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Fixing a Broken System:

Policy Responses to Hospital Acquisitions of Physician Practices That Limit Health Care Access for U.S. Consumers

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EXECUTIVE SUMMARY

The Progressive Policy Institute's new study unpacks ongoing hospital acquisitions of independent physician practices in the U.S. This vertical integration reduces vital competition in critical health care markets. The result is reduced access to health care for Americans, through higher prices and spending, less choice in health care delivery models, and the erosion of physician decision-making autonomy in patient care.

The loss of independent physician practices (IPPs) from hospital and health system acquisitions is a major component of the broader absorption of physician practices into corporate owners such as commercial health insurers, private equity firms, and retail conglomerates such as pharmacy chains. Between 2019 and 2023, the percentage of IPPs owned by hospitals/health systems and other corporate entities increased from 39% to 59%, while the percentage of physicians employed by these same entities increased from 62% to 78%.

American consumers are *already* struggling with less access to health care, including what they pay, how easily they can obtain health care services, whether they have choice in facilities and providers, and the overall stability and resiliency of the health care system. The looming disappearance of the IPP compounds this formidable problem.

A review of 70 economic studies shows that hospital acquisitions of IPPs have myriad adverse effects. This includes higher prices and health care spending and the loss of decision-making autonomy for physicians because of changed corporate financial objectives. The elimination of the IPP as a vital health care delivery model has also reduced access to health care by eliminating an important source of choice for consumers.

PPI's study advances the state of policy analysis regarding the impact of consolidation by tracking the recent decline in IPPs in the U.S., against the backdrop of economic evidence that acquisitions by hospitals harms consumers. PPI looked at the decline in IPPs across nine major medical specialties at the national, state, regional, and rural vs. urban levels in 2017 and 2024. The results of PPI's study highlight several major takeaways:

- **There is mounting economic evidence that vertical integration of hospitals and IPPs increases prices and spending.**
- **The U.S. health care system has sustained a significant decline in IPPs as a result of being acquired by hospitals. These decreases range from 4% to 42% across nine medical specialties.**
- **Hospital acquisitions of physician practices have an outsized impact on rural areas of the U.S. IPPs in rural areas declined by 34%, versus only 22% in urban areas and were the highest in the western Midwest and New England.**
- **Hospitals focus on acquisitions of larger physician practices in establishing or scaling up their market position in a medical specialty area. Large IPPs decreased by 45% and medium size IPPs declined by 36%.**
- **Some of the largest health systems in the U.S. are the most active acquirers of physician practices, exacerbating already high levels of concentration in hospital and medical specialty markets.**

When considered in light of evidence from existing economic studies showing that hospital acquisitions of IPPs increase prices and spending, policy approaches to addressing the precipitous decline in IPPs in the U.S. take on new urgency. For example, studies show average price increases of about 14%, with some increases as high as 33%, and higher increases in markets where a hospital has a dominant position. Evidence also shows that approximately 45% of price increases are due to exploitation of Medicare site-of-service reimbursement rules. The majority of studies also show that hospital acquisitions of IPPs result in increased spending.

PPI's study concludes that better policies, achieved through comprehensive policy reform, are needed to address the loss of IPPs in the U.S. In framing this approach, PPI unpacks the multiple, flawed policies that bear directly on the anticompetitive effects of hospital acquisitions of physician practices. These policies have collectively failed to rein in consolidation and, in some cases, even *incentivize* it.

Major policy areas that bear directly on hospital acquisitions of IPPs and their outcomes include: (1) Medicare reimbursement rules that incentivize vertical integration, (2) below average merger enforcement, (3) state regulations that limit market entry, immunize hospitals from antitrust liability, and encourage gaming of the rules and exceptions to facilitate consolidation; (4) the absence of coherent policy to address a loss of physician autonomy that results from selling an IPP to a hospital; and (5) the need for a policy on health care access for rural areas.

Because of the lightning speed at which hospitals have acquired IPPs over the last two decades — and especially in the last eight years covered by PPI's study — policymakers are now working against the clock. PPI's "call to action" is for policy reform to protect American consumers and physicians, and improve access to the health care system. This effort should garner broad, bipartisan support from Congressional sponsors of site-neutral payment reform, state lawmakers, and federal and state antitrust enforcers. PPI recommends a five-part plan to address rampant hospital acquisitions of IPPs.

