED users should be comprehensive and multifaceted, addressing not only physical and mental health needs but also socioeconomic factors that could contribute to higher rates of ED utilization. Such strategies should strive to ensure access to primary, preventive and behavioral health care, as well as substance use disorder treatment, outside of EDs through the availability of community providers and resources.

Before the COVID-19 pandemic, available state Medicaid data showed that more than 60 percent of enrollees identified as Black, Latino/a, or other individuals of color, with studies finding that enrollees of color experienced poorer outcomes and more barriers to care than whites.⁴⁰ Accordingly, state Medicaid programs should consider the potential health equity implications of strategies to reduce ED visits and address SDOH. Consistent with numerous AMA site-of-service policies (i.e., Policies H-400.957 and D-240.994), state Medicaid program strategies should focus—through patient education and empowerment, 24/7 telephone triage, and telehealth availability, among other efforts—on ensuring that all patients receive health care services in the outpatient setting most appropriate to their symptoms and needs. Accordingly, the Council recommends reaffirmation of Policy H-290.985, which advocates that a long list of criteria be used to monitor and oversee Medicaid managed care plans, including that enrollees are educated about appropriate use of services, including ED services; plans are responsive to cultural, language and transportation barriers to access; off-hours, walk-in primary care is available; there is geographic dispersion and

accessibility of participating physicians and other providers; intensive case management is provided to high utilizers; and payment levels are realistic and based on costs of care and predicted utilization levels.

Because increases in Medicaid payment rates have been found to increase enrollee access to care, the Council recommends reaffirming Policy H-290.976, which affirms the AMA's commitment to advocating that Medicaid should pay physicians at minimum 100 percent of Medicare rates. Finally, the Council recommends rescinding Policy D-130.959, which called for the development of this report.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted and the remainder of the report be filed:

1. That our American Medical Association (AMA) support continued monitoring, by the Centers for Medicare & Medicaid Services and other stakeholders, of strategies and best practices for reducing non-emergency emergency department (ED) use among Medicaid/Children's Health Insurance Program (CHIP) enrollees, including frequent ED users.
2. That our AMA support state efforts to encourage appropriate emergency department (ED) use among Medicaid/CHIP enrollees that are consistent with the standards and safeguards outlined in AMA policy on ED services.
3. That our AMA reaffirm Policy H-130.970, which supports the prudent layperson standard and directs the AMA to work with state insurance regulators, insurers, and other stakeholders to halt the implementation of policies that violate the prudent layperson standard of determining when to seek emergency care.
4. That our AMA reaffirm Policy H-290.985, which advocates that numerous criteria be used in Medicaid managed care monitoring and oversight, including that enrollees are educated about appropriate use of services, including ED services; plans are responsive to cultural, language and transportation barriers to access; off-hours, walk-in primary care is available; and intensive case management is provided to high utilizers.
5. That our AMA reaffirm Policy H-290.976, which affirms the AMA's commitment to advocating that Medicaid should pay physicians at minimum 100 percent of Medicare rates.
6. That our AMA rescind Policy D-130.959, which called for the development of this report.

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APPENDIX - AMA Policies Recommended for Reaffirmation

Policy H-130.970, “Access to Emergency Services”

1. Our AMA supports the following principles regarding access to emergency services; and these principles will form the basis for continued AMA legislative and private sector advocacy efforts to assure appropriate patient access to emergency services:

(A) Emergency services should be defined as those health care services that are provided in a hospital emergency facility after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in: (1) placing the patient's health in serious jeopardy; (2) serious impairment to bodily function; or (3) serious dysfunction of any bodily organ or part.

(B) All physicians and health care facilities have an ethical obligation and moral responsibility to provide needed emergency services to all patients, regardless of their ability to pay. (Reaffirmed by CMS Rep. 1, I-96)

(C) All health plans should be prohibited from requiring prior authorization for emergency services.

(D) Health plans may require patients, when able, to notify the plan or primary physician at the time of presentation for emergency services, as long as such notification does not delay the initiation of appropriate assessment and medical treatment.

(E) All health payers should be required to cover emergency services provided by physicians and hospitals to plan enrollees, as required under Section 1867 of the Social Security Act (i.e., medical screening examination and further examination and treatment needed to stabilize an “emergency medical condition” as defined in the Act) without regard to prior authorization or the emergency care physician's contractual relationship with the payer.

(F) Failure to obtain prior authorization for emergency services should never constitute a basis for denial of payment by any health plan or third-party payer whether it is retrospectively determined that an emergency existed or not.

(G) States should be encouraged to enact legislation holding health plans and third-party payers liable for patient harm resulting from unreasonable application of prior authorization requirements or any restrictions on the provision of emergency services.

(H) Health plans should educate enrollees regarding the appropriate use of emergency facilities and the availability of community-wide 911 and other emergency access systems that can be utilized when for any reason plan resources are not readily available.

(I) In instances in which no private or public third-party coverage is applicable, the individual who seeks emergency services is responsible for payment for such services.

