PHYSICIAN-LED HEALTHCARE FOR AMERICA

Physician-Led Healthcare for America Statement for the Record
House Energy and Commerce Committee, Health Subcommittee
Hearing on "Lowering Unaffordable Costs: Legislative Solutions to Increase Transparency and Competition in Health Care"

April 26, 2023

Physician-Led Healthcare for America (PHA) is pleased to submit this statement for the record of the April 26, 2023, hearing on transparency and competition in healthcare, "Lowering Unaffordable Costs: Legislative Solutions to Increase Transparency and Competition in Health Care," before the Subcommittee on Health of the Committee on Energy and Commerce, U.S. House of Representatives. PHA strongly supports H.R. 977, the Patient Access to Higher Quality Health Care Act of 2023, introduced by Representative Burgess, M.D. (R-TX), with bipartisan support, and appreciates the committee's inclusion of this measure as a part of the hearing.

PHA promotes, educates and advocates for exceptional patient-centered care through physician leadership on behalf of our physician-led and physician-owned hospital members across the United States. We represent physician-led hospitals (PLHs) dedicated to a healthcare system that focuses on the most important partnership in healthcare: the patient-physician relationship. The data are clear: PLHs offer outstanding quality and efficiency to meet the needs of patients and communities.

Since the Affordable Care Act's (ACA's) passage, PLHs have consistently demonstrated that they reduce costs while delivering a high quality of care to patients who live in communities that feature PLHs. Unfortunately, patient access to these high-performing facilities has been limited by the anti-competitive effects of section 6001 of the ACA. The enactment of H.R.977 into law would serve as a tool to combat the higher prices and hospital consolidation that continue to rapidly unfold in the healthcare system.

Energy and Commerce Committee Chair Rodgers (R-WA) and Health Subcommittee Chair Guthrie (R-KY) emphasized in their press release in advance of the hearing the need to empower patients through greater access and choice to healthcare services: "Americans' budgets are being stretched increasingly thin, as health care costs continue to rise at unsustainable rates." Passing H.R. 977, as well as the Senate companion bill (S.470) introduced by Senator Lankford (R-OK), would end the ACA Section 6001 ban on the creation of new and the expansion of existing hospitals with ownership by physicians.

Physician-Led Hospitals: Cost Reduction Leaders

PLHs provide care at lower costs, which generates savings for patients and government healthcare programs. A September 2022 study by *NDP Analytics* found that PLHs produced $217 million in savings to the Medicare program alone, despite the ACA ban that stifles competition and expansion

of this care modality.[1] The report went on to indicate that hospitals below median cost per Medicare beneficiary were at 59 percent for PLHs, whereas non-PLHs were at 51 percent.

Additionally, in the most recent data provided by the Medicare Comprehensive Care for Joint Replacement (CJR) Model, which is designed to improve care for Medicare patients undergoing hip and knee replacements performed in the inpatient setting, PLHs demonstrated significant Medicare cost saving. The CJR program shared savings with the participating hospitals through reconciliation payments; the higher the reconciliation amount, the higher the savings. The average reconciliation payment for the PLH four-year CJR period was $1,562 per case, which is compared to $918 for hospitals without physician ownership, a 70.1 percent higher reconciliation. The CJR program has been successful, and PLHs have been a major contributor to its success in terms of improving outcomes and lowering costs.[2]

Opponents of PLHs have levied unfounded claims regarding "cherry picking" by PLHs. The reality is that PLHs offer a similar patient mix when compared to non-PLHs. A pivotal study out of Harvard, which was published by the British Medical Journal, stated that "[PLHs] were nearly identical to [non-PLHs] in almost every metric that we examined, including their proportions of Medicaid patients and those from ethnic and racial minority groups."[3] This unbiased peer reviewed article definitively refutes the unsubstantiated argument by opponents that PLHs cater to wealthier and less sick patients. In fact, 2022 aggregate Medicare data demonstrate the reality that PLHs performed higher than hospitals without physician ownership. PLH Medicare and Medicaid discharge rates were 35 percent, compared to 34.8 percent for hospitals without physician ownership.[4]

Medicare and some Medicaid programs have built patient risk metrics into their payment formulas (and quality programs) that adjust for patient population variation. In addition to long standing disproportionate share hospital payments (DSH), these risk adjustments have leveled the reimbursement playing field. The reality is that PLHs are paid less (and therefore it costs the government less) for surgeries done in these facilities when compared to large system facilities.