- **Pass federal legislation for site-neutral payment reform to remove the major incentive that drives hospital acquisitions of IPPs.**
- **Strengthen federal and state antitrust enforcement to ensure that anticompetitive hospital acquisitions of IPPs are blocked or adequately remedied.**
- **Consider reforming or revisiting state laws that govern hospital entry and shield powerful companies from antitrust scrutiny.**
- **Protect physician autonomy by advancing policies that focus on quality of care, physician leadership in governance in hospital settings, physician-led initiatives, and telemedicine.**
- **Develop policies to ensure access to health care in rural areas by reinvesting in rural hospitals, moving to value-based care, and supporting innovative business models and technology use.**

I. AMERICANS ARE INCREASINGLY WORRIED ABOUT DECLINING ACCESS TO U.S. HEALTH CARE

Health care is one of the five largest categories of spending by U.S. consumers.[1] Close to three-quarters of this spending in 2023 went to health care insurance premiums, and the remainder to medical services. Meanwhile, national health care expenditures are on the rise. Total expenditures, adjusted for inflation, grew 3.3% between 2022 and 2023. This rate of increase is the highest since 2015, with the exception of the pandemic year 2020.[2] Annual real expenditures on physician and clinical services between 2000 and 2023 rose by close to 3.0%. Both of these rates of increase exceed the average rate of inflation, which was about 2.6%.[3]

By all accounts, Americans are increasingly worried about their ability to access medical services. As measured by the volume of internet searches, public interest in access to medical services started trending upward in about 2015, increasing markedly beginning in 2023, with a sustained increase in attention since.[4] A Pew Research Center poll in May 2024 reveals that 57% of respondents view the affordability of health care as the third largest problem, surpassed only by inflation and the ability of Republicans and Democrats to work together.[5]

In addition to prices and cost, access to health care is also about consumers' ability to connect with providers and health care facilities. Factors that limit access include the loss of competition from mergers and acquisitions that reduce the number of facilities and providers, workforce shortages, the availability of transportation to get to and from appointments, and long wait times. In rural communities, where there is already limited competition and access, these factors are markedly more distinct.[6]

II. CONSOLIDATION HAS FUNDAMENTALLY CHANGED U.S. HEALTH CARE MARKETS

Health care markets in the U.S. are broadly affected by consolidation.[7] Not all consolidation is harmful but mergers and acquisitions that are anticompetitive have adverse effects. Studies show that consolidation in health care plays a major role in driving up prices and costs, and reducing quality and choice, all of which limit consumer access to providers and facilities. Consolidation takes many forms. For example, there is horizontal consolidation, where businesses operating in the same product and/or geographic market merge, such as hospitals and commercial health insurers.

The Federal Trade Commission (FTC) has had mixed success in stopping hospital mergers that raise prices to insurers, employers, and consumers, lower compensation to providers, and threaten higher costs and reduced quality of care. The American Medical Association estimates that in 2021, 99% of hospital markets were highly concentrated, with 77% featuring a single hospital with a market share in excess of 50%.[8] KFF counts 1,573 hospital mergers between 1998 and 2017, and another almost 430 hospital and health system mergers that were announced between 2018 and 2023.[9] Studies indicate price increases ranging from 3% to 65% in hospital mergers, and lower wages for health care workers.

Commercial health insurance markets in the U.S. also lack robust competition. That is why the U.S. Department of Justice (DOJ) successfully blocked the mergers of health insurers in the mid-2010s, including Aetna-Humana and Anthem-Cigna.[10] Yet, concentration remains high. For example, the American Medical Association estimates that 95% of metropolitan statistical area commercial markets were highly concentrated in 2023. At least one commercial health insurer had a market share of 30% or more in 89% of markets.[11] In 47% of markets, a single insurer was dominant, with a share of at least 50%.

Vertical consolidation in U.S. health care markets also plays a large role in reducing competition that limits health care access. Vertical mergers combine entities operating in complementary markets, such as hospitals and physician practices, and commercial health insurers and pharmacy benefit managers. Competitive concerns in these vertical transactions center on strengthening incentives for a vertically integrated entity with market power in one or both markets, to frustrate competitors' access to critical inputs and distribution channels."

Nonetheless, the DOJ and FTC have largely blessed vertical mergers in health care, including Aetna-CVS, Cigna-Express Scripts, and hospital acquisitions of physician practices. Historically, strong deference by antitrust enforcers and courts to arguments that vertical integration, on balance, is pro-competitive (or benign) may account for these outcomes.[12]

The U.S. health care landscape is also increasingly peppered with cross-market mergers, or the consolidation of large hospital and health systems that are located in different geographic markets. Cross-market mergers can increase the bargaining power of a hospital or health system vis-à-vis intermediaries such as commercial health insurers. Less competition among merging hospitals for inclusion in insurer networks, therefore, can lead to higher prices and lower-quality care that harms consumers.[13]

Consolidation in the U.S. health care sector also features an upswing in ownership of health care assets by hospitals and health systems, and other corporate players. For example, private equity firms have made significant incursions in acquiring hospitals, physician practices, and nursing and home health care services. They often engage in smaller, successive acquisitions to increase market share and gain market power.[14] Against this backdrop, hospital acquisitions of physician practices pose a particularly concerning development.