2. Our AMA will work with state insurance regulators, insurance companies and other stakeholders to immediately take action to halt the implementation of policies that violate the “prudent layperson” standard of determining when to seek emergency care. (CMS Rep. A, A-89; Modified by CMS Rep. 6, I-95; Reaffirmation A-97; Reaffirmed by Sub. Res. 707, A-98; Reaffirmed: Res. 705, A-99; Reaffirmed: CMS Rep. 3, I-99; Reaffirmation A-00; Reaffirmed: Sub. Res. 706, I-00; Amended: Res. 229, A-01; Reaffirmation and Reaffirmed: Res. 708, A-02; Reaffirmed: CMS Rep. 4, A-12; Reaffirmed: CMS Rep. 07, A-16; Appended: Res. 128, A-17; Reaffirmation: A-18; Reaffirmed in lieu of: Res. 807, I-18)

Policy H-290.985, “Monitoring Medicaid Managed Care”

As managed care plans increasingly become the source of care for Medicaid beneficiaries, the AMA advocates the same policies for the conduct of Medicaid managed care that the AMA advocates for private sector managed care plans. In addition, the AMA advocates that the following criteria be used in federal and/or state oversight and evaluation of managed care plans serving Medicaid beneficiaries, and insists upon their use by the Federation in monitoring the implementation of managed care for Medicaid beneficiaries:

(1) Adequate and timely public disclosure of pending implementation of managed care under a state program, so as to allow meaningful public comment.

(2) Phased implementation to ensure availability of an adequate, sufficiently capitalized managed care infrastructure and an orderly transition for beneficiaries and providers.

(3) Geographic dispersion and accessibility of participating physicians and other providers.

(4) Education of beneficiaries regarding appropriate use of services, including the emergency department.

- (5) Availability of off-hours, walk-in primary care.
- (6) Coverage for clinically effective preventive services.
- (7) Responsiveness to cultural, language and transportation barriers to access.
- (8) In programs where more than one plan is available, beneficiary freedom to choose his/her plan, enforcement of standards for marketing/enrollment practices, and clear and comparable disclosure of plan benefits and limitations including financial incentives on providers.
- (9) Beneficiary freedom to choose and retain a given primary physician within the plan, and to request a change in physicians when dissatisfied.
- (10) Significant participating physician involvement and influence in plan medical policies, including development and conduct of quality assurance, credentialing and utilization review programs.
- (11) Ability of plan participating physicians to determine how many beneficiaries and the type of medical problems they will care for under the program.
- (12) Adequate identification of plan beneficiaries and plan treatment restrictions to out-of-plan physicians and other providers.
- (13) Intensive case management for high utilizers and realistic financial disincentives for beneficiary misuse of services.
- (14) Treatment authorization requirements and referral protocols that promote continuity rather than fragment the process of care.
- (15) Preservation of private right of action for physicians and other providers and beneficiaries.
- (16) Ongoing evaluation and public reporting of patient outcomes, patient satisfaction and service utilization.
- (17) Full disclosure of plan physician and other provider selection criteria, and concerted efforts to qualify and enroll traditional community physicians and other existing providers in the plan.
- (18) Absence of gag rules.
- (19) Fairness in procedures for selection and deselection.
- (20) Realistic payment levels based on costs of care and predicted utilization levels.
- (21) Payment arrangements that do not expose practitioners to excessive financial risk for their own or referral services, and that tie any financial incentives to performance of the physician group over significant time periods rather than to individual treatment decisions.
- (22) Our AMA urges CMS to direct those state Medicaid agencies with Medicaid managed care programs to disseminate data and other relevant information to the state medical associations in their respective states on a timely and regular basis. (CMS Rep. 5 A-96; Reaffirmed and Appended: Sub. Res. 704, I-97; Reaffirmation A-00; Reaffirmation I-04; Reaffirmed: CMS Rep. 1, A-14)

Policy H-290.976, “Enhanced SCHIP Enrollment, Outreach, and Reimbursement”

1. It is the policy of our AMA that prior to or concomitant with states’ expansion of State Children’s Health Insurance Programs (SCHIP) to adult coverage, our AMA urge all states to maximize their efforts at outreach and enrollment of SCHIP eligible children, using all available state and federal funds.
2. Our AMA affirms its commitment to advocating for reasonable SCHIP and Medicaid reimbursement for its medical providers, defined as at minimum 100 percent of RBRVS Medicare allowable. (Res. 103, I-01; Reaffirmation A-07; Reaffirmation A-11; Reaffirmed: CMS Rep. 7, I-14; Reaffirmation A-15; Reaffirmed: CMS Rep. 3, A-15; Reaffirmation: A-17; Reaffirmed: CMS Rep. 02, A-19; Reaffirmed: CMS Rep. 5, I-20; Reaffirmed: CMS Rep. 9, A-21; Reaffirmed: CMS Rep. 3, I-21)

2. CORPORATE PRACTICE OF MEDICINE (RESOLUTION 721-A-22)

Reference committee hearing: see report of Reference Committee J.

**HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
IN LIEU OF RESOLUTION 721-A-22
REMAINDER OF REPORT FILED
*See Policy TBD***

At the 2022 Annual Meeting, the House of Delegates referred Resolution 721, “Amend Policy H-215.981, ‘Corporate Practice of Medicine,’” which was sponsored by the Resident and Fellow Section. Resolution 721-A-22 asked the American Medical Association (AMA) to “amend AMA Policy H-215.981, ‘Corporate Practice of Medicine,’ by addition of a fourth clause that reads: ‘4. Our AMA acknowledges that the corporate practice of medicine has led to the erosion of the physician-patient relationship, erosion of physician-driven care and created a conflict of interest between profit and training the next generation of physicians.’”

The referral of Resolution 721-A-22 included specific concern that the study should include the impact of the corporate practice of medicine on all practice types. The Board of Trustees assigned this item to the Council on Medical Service for a report back to the House of Delegates. The Council notes that a related report is being presented by the Council on Medical Education at this meeting (CME Report 1-I-22 “The Impact of Private Equity on Medical Training”). The Council recognizes that private equity and corporate investors are becoming increasingly involved in graduate medical

education, residencies, fellowships, and training of non-physician practitioner. We have chosen to focus this report on the general aspects of the corporate practice of medicine.