Physician-Led Healthcare: Physician Ownership Exceptions Allow Competition Across Other Health Segments

Medicare allows physician ownership in numerous settings, including ambulatory surgery centers, imaging, physical therapy, value-based arrangements and other segments of the healthcare industry. The Centers for Medicare & Medicaid Services (CMS) stated in a November 20, 2020, final rule that exemptions to the physician self-referral law are allowed "to design and enter into value-based arrangements without fear that legitimate activities to coordinate and improve the quality of care for patients and lower costs would violate the Stark Law." Ultimately, exemptions to the ban on physician ownership are allowed in numerous cases in which physician ownership improves quality and efficiency for Medicare patients, and the physician ownership of hospitals is no different than these scenarios.

As Representative Burgess has stated well: "Hospitals can own physicians and physician practices, but physicians cannot own hospitals." Allowing health insurers, health systems and other for-profit entities to own and purchase hospitals, while blocking physicians from doing so, creates an un-level playing field that boxes out the highest trained medical professional from ownership. This anti-

[1] https://physiciansled.com/wp-content/uploads/2022/09/Economic-Impact-Report-2022-1.pdf.
[2] Source: CMS Final Performance Year 3 Reconciliation Payments and Preliminary Performance Year 4 Reconciliation Payments.
[3] *BMJ* 2015; 351 doi: https://doi.org/10.1136/bmj.h4466 (Published 02 September 2015).
[4] Analysis of 2022 American Hospital Directory data.

competitive ban does not serve the most important healthcare stakeholder, our patients, who benefit from the medical care and treatment at these facilities.

Hospital, Physician and Health Plan Consolidation and Self-Referral Patterns

Both sides of the political aisle have expressed strong concerns related to the consolidation of hospitals, physicians and commercial health insurance plans. As President Biden underscored in his 2021 "Executive Order on Promoting Competition in the American Economy," hospital mergers and the associated market consolidation, including health insurer and health system acquisitions by non-profit and for-profit entities, is not reducing healthcare costs for employers or the government. Instead, many of the acquisitions are proving to be harmful to patients.

It is critical for each community to have a healthcare ecosystem that features a variety of hospitals, physician practices and commercial health insurance plans. Unfortunately, our nation is running out of tools to allow physicians and hospitals to remain independent, and independent physicians and hospitals represent one piece of a healthy healthcare ecosystem. PLHs represent one of the final tools remaining to create competition in our nation's healthcare markets.

Almost 75 percent of physicians nationally are employed by either hospitals, health systems health insurers or other entities, as cited by the Physicians Advocacy Institute (PAI) in an extensive analysis. The study found that 74 percent of primary care physicians, 75 percent of surgical specialties, 75 percent of pediatricians and 82 percent of internal medicine subspecialties are now employed across the country. Further, PAI found that the time period of 2019 to 2021 featured a 25 percent increase in hospitals or corporate entities purchasing physician practices.[5]

Hospital-physician practice consolidation has led to contractually mandated self-referral and increased utilization of healthcare services by physicians within the systems that purchase their practices. This is one of the primary reasons that healthcare costs have experienced such a dramatic increase. Little, if any, research exists to suggest that market consolidation has increased quality of care or reduced costs. In fact, there have been more questions about the effect of these mergers on decreased quality and higher costs. A 2016 study found that "a hospital's ownership of a physician dramatically increases the probability that the physician's patients will choose the owning hospital," and further that "patients are more likely to choose a high-cost, low-quality hospital when their physician is owned by that hospital."[6] In addition, Martin Gaynor of Carnegie Mellon University, a leading expert on healthcare consolidation, concluded in testimony before the U.S. Senate in 2021 that "the strongest scientific studies find that quality is lower where there's less competition."[7]