III. THE INDEPENDENT PHYSICIAN PRACTICE IS AT RISK OF EXTINCTION

Perhaps more than any other type of consolidation, acquisitions of physician practices by hospitals and health systems have affected consumers' access to health care. Over the last two decades, freestanding physician practices have been acquired by hospitals and health systems and other corporate entities such as private equity firms, commercial health insurers, and retail conglomerates.

Between 2019 and 2023, the percentage of IPPs owned by these entities increased from 39% to 59%.[15] Similarly, the percentage of physicians employed by hospitals and health systems and other corporate entities increased from 62% to 78%.[16] The sea-change in physician employment and practice ownership is often attributed to physicians' desire for higher payments and financial security, needed access to costly resources, more focus on clinical care, and avoiding the administrative and regulatory burdens and costs of managing an independent medical practice.[17] Selling an independent physician practice to a hospital, however, is not without significant downsides, and the implications of the loss of the IPP as a distinct health care delivery model are widely overlooked.

For example, much like independent pharmacies and grocers, "indy" doctors have strong incentives to compete on service, access, and quality — competition that is valued by consumers. As their own bosses, independent physicians have autonomy in medical decision-making and control over day-to-day operations. Hospital ownership comes with a significant loss of bargaining power and stronger incentives to meet the financial objectives of the hospital or corporate principal to which owned physician practices report.[18]

A major concern is that some vertical mergers can strengthen incentives to raise rival's costs, thereby limiting competition, and raising prices. These incentives can translate into strategies to frustrate competing hospitals' access to patients through restrictive policies on inpatient and outpatient referrals.[19] Physicians (e.g., primary care practitioners) are particularly exposed because they make hospital recommendations and refer patients to admitting physicians.[20]

This often takes the form of "steering" patients to the owning hospital and away from competing hospitals. The incentive to do so is stronger when the owned physician practice accounts for a large share of the medical specialty market in a particular geographic area.[21] Indeed, studies show that physician practices owned by a hospital direct about 83% of admissions to an owning hospital.[22] Other ways to stifle competition include frustrating access by IPPs to a dominant hospital that owns competing physician practices. This can also raise prices to commercial insurers and, ultimately, to consumers.

IV. PAST STUDIES RAISE SERIOUS CONCERNS ABOUT HOSPITAL ACQUISITIONS OF PHYSICIAN PRACTICES

A. The Economic Context

Microeconomic models of vertical integration of hospitals and physician practices set the framework for assessing the costs and benefits of integration and informing policy implications. A standard approach is to assess costs and benefits across levels in a hospital or health system.[23] Benefits from vertical integration can emerge around shared ownership or joint management of hospital and physician practices that improve quality and spur organizational efficiencies.[24]

These include better access to capital to support infrastructure, information technology, or care management; standardization of care from better-aligned incentives across the integrated system; or better coordination of care.[25] On the other hand, integration can drive harmful price increases steering patients to higher-priced, lower-quality integrated hospital services, unnecessary tests or procedures, and less patient-focused care.[26] Outside constraints and forces can have a large impact on anticompetitive incentives for hospital acquisitions of IPPs, including state-level regulation and Medicare policies for reimbursement based on site-of-service.

The economic literature on hospital acquisitions of physician practices supports concerns that consolidation has limited competition and harmed consumers. PPI reviewed these studies, which incorporate a range of designs, methodologies, time periods, measures of impact, and data sources. The review covers 70 studies, most of which are examined in two major, systematic reviews of the extant literature on vertical integration covering the period 1994-2021.[27]

Empirical results focus on prices, spending, quality of care, utilization, and patient-centered outcomes. The studies evaluate the impact of integration on prices paid by consumers and spending, or costs to commercial insurers, Medicare, and hospitals. Quality of care and patient-centered outcomes encompass a range of metrics such as optimal care for specific conditions, cancer screenings, patient satisfaction ratings, mortality, and physician-patient relationships. Utilization effects encompass a wide range of metrics, such as ambulatory care-sensitive admissions, readmissions, and rates of emergency department use. The studies categorize the effects of vertical integration across all of these variables as beneficial, harmful, mixed, and neutral (i.e., absence of statistically significant findings).

B. Effects of Integration on Prices

Economic studies reveal strong evidence that hospital acquisitions of IPPs increases prices. Of the 10 studies that examine price effects, eight show that integration increased prices, and two find no statistically significant difference as compared to non-integration scenarios. For example, one study finds an average increase in prices of about 14% for services provided by acquired physicians, with some increases in specialty areas as high as 33%.[28] Notably, that same study finds that 45% of the identified price increases resulting from integration were due to exploitation of Medicare site-of-service reimbursement rules.[29]

As discussed later, once hospitals own the physician practice, they can tack on higher

"facility fees" for identical services provided in a freestanding physician practice.[30] Facility fees are not justified on the basis of health care costs or quality and distort incentives to bill services in the highest-cost setting and incentivize further vertical integration. Some studies reveal payment increases relating to site-of-service payment differentials of 74% to 224% for specialists and 78% for primary care.[31] Finally, studies reveal that prices for physician services under integrated ownership are 35% higher in markets where a hospital has a dominant position.[32]

Some studies also note that large health systems have engaged in acquisitions of multiple physician practices. For example, in one study sample, 24 health systems acquired more than 10 practices, and four health systems acquired more than 20 practices. The risk of higher prices post-acquisition for these types of mergers is evident in high "diversion ratios," where acquired physician practices are very close competitors.[33] These diversion ratios tend to be much higher for health system acquisitions of physician practices versus non-health system acquisitions.