BACKGROUND

The Council recently prepared CMS Report 11 at the 2019 Annual Meeting which addressed a similar topic. The corporate practice of medicine is broadly defined as non-physician investment in medical practices. Two examples of corporate medicine include private equity investment funds and physician management groups. Private equity funds are pooled investments used to buy controlling shares of companies or other entities. After taking control, private equity funds typically streamline the business (which often includes cutting costs and reducing the ability for prior physician owners to make governance decisions) with the goal of selling the business for a profit in three to seven years. The types of investment range from venture capital (VC) firms that primarily invest in early-stage companies in exchange for minority ownership to more traditional private equity firms that borrow money to take a controlling stake in mature yet undervalued or underperforming companies through leveraged buyout deals.¹ Alternatively, a practice management company is a privately held or publicly traded for-profit company that manages the back-end administrative functions of medical practices, such as insurance contracting and billing. Many practice management companies, often referred to as staffing companies, also contract with hospitals and ambulatory surgical centers to provide professional staffing and management services. Investments in practice management companies by private equity funds have led to an increase in their utilization.²

While the extent of corporate investment in physician practices is not precisely known, a growing number of physicians are employed by corporations including hospitals, health systems, and insurers. Concerns regarding these partnerships have primarily centered on the potential for subsequent increases in prices, service volume, and internal referrals, as well as the use of unsupervised non-physician practitioners. An array of factors has led to these changes, including changes in payment and delivery models, physician payment challenges, high costs of new technology and equipment, and increased administrative and regulatory burdens.

In addition to employment by hospitals, health systems, and insurers, private equity firms and publicly traded for-profit corporations may invest in physician practices. Increasingly, private equity firms have acquired majority and/or controlling interests in entities that manage physician practices. However, there is little peer-reviewed evidence regarding the impact of these arrangements on physicians, patients or health care prices, and physician opinions vary. Hospitals, health systems, academic medical centers, large multispecialty groups, and corporate buyers frequently compete with private equity investors for the same physician practice targets. Corporate buyers may also partner with private equity investors or form consortia of buyers to acquire highly sought-after practices. Increased competition for physician groups in some specialties has led price valuations of these practices to rise. Because many private equity transactions are not disclosed (non-disclosure agreements are commonly used), the degree of investment in physician practices, while believed to be relatively small overall, cannot be precisely determined. Incomplete data on corporate transactions involving physician practices is a significant impediment to determining the impact of corporate investors on physicians, patients, and the health care marketplace.³

State-by-State Differences

Generally, corporate practice of medicine doctrines prohibit corporations from practicing or interfering with the practice of medicine. The doctrines arise from state medical practice acts and are based on a number of public policy concerns, such as: (1) allowing corporations to practice medicine will result in the commercialization of the practice of medicine; (2) a corporation's obligation to its shareholders may not align with a physician's obligation to their patients; and (3) corporate interests may interfere with the physician's independent medical judgment.⁴ It is important to note that while most states have a prohibition on the corporate practice of medicine, every state provides an exception for professional corporations and many states provide an exception for employment of physicians by certain entities. For example, some states explicitly permit hospitals to employ physicians, some states allow nonprofit hospitals to employ physicians, and other states recognize an unwritten exception to the corporate practice of medicine for hospitals employing physicians.⁵ Many states that allow hospitals to employ physicians specifically prohibit the hospital from interfering with the independent medical judgment of the physician, thereby protecting the autonomy of the physician's clinical decision-making.⁶ For example, in California and Indiana, clinics and hospitals may employ physicians as long as the entity does not direct or control independent medical acts, decisions or judgments of the licensed physician. On the other hand, in Colorado and Arkansas, all shareholders and officers of a medical corporation must be licensed physicians, consistent with each state's licensing laws. In Texas, state laws allow critical access

hospitals, sole community hospitals, and hospitals in counties with fewer than 50,000 people to employ physicians, with the requirement that physicians must “retain independent medical judgment in providing care to patients at the hospital or other health care facilities owned or operated by the hospital and may not be disciplined for reasonably advocating for patient care.”⁷

Recently, there have been complaints filed in state courts arguing that some of these firms have overstepped and are in violation of state corporate practice of medicine doctrines. One example of this is a lawsuit filed in California by the American Academy of Emergency Medicine Physician Group (AAEM-PG) against Envision Healthcare Corporation. In its filing, AAEM-PG alleges that Envision is in violation of the state’s corporate practice of medicine doctrine, as Envision either forms new medical groups with non-physician officers or “installs Envision executives or officers in pre-existing medical groups.” Specifically, the lawsuit alleges that Envision: “decides how many and which physicians to hire, their compensation and work schedule...controls and influences advertising for physician vacancies, vetting physicians, establishing the terms of employment, the physician’s rate of pay, scheduling the hours physicians will work, staffing levels, the number of patient encounters and working conditions...when to terminate physicians and denies them rights to appeal via traditional medical staffing mechanisms...negotiates the groups’ contracts with third-party payers and health insurers and decides whether the group will agree to the terms...physicians are not made aware of the terms of their contracts with third-party payers.” The lawsuit was originally filed in December 2021. In May 2022, a judge for the United States District Court for the Northern District of California denied Envision Healthcare’s motion to dismiss the case; therefore, the case remains ongoing. The American College of Emergency Physicians and the California Medical Association have both filed amicus briefs in support of AAEM-PG.⁸ Further details and copies of court documents can be found on <https://www.aem.org/envision-lawsuit>.