Consolidation also contributes to physician burn-out, as addressed by a 2023 paper on hospital competition: "[T]hese harms also can extend upstream into healthcare labor markets, as reflected by a recent epidemic of physician burn-out, which has been attributed to a loss of control over the clinical practice environment."[8] PLHs offer an environment which supports physician autonomy and

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[5] Physicians Advocacy Institute and Avalere Health, "Physician Employment and Acquisitions of Physician Practices 2019-2021 Specialties Edition," June 2022.
[6] Baker, Laurence & Bundorf, M. & Kessler, Daniel. (2016). The Effect of Hospital/Physician Integration on Hospital Choice. Journal of Health Economics. 50. 10.1016/j.jhealeco.2016.08.006.
[7] U.S. Senate Committee on the Judiciary Subcommittee Hearing: "Antitrust Applied: Hospital Consolidation Concerns and Solutions." May 19, 2021.
[8] Mandelberg, Matthew and Smith, Michael and Ehrenfeld, Jesse and Miller, Brian, Hospital Competition and Restrictions on Physician-Owned Hospitals (February 5, 2023). Available at SSRN: https://ssrn.com/abstract=4350105 or http://dx.doi.org/10.2139/ssrn.4350105.

the physician-patient relationship, alleviating the lack of control many physicians experience in other settings.

PLHs and High-Quality Care – Benefits of Physician Leadership

Numerous recent articles in peer reviewed publications highlight the value of PLHs in both quality and cost. For example, a systematic review published by the Mercatus Center found that PLHs provide either higher quality care at lower cost with greater efficiency or equivalent care, when compared to other community hospitals.[9] PLHs include both acute care (or community) hospitals as well specific focus hospitals. These competitive alternatives preserve the patient-physician relationship by giving patients increased choice in care sites and modalities while preserving physicians' greater autonomy in care decisions for the benefit of their patients.

The authors further emphasized the benefits of "integrated, coordinated care delivery." Within PLH models, these experts identified an increasing focus on value, improving and increasing the capability of "sharing clinical information" at the point of care, "improving consumer experience of care delivery," and providing patients with certain aspects of "one-stop shopping" that may not be available otherwise.

The most recent CMS Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) data show that PLHs have markedly higher patient experience ratings when compared to all hospitals. Patient satisfaction and experience are critical components of improved healthcare delivery and important markers for healthcare access. In addition, specialty PLHs (cardiology and orthopaedic) were found to deliver *higher quality care than non-profit hospitals, with lower rates of hospital readmission or mortality for high-risk surgery*. For example, PLHs offer significantly lower costs for high quality, critically needed services such as hip and knee replacement and cardiac bypass surgery, all of which keep our seniors mobile, healthy and independent. Further, in the four years of the CJR program, 48.4 percent of the PLHs received an Excellent CQS compared to only 19.8 percent of the hospitals without physician ownership.

Patients are best served when physicians are at the center of healthcare delivery, where patients and physicians work together to identify optimal treatment plans, because the goals of the hospital, the patients and physician owner are integrally and inseparably aligned in a PLH. This cannot be universally claimed in the non-PLH setting.

Physician-Led Healthcare and Increased Patient Access for All Patient Populations

The removal of the anticompetitive and arbitrary ban instituted by section 6001 of the ACA would advance much needed competition among healthcare facilities and physicians. It would also help protect the vital (but vanishing) rural hospitals. These essential institutions, once prevalent across this country, form a foundational fabric of the rural safety net system of health and medical care delivery. In addition, they often represent one of the largest employers in a community. However, rural hospitals are either closing in a rapid manner or at risk of closing in many communities.[10] For example, a recent study by Chartis found that 143 rural hospitals closed in the past 13 years. Meanwhile, another 453 rural hospitals are vulnerable to closure, while 43 percent of all rural hospitals feature negative operating margins.[11] Recent legislative and regulatory efforts have not

[9] Mercatus Center Systematic Review, September 7, 2021.
[10] Center for Healthcare Quality and Payment Reform; numerous studies available, including "Rural Hospitals at Risk of Closing."
[11] Chartis, https://www.chartis.com/insights/rural-health-safety-net-under-renewed-pressure-pandemic-fades, February 7, 2023.

addressed this issue, and PHA believes that this is because policymakers have failed to focus on the actual receivers and providers of care – patients and physicians. Instead, the measures have simply focused on the facilities and/or their ancillary services.