C. EFFECTS ON SPENDING, QUALITY OF CARE, UTILIZATION, AND PHYSICIAN AUTONOMY

Of the 35 studies that examine the effects of vertical integration on health care spending, four identify beneficial outcomes, 21 show harmful outcomes, eight neutral outcomes, and two mixed outcomes. Harmful outcomes include increases in different types of spending, such as annual per-patient expenditures, per-procedure Medicare payments, hospital operating expenses, and commercial spending per enrollee. For example, one study finds that there was a $127 per beneficiary increase in Medicare spending for a colonoscopy after hospital-physician practice integration that was driven by an increase in billing for facility fees.[34] Another study finds that Medicare spending on inpatient and outpatient care is $849 higher per patient in hospital-based groups.[35]

Of the 38 studies that evaluate the impact of vertical integration on setting-specific quality of care, eight reveal beneficial effects, six harmful effects, 14 neutral effects, and 10 mixed effects. One study, for example, finds that hospital-owned physician practices have lower rates of hemoglobin A1c screening and monitoring for patients with diabetes, as compared to IPPs.[36] Another study finds, however, that three years post-acquisition, there is a statistically significant increase in overall diabetes care performance.[37] Another looked at different levels of integration (e.g., high, low, etc.) and found no statistically significant association with quality of care.[38]

Thirty-two studies look at the effect of vertical integration on utilization. Four show beneficial effects, eight harmful effects, nine neutral effects, and 11 mixed effects. One study in a systematic review finds higher rates of ambulatory case-sensitive admissions in hospital-owned practices, as compared to IPPs.[39] The studies also reveal that integration of hospitals and physician practices leads to greater utilization of unnecessary services, such as diagnostic tests and imaging, through self-referrals. However, another study covered by a systematic review finds that "patients with [Council of Accountable Physician Practices (CAPP)]-affiliated physicians had lower [ambulatory case-sensitive] admission

rates compared with patients with non-CAPP physicians."[40]

Finally, two major studies focus on the effect or vertical integration on physician autonomy. For example, one study finds that "almost 60 percent of physicians reported that reduced autonomy was one of the top negative impacts of ownership changes on patient care, citing an erosion in clinical autonomy and a greater focus on financial incentives."[41] Reduced physician autonomy and increased focus on corporate financial incentives have prompted adjustments in treatment plans to reduce costs, steering patients toward the services offered by the owning hospital, and less time spent with patients in order to increase volume.[42] Empirical analysis reveals that integration with high steering potential yields price increases of about 7%.[43]

In sum, PPI's review of the empirical evidence reveals that vertical integration of hospitals and IPPs produces higher prices, on average, and increased spending for health care services. While results for metrics such as quality and utilization are more mixed or neutral, the totality of studies show that across all metrics, negative findings significantly outweigh positive effects. Consolidation has reduced physician autonomy and aligned financial incentives with hospital owners and successive acquisitions by large health systems have materially reduced patient choice.

V. UNPACKING THE DATA ON HOSPITAL ACQUISITIONS OF INDEPENDENT PHYSICIAN PRACTICES

The shift from predominantly independent physician practices to hospital ownership of the vast majority of physician practices began in the 1990s. At that time, hospitals and commercial insurers pursued mergers and acquisitions to create "integrated delivery networks" to gain more bargaining power vis-à-vis increasingly powerful commercial health plans. But the sea-change was also driven by a surge in direct employment of physicians by hospitals. With a base of already employed physicians, further acquisitions of providers, especially in lucrative medical specialties, were a good way to build out a larger base of hospital-controlled physician services.[44]

PPI's analysis focuses on the period from 2017 to 2024. To be sure, much of the loss of IPPs occurred before 2017, but the pre-2017 period also covers a series of large mergers involving hospitals and commercial health insurers.[45] The relatively quiet period from 2017-2024 reflects a settling of health care markets and provides a good starting point to evaluate further activity around hospital acquisitions of IPPs.