As previously stated, there is limited data on the extent of physician practice acquisition by private equity firms; however, private equity acquisition of physician practices increased from 59 deals in 2013 to 136 deals in 2016.⁹ In April 2022, *JAMA Health Forum* published data on the geographic variations in private equity penetration of physician practices (defined as the share of physicians in private equity-acquired practices) across six specialties: dermatology, gastroenterology, ophthalmology, obstetrics/gynecology, orthopaedics, and urology. Private equity penetration was highest in the Northeast (6.8 percent) and lowest in the Midwest (3.8 percent). Twelve states and the District of Columbia (DC) have an above average share of physicians in private equity practices, while eleven states have no identified acquisitions. States with the highest private equity penetration are Washington, DC (18.2 percent), Arizona (17.5 percent), New Jersey (13.6 percent), Maryland (13.1 percent), Connecticut (12.6 percent), and Florida (10.8 percent). By specialty, private equity penetration was highest in dermatology, followed by gastroenterology, ophthalmology, obstetrics/gynecology, and orthopaedics.¹⁰

Risks and Benefits

As with any practice type, there are risks and benefits associated with entering into corporate partnerships. Risks include loss of control over the physician practice and future revenues, loss of autonomy in decision-making, an emphasis on profit or meeting financial goals, potential conflicts of interest, and potential uncertainties for non-owner early and mid-career physicians. Additionally, after a buyout there could be added layers of bureaucracy that could add burdens to physicians. Examples could be new checks and balances or updated workflows. Benefits include financially lucrative deals for physicians looking to exit ownership of their practices, access to capital for practice expenses or expansions (which may relieve physicians’ financial pressures), potentially fewer administrative and regulatory burdens on prior practice owners, and centralized resources for certain functions such as IT, marketing, and human resources.

There can also be risks to patients when physicians enter into these agreements. Recent evidence has shown a 10 percent increase in short-term mortality in private equity-owned nursing homes compared to non-private equity owned nursing homes. This is possibly due to decreases in nursing staff and declines in compliance with federal and state standards of care.¹¹ Another study evaluating private equity acquisitions of US hospitals demonstrated increased charges, increased net income, and increased patient risk scores, along with fewer Medicaid patients admitted, after private equity acquisition relative to control groups.¹² A third study showed that private equity-owned dermatology practices were associated with 3 percent-5 percent higher prices for routine medical visits at 1.5 years after acquisition as compared with non-private equity-owned practices. Other studies have shown increased rates of surprise billing, overutilization of high-margin or low-value services, and pressure to up-code charges after private equity acquisition.¹³

Impact on Patient-Physician Relationship

Research is ongoing about the effects of corporate medicine investment on patient outcomes and cost-savings. A study of 176 hospitals acquired by private equity firms during 2005-2014 was conducted to compare financial performance to matched control hospitals.¹⁴ Private equity acquisition of short-term acute care hospitals was associated with decreased costs per discharge and increased margins. The study highlights early findings on the impact private equity investment has on the health care system. Preliminary data show that financial performance improved after acquisition; however, patient utilization of services increased, and staffing decreased. Importantly, the study found that the decline in total costs per discharge was not adjusted for total full time hospital personnel, which suggests that hospitals cut costs in other dimensions, not only labor, after private equity acquisition. The authors of the study note that although improved financial performance occurred broadly, the findings are not evidence that gains in efficacy translate to improved patient outcomes or clinical experiences in either the short or long term.¹⁵

Under private equity investment, maintaining physician autonomy and a physician-led care team is crucial. Physicians should retain complete control of clinical decision making, as well as decisions regarding who is a member of their care team. Care provided by non-physician practitioners has been shown to be more costly than care provided by a physician-led team. An example of this is at the Hattiesburg Clinic in Mississippi. An examination of cost data for the South Mississippi system's accountable care organization (ACO) revealed that care provided by non-physician practitioners working on their own patient panels was more expensive than care delivered by physicians. The 2017-2019 Centers for Medicare & Medicaid Services (CMS) cost data on Medicare patients without end-stage renal disease and who were not in a nursing home showed that per-member, per-month spending was \$43 higher for patients whose primary health professional was a nonphysician instead of a physician. This finding could translate to \$10.3 million more in spending annually if all patients were followed by non-physician practitioners. Citing the results of the clinic's study, researchers found that "the results are consistent and clear: By allowing advanced practice providers to function with independent panels under physician supervision, we failed to meet our goals in the primary care setting of providing patients with an equivalent value-based experience." These findings underscore the importance of physician-led care teams, regardless of business model or private equity investment, both to control costs and improve patient outcomes.¹⁶

AMA POLICY

Long-standing AMA policy states that physicians are free to choose their mode of practice and enter into contractual agreements as they see fit.

Policy H-215.981 opposes federal legislation preempting state laws prohibiting the corporate practice of medicine; states that the AMA will continue monitoring the corporate practice of medicine and its effect on the patient-physician relationship, financial conflicts of interest, and patient-centered care; and directs the AMA to provide guidance, consultation, and model legislation regarding the corporate practice of medicine, at the request of state medical associations, to ensure the autonomy of hospital medical staffs, employed physicians in non-hospital settings, and physicians contracting with corporately-owned management service organizations.

Policy H-285.951 states that physicians should have the right to enter into whatever contractual arrangements they deem desirable and necessary but should be aware of potential conflicts of interest due to the use of financial incentives in the management of care.

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 care.

Policy H-225.947 encourages physicians who seek employment as their mode of practice to strive for employment arrangements consistent with a series of principles, including: (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 accountability across the system to those measures.