Americans are inundated with countless media reports of rural and urban hospitals and other health facilities closing departments of care because the facilities cannot sustain the functions without physicians staffing and providing the majority of the needed healthcare services.[12] However, it is not just rural Americans who are in need of access to these services; urban and suburban communities are also facing closures due to the unchecked and widespread consolidation of physician practices and hospital systems, physician retirements or the closure of physician practices.

Hospital Bed Shortage: PLHs as a Solution

The Covid-19 pandemic exposed the insufficiency of hospital beds in the United States. In 1975, the nation featured 1.5 million hospital beds. However, by 2019 the number had dropped to just 919,000, or approximately two beds per 1,000 individuals (the US ranks 27th in the world, with Japan topping the list at nearly 13 beds per 1,000 individuals).

Fortunately, PLHs were ready to step up in many communities to meet the Covid-19 pandemic hospital bed deficits. Physician-led community hospitals stepped up during the pandemic to fill a significant part of that gap by providing Covid-19 care to patients. In other cases, physician-led surgical hospital partners of larger community hospital systems took the surgical burden off the community hospitals to allow the community hospitals to focus on Covid-specific care.

The PLH response to Covid-19 makes it clear that it is critical to ensure that PLHs have the flexibility to meet any need facing a community and not be handcuffed by arbitrary, anti-competitive growth restrictions.

PLH Community Investment

PLHs make significant economic impacts in local communities and, ultimately, the country as a whole. According to the 2022 NDP Study, "in 2021, physician-led hospitals supported over 166,000 jobs with $10.3 billion in wages. They generated $43.1 billion in economic activity for the economy and paid an estimated $1.2 billion in payroll and income taxes."[13]

The ACA's prohibition on PLHs eliminated 45 hospital expansion projects and stopped more than 75 planned new or under development hospitals. It resulted in a $275 million loss of economic activity for the halted expansion projects and $2.2 billion in losses attributed to the new and under development hospitals.[14]

Conclusion

PHA's physician-led hospital members are ready and willing to invest in healthcare delivery modernization, workforce recruitment and retention, and increased patient choice for medical services close to home – to increase price, quality and innovation competition. We offer a

[12] Gruca TS, Nelson GC, Shultz C. Trends in Rural Outreach by Orthopedic Surgeons. Iowa Orthop J. 2021;41(1):25-31. PMID: 34552400; PMCID: PMC8259181.
[13] https://physiciansled.com/wp-content/uploads/2022/09/Economic-Impact-Report-2022-1.pdf.
[14] "Reversing Hospital Consolidation: The Promise of Physician-Owned Hospitals", Health Affairs Blog, April 12, 2021.

competitive force to enhance patient-centered care and grow healthcare infrastructure – putting patients and their relationship with physicians at the center of the healthcare delivery equation and countering the forces of consolidation that are raising prices without improving quality.

We must take advantage of the vital resource that physician-led healthcare offers to immediately help counteract the negative consequences of consolidation. It is time to allow physicians to lead healthcare delivery in their communities. It is time to make sure that we gain, not lose, access to specialty services and critical access care at the local level to prevent underservice and preserve patient choice. It is time to eliminate the ban on PLHs and allow those best qualified to understand and allocate health care resources for the benefit of patient health and medical care. We commend the GOP Healthy Future Taskforce for recognizing that over a decade of data has shown that when physicians can compete, costs are contained and patients win. We respectfully urge this committee and Congress to support the passage of H.R. 977 and S. 470, the Patient Access to Higher Quality Health Care Act of 2023 into law.