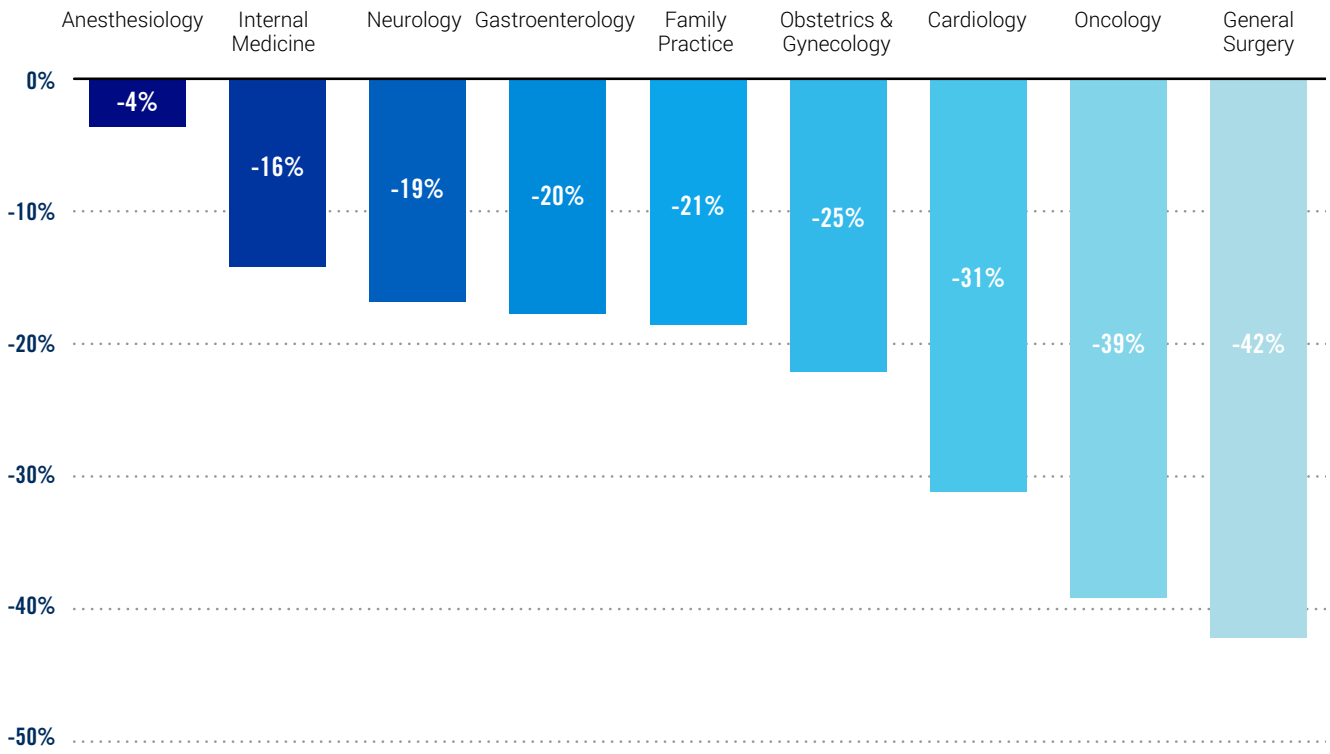
PPI utilized One-Key IQVIA data for the years 2017 and 2024 to assess the degree to which IPPs have been eliminated through acquisitions by integrated delivery networks. These are arrangements where health care providers work together to provide collaborative and coordinated care and include hospitals that own physician practices.[46] The data cover nine medical specialties that are the highest in demand, based on a survey of the literature. These include: anesthesiology, cardiology,

family practice, gastroenterology, general surgery, internal medicine, neurology, obstetrics/gynecology, and oncology. The data also allow for analysis based on state, census area, rural vs. urban area, practice size, and type of acquirer.

To identify which physician practices were purchased between 2017 and 2024, PPI's analysis narrowed the IQVIA data to focus on those that were independent in 2017 but not independent in 2024. These are called "converted" practices and account for about 29% of all practices that appear in the data in *both* 2017 and 2024. The remaining 71% of practices include those that were independent in 2017 and 2024, not independent in 2017 and 2024, and a small percentage that switched from not independent in 2017 to independent in 2024.