Policy H-160.960 states that when a private medical practice is purchased by corporate entities, patients shall be informed of the ownership arrangement by the corporate entities and/or physicians. Policy H-160.891 lists guidelines for physicians to consider when they are contemplating corporate investor partnerships. These guidelines include: (a) how the practice's current mission, vision, and long-term goals align with those of the corporate investor; (b) due diligence should be conducted that includes, at minimum, review of the corporate investor's business model, strategic plan, leadership and governance, and culture; (c) external legal, accounting and/or business counsels should be obtained to advise during the exploration and negotiation of corporate investor transactions; (d) retaining negotiators to advocate for best interests of the practice and its employees should be considered; (e) whether and how corporate investor partnerships may require physicians to cede varying degrees of control over practice decision-making and day-to-day management; (f) the potential impact of corporate investor partnerships on physician and practice employee satisfaction and future physician recruitment; (g) a clear understanding of compensation agreements, mechanisms for conflict resolution, processes for exiting corporate investor partnerships, and application of restrictive covenants; (h) corporate investor processes for medical staff representation on the board of directors and medical staff leadership selection; and (i) retain responsibility for clinical governance, patient welfare and outcomes, physician clinical autonomy, and physician due process under corporate investor partnerships. Additionally, Policy H-160.891 states that the AMA supports improved transparency regarding corporate investment in physician practices and subsequent changes in health care prices; encourages national medical specialty societies to research and develop tools and resources on the impact of corporate investor partnerships on patients and the physicians practicing in that specialty; and supports consideration of options for gathering information on the impact of private equity and corporate investors on the practice of medicine.

DISCUSSION

The Council recognizes that private equity investment and the corporate practice of medicine are continuing to change the health care landscape. This report describes various investment opportunities and their impact on medical practice. Anecdotally, there have been challenges associated with the corporate practice of medicine and evidence that some investment firms have overstepped and could be in violation of state corporate practice of medicine doctrines. It is clear that in order to control spending and provide optimal care for patients, care teams should be physician-led.

The AMA has long-standing policy that supports a physician's right to choose their mode of practice and type of employment, and we acknowledge that investor partnerships can be lucrative and successful. The AMA has published several resources and ethical opinions to guide physicians as they make the choice that is best for them.

The Council recommends new policy to address the concerns outlined in this report, including the potential to erode the patient-physician relationship and create conflicts of interest in medical education. In addition, the Council recognizes that the nature of corporate investor relationships could potentially change in the future and recommends amending Policy H-160.891 regarding corporate investors to strengthen the physician's role in clinical decision-making, medical education, and determining the composition of the care team.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 721-A-22, and the remainder of the report be filed:

1. That our American Medical Association (AMA) acknowledge that the corporate practice of medicine has the potential to erode the patient-physician relationship.
2. That our AMA acknowledge that the corporate practice of medicine may create a conflict of interest between profit and best practices in residency and fellowship training.
3. That our AMA amend Policy H-160.891 by addition of two new clauses, as follows:
 - j. Each individual physician should have the ultimate decision for medical judgment in patient care and medical care processes, including the supervision of non-physician practitioners.
 - k. Physicians should retain primary and final responsibility for structured medical education inclusive of undergraduate and graduate medical education including the structure of the program, program curriculum, selection of faculty and trainees, as well as educational and disciplinary issues related to these programs.

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3. HEALTH SYSTEM CONSOLIDATION

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

At the 2022 Annual Meeting, the House of Delegates adopted Policy D-215.984, "Health System Consolidation," which was sponsored by the Private Practice Physicians Section. Policy D-215.984 asks the American Medical Association (AMA) to (1) "study nationwide health system and hospital consolidation for the benefit of patients and physicians who face an existential threat from health care consolidation," and (2) "regularly review and report back on these issues to keep the House of Delegates apprised on relevant changes that may impact the practice of medicine, with the first report no later than A-23." This report, which is presented for the information of the House of Delegates, summarizes hospital and hospital-physician group merger and acquisition activity, including background and trends on hospital and hospital-physician group consolidation. This is the first report of a series the Council will be working on addressing this and related topics.

The Council notes that this report specifically addresses hospital and hospital-physician group consolidation, regardless of ownership model. Further information on the corporate practice of medicine and private equity investment in health care can be found in CMS Report 2-I-22, which is before the House at this meeting. A primary purpose of this report is to provide background and baseline knowledge for upcoming reports on this topic. A glossary of common terms and abbreviations can be found in Appendix A.

BACKGROUND

Horizontal and Vertical Integration

There are two types of integration for firms to pursue when merging with or acquiring other firms. Horizontal consolidation occurs when one entity acquires or merges with another entity at the same level in an industry. An example of horizontal integration in health care would be two hospitals merging with one another. Vertical

consolidation occurs when one entity acquires or merges with another entity at a different level of industry. In health care, an example of vertical consolidation would be a hospital or health system acquiring a physician practice.

A critical question is whether mergers and acquisitions are beneficial or harmful to society. Theoretically, both types of integration can result in both benefits and harms. Horizontal integration can lead to economies of scale, which could reduce the cost of production and lower prices, but it can also lead to the exercise of market power and increase prices or lower quality. Horizontal integration could also lead to potential loss of physician autonomy. Vertical integration between physicians and hospitals has several potential benefits, including improved care coordination, improved alignment of provider incentives through the “internalization” of externalities, less duplication of services, and economies of scale for administrative functions such as deployment of health records, which reduce prices or improve quality. However, vertical integration could also hurt merging parties’ competitors by inhibiting them from accessing needed supplies for production or raising their costs. Moreover, Medicare billing practices could make hospital-based outpatient care more expensive than that based in a physician office. In these cases, vertical integration could lead to higher prices or spending. In short, each type of integration could lead to different outcomes and could have different impacts on price, quality, and/or spending.