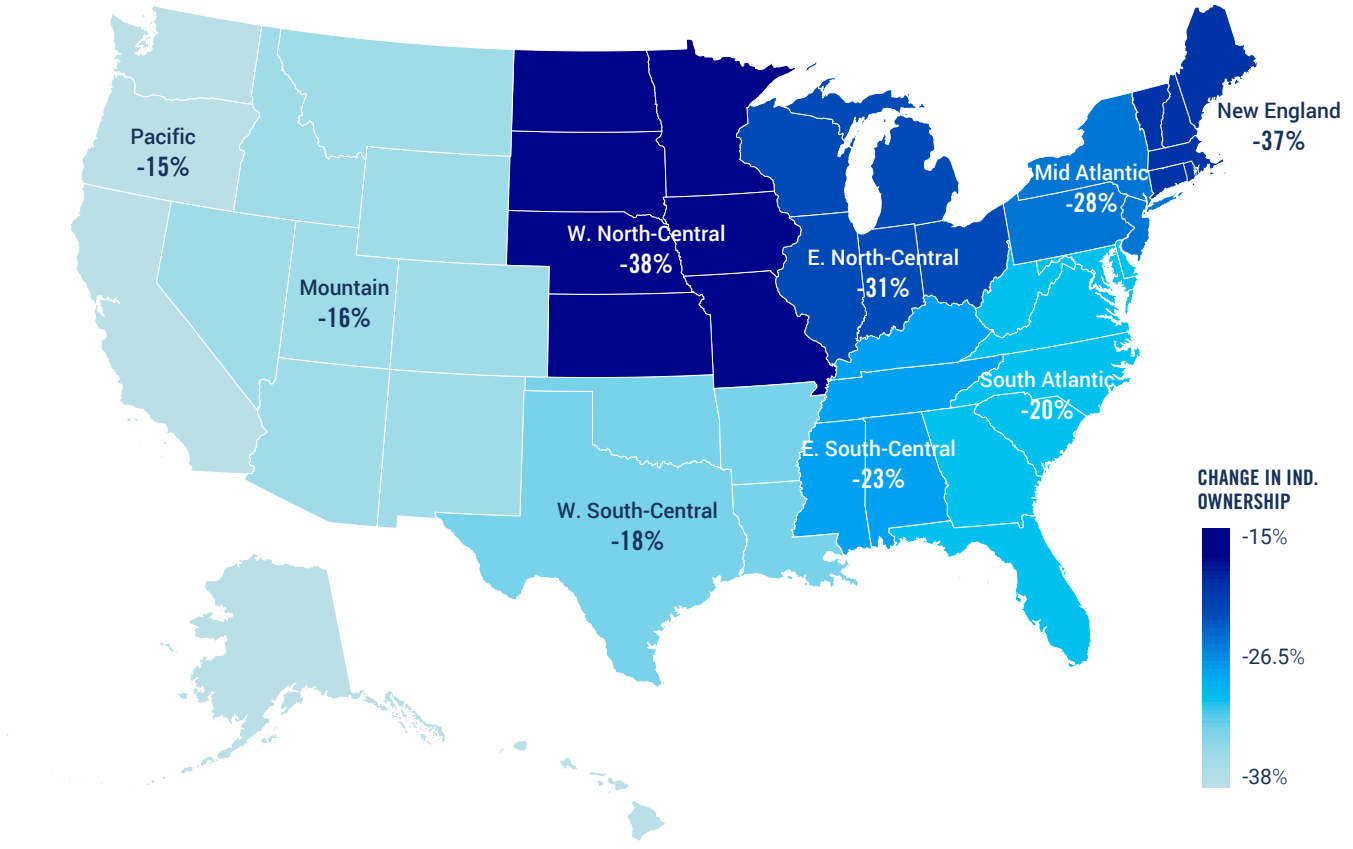
PPI then identified "converted" physician practices due specifically to hospital acquisitions between 2017 and 2024. About 51% of all practices that were independent in 2017 and not independent in 2024 were acquired by a hospital. The remainder were acquired by other types of corporate entities, such as commercial insurers and private equity firms. The percentage decline in independent ownership due to hospital acquisitions for the nine medical specialties is shown in Figure 1.

FIGURE 1: DECLINE IN THE PERCENTAGE OF INDEPENDENT PHYSICIAN PRACTICES DUE TO HOSPITAL ACQUISITIONS, BY MEDICAL SPECIALTY (2017 TO 2024)



As shown in Figure 1, general surgery shows the largest decline of 42%, followed by oncology, cardiology, while the smallest declines are in internal medicine, at 16%, followed by anesthesiology at 4%. Other features of hospital acquisitions of physician practices reveal important information about the intensity of consolidation activity from 2017 to 2024. For example, independent ownership due to hospital acquisitions fell by almost 34% in rural areas but only 22% in urban areas. As shown in Figure 2, the western Midwest and New England show the largest impact of hospital acquisitions of IPPs, with decreases in independent ownership of 38% and 37%, respectively. The lowest conversion of IPPs to hospital-owned is in the Pacific and Mountain regions, with decreases of only 15% and 16%, respectively.

FIGURE 2: DECLINE IN PERCENTAGE OF INDEPENDENT PHYSICIAN PRACTICES DUE TO HOSPITAL ACQUISITIONS BY U.S. CENSUS AREA (2017 TO 2024)



PPI also asked if hospital acquisitions reveal information about a focus on physician practice size. Hospital acquisitions appear to target medium to large practices (i.e., in excess of about 10 providers) versus solo practitioners or small practices. Between 2017 and 2024, there was a 45% decrease in large IPPs and a 36% decrease for medium IPPs. The decreases for small and solo IPPs, however, were only 23% and 9%, respectively.

Acquisitions of larger practices may be designed to more quickly establish a market position in a medical specialty area where the hospital does not have an existing practice, or expand or scale up a market position for a hospital that acquired practices in the past. This is particularly the case for large health system purchasers. This could have the ancillary effect of furthering the trend toward larger IPPs and, therefore, the gradual elimination of the small medical practice.[47]

Finally, PPI's analysis identified 130 large hospital and health systems that expanded their ownership of physician practices during the period. On average, the group owned about 90 practices each in 2017 and 154 practices in 2024. Some large systems increased their ownership by several hundred percent, including Bon Secours Mercy Health and Advocate Health. Other large systems that made significant acquisitions of IPPs during the period include Lifepoint Health, Intermountain Healthcare, HCA Healthcare, and Tenet Healthcare. The top 10 largest health systems account for around 17% of all hospital-acquired practices, while the top 12 largest health systems account for around 19%. With acquisitions and a shift toward physician employment by hospitals, large systems have consolidated their position in concentrated hospital and physician practice markets.

In sum, PPI's analysis of the data on hospital acquisitions of "converted" IPPs highlights several takeaways.

- **There has been a sizeable decline in the percentage of IPPs across nine medical specialties due to hospital acquisitions.**
- **Hospital acquisitions of physician practices have an outsized impact on rural areas in the U.S.**
- **Hospitals focus on acquisitions of larger physician practices in expanding their market position in a specialty.**
- **Some of the largest health systems in the U.S. have been the most active acquirers of physician practices, exacerbating consolidation.**

VI. HOSPITAL ACQUISITIONS OF PHYSICIAN PRACTICES ATTRACT LITTLE ANTITRUST ATTENTION

Antitrust enforcement is a key tool in the suite of policies that can work to combat harmful integration of hospital mergers with physician practices. The unique, three-legged system of enforcement in the U.S. is particularly important in health care. Enforcement of federal antitrust law under the Sherman Act, Section 1 (anticompetitive agreements) and Section 2 (monopolies), and the Clayton Act, Section 7 (mergers) resides with the FTC and DOJ.[48] State attorney generals also enforce federal antitrust laws on behalf of their citizens. Private cases against prospective mergers can also be filed, but they are uncommon. It is more likely, should

private enforcement take a more active role in merger enforcement, that cases would be filed after harmful mergers are consummated.

A. Merger Enforcement Involving Hospitals and Ambulatory Health Services is Below Average

Trends in key metrics of federal enforcement support public policy analysis of emerging competition issues in health care. They often mirror emerging issues involving strategic anticompetitive conduct, changes in the regulatory environment, and advances in technology or business models. To get a better sense of how federal antitrust enforcement has approached consolidation, PPI unpacked merger enforcement statistics collected as part of the Hart Scott Rodino Act requirements for the two major sectors involved in the integration of hospitals and physician practices.[49] These include the hospital and ambulatory health services sectors, which correspond to North American Industrial Classification System codes 622 and 621, respectively.[50]

Figure 3 shows three major rates of merger enforcement over the period 2017-2024. One is the percentage of reportable transactions that are cleared to either the FTC or DOJ for further review. A second is the percentage of cleared transactions that receive an agency request for more information ("second request") to further evaluate the impact on competition. A third measure is the percentage of cleared transactions that the agencies challenge as illegal under Section 7 of the Clayton Act.

FIGURE 3: MERGER ENFORCEMENT RATES FOR HOSPITALS AND AMBULATORY HEALTH SERVICES (2017 TO 2024)