Market Definition, Market Shares, and the Herfindahl-Hirschman Index (HHI)

Firms’ market shares are a critical metric in the assessment of the competitive effects of mergers and acquisitions. In general, firms with larger market shares may be more able to engage in anticompetitive conduct. One way to assess the level of market competition is by determining the level of market concentration. Market concentration can be measured by calculating the HHI, which is a useful indicator of market power and serves as a signal of the likely impact of a merger on competition. The Department of Justice (DOJ) and the Federal Trade Commission (FTC) use the HHI as an aid in assessing the potential for anticompetitive effects of proposed horizontal mergers. They may also consider market shares and market concentration in the evaluation of vertical mergers. The HHI is the sum of the squared market shares for all firms in a market. As an example, a market with 4 firms that each held 25 percent of the market share would have an HHI of 2,500. The largest value HHI can reach is 10,000, indicating a monopoly, where one entity holds the entire market share. A higher HHI indicates greater concentration and suggests lower market competition.¹

Health care markets are generally considered to be local, as health care consumers need to travel to obtain care. Studies typically define hospital geographic markets as metropolitan statistical areas (MSAs). Markets that are very large (e.g., New York, Chicago), can be defined as smaller parts of those MSAs called metropolitan divisions. The HHI is calculated for each MSA. Using data from 2013, 2016, and 2017, one study found that in 95 percent of MSA-level markets in the United States, at least one hospital (or hospital system) had a market share of 30 percent or greater in those years. Seventy-two percent of markets had one hospital (or hospital system) with a share of 50 percent or more in 2016 and 2017. Additionally, in 40 percent of markets, a single hospital (or hospital system) had a market share of 70 percent or more in 2016 and 2017.² Over half (55 percent) of markets experienced an increase in concentration between 2013 and 2017. In 17 percent of markets, the HHI equaled 10,000 in both of those years, indicating a monopoly. In 2017, the average HHI across markets was 3,853 and 92 percent of markets were considered highly concentrated.³ It is crucial to note that the study cited here considers the potential weakness with HHI calculation and looked only at comparable hospitals within a market when calculating market concentration. The study specifically outlines this when explaining the data and methods used in calculating HHI for these markets.

Changes in Practice Ownership and Physician Employment

The COVID-19 pandemic put tremendous strain on the health care industry, particularly on smaller practices. With smaller practices finding it difficult to continue to operate independently, larger health systems had an opportunity to acquire them. The Coronavirus Aid, Relief, and Economic Security Act and the Paycheck Protection Program and Health Care Enhancement Act allocated \$175 billion for grants to providers that were partly intended to make up for revenue lost due to coronavirus, but analysis shows that the first \$50 billion in grants were not targeted to providers most vulnerable to revenue losses.⁴ The resulting economic pressure on physicians could potentially lead to more mergers or closing of private practices, resulting in physicians then seeking employment within a hospital or health system.

However, changes in physician practice arrangements were already underway prior to the COVID-19 pandemic. According to the AMA’s 2020 Physician Practice Benchmark Survey, almost 40 percent of physicians worked directly

for a hospital or for a practice that was at least partially owned by a hospital or health system—up from 29 percent in 2012. In 2020, 50.2 percent of physicians were employed, compared to 41.8 percent in 2012, and 44 percent had an ownership stake in their practice—lower than the 53.2 percent who were owners in 2012. In fact, 2020 was the first year in which less than half (49.1 percent) of physicians worked in practices that were wholly owned by physicians (i.e., private practice).⁵ This percentage includes the physicians who are private practice owners (38.4 percent of all physicians), the employed physicians who work for them (8.2 percent), and the physicians who are on contract with the practice (2.5 percent).⁶ As the number of physicians in private practice has fallen, the share of physicians who work directly for a hospital or for a practice at least partially owned by a hospital or health system has increased.

Antitrust Enforcement and Regulation

Consolidation in health care is under increased scrutiny by antitrust authorities and state regulators.⁷ At the federal level, the FTC is tasked with reviewing mergers involving hospitals and physicians. While a handful of mergers have been blocked in recent years, health care markets continue to become more consolidated. The FTC cites several constraints on their ability to enforce antitrust laws in the health care sector. Most notably, the FTC and DOJ antitrust division budgets have remained flat, even as the pace of mergers has increased.⁸ It is important to note that vertical integration is a particular challenge to regulate. For example, this would include a hospital or health system acquiring a physician practice. A challenge arises because such transactions mostly fall under the threshold required for FTC/DOJ notification and review. Thus, they can proceed without antitrust scrutiny that could otherwise assess and weigh their benefits and harms. Another noted challenge is the inability of the FTC to enforce antitrust rules on non-profit hospitals (although it can review mergers that involve a non-profit hospital). In 2019, 66 percent of hospital and health system mergers and acquisitions involved a non-profit entity purchasing another non-profit entity, putting these transactions out of the scope of FTC review.⁹

In 2013, the FTC and state of Idaho sued St Luke’s Health System and Saltzer Medical Group for violating the Clayton Act and state antitrust laws. The complaint alleged anticompetitive effects in the primary care market. According to the complaint, the combination of St. Luke’s and Saltzer would give it the market power to demand higher rates for health care services provided by primary care physicians in Nampa, Idaho and surrounding areas, leading to higher costs for health care consumers.¹⁰ The district court did note that they believed that St. Luke’s and Saltzer genuinely intended to move towards a better health care system, but ultimately found that the “huge market share” of the post-merger entity “creates a substantial risk of anticompetitive price increases” in the primary care market in Nampa, Idaho, where the facilities are located. The ruling was appealed and upheld in 2015, resulting in the unwinding of the merger of these two entities.¹¹

States play a significant role in regulating hospital markets. 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.

Summary of Recent Transactions

The 2021 Health Care Services Acquisition Report highlights hospital merger and acquisition activities for the past five years. Hospital merger and acquisition activity dropped off in 2020 as the coronavirus pandemic swept the United States and hospitals’ finances were ravaged as a result.¹² Sixty-five of the 79 hospital merger and acquisition deals announced in 2020 were United States-only targets that were not involved in bankruptcy proceedings.¹³ These deals covered 119 hospitals and 15,996 beds. The total acquired revenue figure for 2020 was nearly \$16.4 billion.¹⁴ Full details on all hospital and health system mergers and acquisitions can be found in the 2021 Health Care Services Acquisition Report (Twenty-Seventh Edition). The table below shows notable hospital transactions in the United States in 2020:¹⁵

Notable US Hospital Transactions, 2020

Acquirer	Target	Price	Hospitals	Beds
Novant Health	New Hanover Regional Medical Center	\$1,500,000,000	1	677
Prime Healthcare Services	St. Francis Medical Center	\$275,000,000	1	344
Banner Health	Wyoming Medical Center	\$207,000,000	1	212
Carle	2 Advocate Aurora hospitals	\$190,000,000	2	231
Orlando Health	Bayfront Health St. Petersburg	\$147,135,471	1	343
Chan Soon-Shiong Family Foundation	St. Vincent Medical Center	\$135,000,000	1	320
LCMC Health	East Jefferson General Hospital	\$90,000,000	1	309
Iron Stone Real Estate Partners	St. Christopher’s Hospital for Children	\$65,000,000	1	188

Source: HealthCareMandA.com, January 2021. Health Care Services Acquisition Report (Twenty-Seventh Edition. Does not include transactions that took place outside of the United States.)

The table below shows the largest physician medical group transactions from 2016-2020:¹⁵

Notable US Physician Medical Group Transactions, 2020

Acquirer	Target	Price	Year
KKR & Co. L.P.	Envision Healthcare Corporation	\$9,900,000,000	2018
Envision Healthcare Holdings, Inc.	AmSurg Corp.	\$6,726,000,000	2016
The Blackstone Group	TeamHealth Holdings, Inc.	\$6,100,000,000	2016
Optum	DaVita Medical Group	\$4,340,000,000	2017
Optum	Surgical Care Affiliates, Inc.	\$3,277,410,000	2017
West Street Capital Partners VII	Capital Vision Services LP	\$2,700,000,000	2019
Partners Group	EyeCare Partners	\$2,200,000,000	2019
Summit Partners	Sound Inpatient Physicians Holdings, LLC	\$2,150,000,000	2018
Ares Management L.P.	DuPage Medical Group	\$1,450,000,000	2017
Aspen Dental Management, Inc.	Clear Choice Management Services	\$1,100,000,000	2020

Source: HealthCareMandA.com, January 2021. Health Care Services Acquisition Report (Twenty-Seventh Edition. Does not include transactions that took place outside of the United States.)

Impacts on Health Care Price and Quality

Previous studies show that both horizontal and vertical integration impact the price of health care. However, research on the impact of hospital and hospital-physician consolidation on quality of care is limited and inconclusive. Research suggests that horizontal and vertical integration among providers is associated with higher health care prices paid by private insurers. In Medicare, payment policies protect Medicare from increased prices due to horizontal consolidation but have led to higher Medicare costs in the case of vertical integration.

In the case of horizontal integration, the 2020 Medicare Payment Advisory Commission reviewed published research on hospital consolidation and concluded that the “preponderance of evidence suggests that hospital consolidation leads to higher prices.” An analysis of data from employer-sponsored coverage found that hospitals that do not have any competitors within a 15-mile radius have prices that are 12 percent higher than hospitals in markets with four or more competitors. Furthermore, a separate analysis of hospital mergers over a 5-year period found that mergers of two hospitals within five miles of one another resulted in an average price increase of 6.2 percent and that price increases continued in the two years following the merger.¹⁶

There is evidence that prices increase even when hospitals merge with other hospitals in different geographic markets. One analysis found that prices at hospitals acquired by out-of-market systems increased by about 17 percent more

than unacquired, stand-alone hospitals. One reason for rising prices following mergers is that larger hospital systems can influence the dynamics of negotiations with insurers and shift volume to higher cost facilities. For example, hospital systems with significant bargaining power may require that insurers include all hospitals in their system in a provider network. This can lead to higher cost hospitals being in a provider network when there are lower cost hospitals nearby. In one recent antitrust case in California, the Sutter Health system was accused of violating antitrust laws by using its market power to illegally drive up prices. In the settlement, Sutter Health agreed to stop requiring that all of its hospitals be included in an insurer's network and also agreed to pay additional damages.¹⁷

Vertical integration between hospitals and physicians can also raise prices or spending. A study analyzing highly concentrated markets in California found that an increase in the share of physicians in practices owned by a hospital was associated with a 12 percent increase in premiums for private plans sold in the state's Affordable Care Act Marketplace. Additionally, a study conducted to examine Medicare beneficiaries' pattern of health care utilization found that "patients are more likely to choose a high-cost, low-quality hospital when their physician is owned by that hospital." In May 2022, *Health Affairs* published a study on the price effects of vertical integration and joint contracting in Massachusetts. This study found that vertical integration and joint contracting led to price increases from 2013 to 2017, from 2.1 percent to 12.0 percent for primary care physicians and from 0.7 percent to 6.0 percent for specialists, with the greatest increases seen in large health systems.¹⁸

Studies examining the impact of consolidation on quality of care have produced mixed results. Some studies have shown that quality does not improve, or even gets worse, after vertical integration and others have shown modest improvements. One study of 15 integrated delivery networks found no evidence that hospitals in these systems provide better clinical quality or safety scores than competitors. Another study found that larger hospital-based provider groups had higher per beneficiary Medicare spending and higher readmission rates than smaller groups. However, one other study found that vertical integration had a limited positive effect on a small subset of quality measures.¹⁹ Regarding horizontal consolidation, studies have shown that quality may decrease in highly concentrated markets. One study found that risk-adjusted one-year mortality for heart attacks in Medicare patients was 4.4 percent higher in more highly concentrated hospital markets compared to less concentrated markets. A study published in 2020 followed hospitals for three years after a merger and compared outcome measures with a control group of hospitals that had no change in ownership. The analysis found that scores for 30-day readmissions and mortality rates among patients discharged from a hospital did not improve in the hospitals that merged, when compared to the control group. Given the differences in these results, it is imperative for these systems to continue to collect data and monitor potential impacts of consolidation on the quality of care. In sum, although previous research generally finds that horizontal and vertical integration among providers is associated with higher health care prices, the net effect of such integration on quality is yet unknown.

AMA POLICY AND ADVOCACY

The Council reviewed relevant AMA policy and highlights Policy H-215.960, established by Council on Medical Service Report 7-A-19: (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; (d) antitrust relief for physicians remains a top AMA priority; and (e) close monitoring of health care markets is a key aspect of AMA antitrust activity.

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 FTC and DOJ, and the creation of practical physician resources. Furthermore, the AMA has pursued alternative solutions that promote competition and choice, including: eliminating state certificate of need laws; repealing the ban on physician-owned hospitals; reducing the administrative burden to enable physicians to compete with hospitals; and achieving meaningful price transparency (Policy H-215.960).

In addition, 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-led hospitals. Repealing this ban would allow new entrants into hospital

markets, thereby increasing competition. 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 (Policy D-215.995).

In the event of a hospital or health system merger, acquisition, consolidation or affiliation, the AMA believes 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) 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 efficient performance data for all participants and accountability across the system to those measures (Policy H-215.969).

DISCUSSION

While it is recognized that most hospital markets are highly concentrated and do not function as well as they could, or should, it is also recognized that hospital markets are local, and 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.

Consistent with Policy D-215.984, the Council will continue to monitor trends in health system consolidation and the impact on physicians and their patients, using additional data when available. As previously noted in CMS Report 7-A-19, the Council remains concerned regarding the potential negative consequences for physicians and patients in highly concentrated hospital markets (such as increased prices, reduced choice, and fewer physician practice options). In addition to reviewing the current 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 Council believes it is not possible to actively oppose all future hospital mergers. Attempting to address hospital mergers in the same manner the AMA has addressed major health insurance mergers would require enormous resources and may alienate AMA members who work for hospitals and health systems.

While previous studies suggest that hospital and hospital-physician consolidation is associated with higher health care prices, the impact on quality of care is still unknown. The economic pressures facing physicians were exacerbated by the COVID-19 pandemic and could result in continued mergers—both horizontal and vertical. Struggling private practices may find it beneficial to join with other private practices to form a larger practice (horizontal integration) or be acquired by a hospital or health system (vertical integration).

CONCLUSION

Hospital and hospital-physician mergers are shown to increase health care prices and spending. Nonetheless, the impact of hospital and hospital-physician mergers on the quality of health care and patient outcomes is limited and inconclusive at this time. The AMA has robust policy and guidelines on hospital and hospital-physician mergers and acquisitions. In accordance with Policy D-215.984, the Council will continue to review and report back to the House of Delegates as any new data become available, especially with respect to the impact of these mergers on health care prices and quality of care. The Council's review could include monitoring relevant FTC-DOJ mergers to determine trends and better understand the impact of these mergers on hospitals, health systems, and physician groups.

This report represents the first in a series on health system consolidation and related topics. Potential future report topics may include physician satisfaction and burnout associated with mergers, acquisitions, and consolidation; anti-trust issues; hurdles physicians face when starting a private practice either within a hospital employment or non-employed setting before and after a hospital merger; quality of care; and impacts on patient outcomes and mortality.

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APPENDIX - Glossary of Terms

Antitrust – The regulation of the concentration of economic power, particularly in regard to monopolies and other anticompetitive practices. Antitrust laws exist as both federal and state statutes.

Department of Justice (DOJ) – A federal executive department of the United States government. Specific Antitrust Division housed within the Department whose mission is to promote economic competition through enforcing and providing guidance on antitrust laws and principles. The DOJ Antitrust Division works closely with the Federal Trade Commission (FTC) to review potential mergers and acquisitions.

Federal Trade Commission (FTC) – An independent agency of the United States government whose principal mission is the enforcement of civil U.S. antitrust law and the promotion of consumer protection. These laws promote vigorous competition and protect consumers from anticompetitive mergers and business practices. The FTC shares jurisdiction over federal civil antitrust enforcement with the DOJ Antitrust Division.

Herfindahl-Hirschman Index (HHI) – A commonly accepted measure of market concentration calculated by squaring the market share of each firm competing in the market and then summing the resulting numbers. HHI calculations of 10,000 indicate a monopoly.

Horizontal Integration – A business strategy in which one company acquires or merges with another that operates at the same level in an industry. An example in health care would be two hospitals merging or two physician practices merging.

Integration vs. Consolidation – Closely related, but not synonymous. Consolidation typically refers to mergers and acquisitions. Consolidation does not necessarily imply integration. Integration means firms are truly integrating their operations, for the purpose of aligning and creating efficiency.

Metropolitan Statistical Area (MSA) – A core area containing a substantial population nucleus, together with adjacent communities having a high degree of economic and social integration with that core. MSAs are determined with the U.S. Census and are one way to define geographic markets when calculating the HHI. Particularly large MSAs (i.e., New York City, Chicago, Los Angeles, etc.) are further broken down into submarkets.

Vertical Integration – The combination in one company of two or more stages of production normally operated by separate companies. An example in health care: hospitals can buy physician groups or health systems can form drug companies.