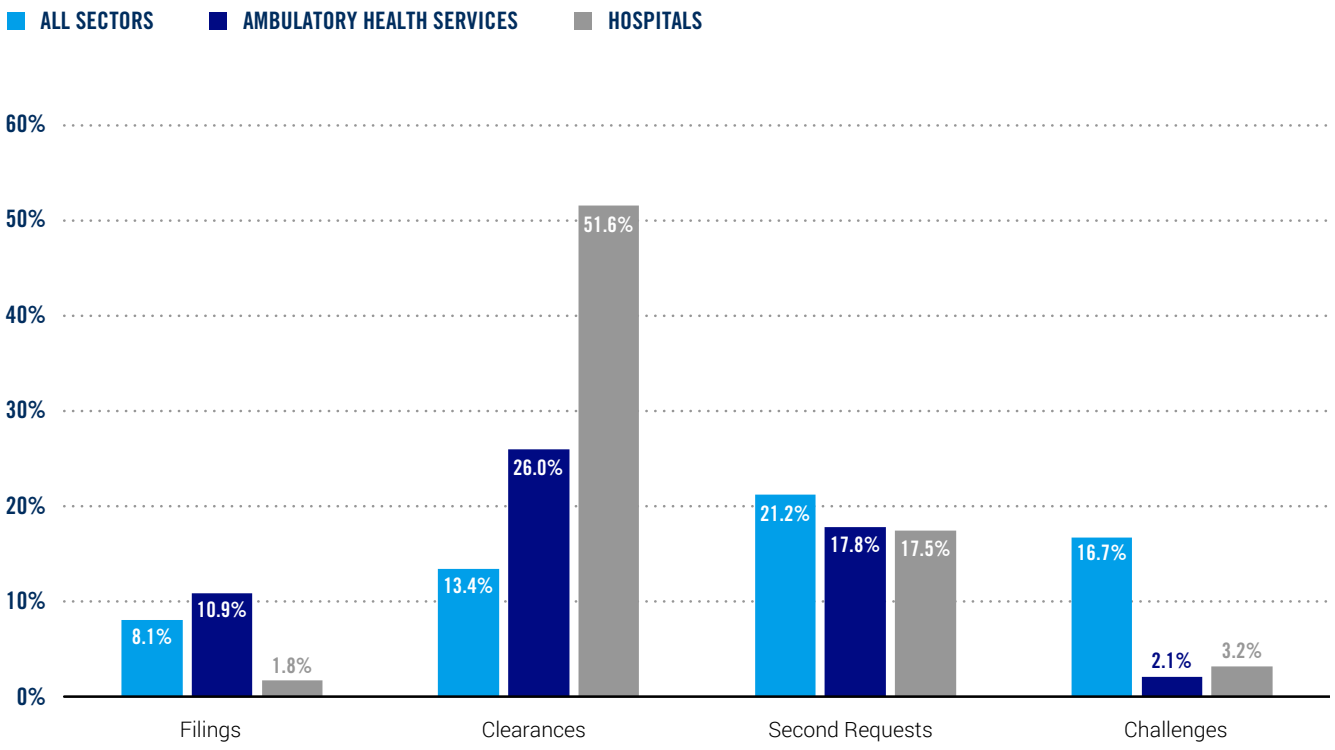


Figure 3 shows that the rate of clearances for both sectors is higher than the all-sector average – markedly so for hospitals, at about 52% and 26% for ambulatory health services, as compared to about 13% across all sectors. This may signal the agencies' intention to more intensely scrutinize mergers in these sectors.

This pattern reverses at the second request stage. The rate of second requests is lower than the all-sector average for ambulatory health services and hospitals. This gap worsens for the rates at which the agencies challenge merger transactions as illegal. For ambulatory health services, the challenge rate is eight times lower than average, and for hospitals, it is about five times lower than average. Overall, enforcement rates reveal that the FTC and DOJ take much harder, earlier looks at consolidation involving hospitals and physician practices, but back off significantly on later-stage investigations that could lead to merger challenges. This has surely played a role in signaling to the health care business community that the agencies do not intend to aggressively scrutinize consolidation.

B. Enforcers Challenged Only a Handful of Hospital Acquisitions of Independent Physician Practices

PPI reviewed federal and state enforcement actions involving hospital acquisitions of IPPs from 1990 to the present. The FTC and state attorneys general brought nine antitrust enforcement actions over the past 35 years. In identifying these cases, PPI's analysis focused only on acquisitions of IPPs by hospitals that either were acquiring a practice for the first time or acquiring additional practices. PPI did not look at mergers of hospitals that already owned physican practices.

Challenged mergers that meet these criteria include: Carilion Clinic (2009), Renown Health (2012), Reading Health System (2012), St. Luke's Health System (2012), Sanford Health (2017 and joined by the state of Nebraska), and CentraCare Health System (2017). State enforcement actions include: Washington v. Franciscan Health System (2017), In re Sisters of Mercy Health System (Missouri, 1994), and Maine v. Maine Health (2012).[51] The medical specialty markets in all of these cases range from primary care to multi-specialty practices, imaging, cardiology, orthopedics, and OB/GYN.

In the foregoing cases, the FTC or states often alleged that the merger eliminated head-to-head competition between providers, leading to increased prices paid by commercial health care payers and higher insurance premiums to patients.[52] The FTC succeeded in forcing the hospital or health system acquirer to abandon two transactions and in the remaining seven cases, the courts approved a variety of conditions to protect physicians and patients from anticompetitive outcomes.

On the consumer side, for example, enforcers required divestitures to reduce the merged entity's incentives to exercise market power.[53] Other remedies include injunctive relief and conditions that prohibit or require certain practices. These include bans on price fixing; ensuring access to facilities for physicians outside the merged entity, informing patients about alternative facility options, ensuring flexibility for provider participation in networks, and allowing incentive-based compensation based on quality of care versus volume.[54]

On the physician side, enforcers conditioned approval of some mergers on changing

physician compensation structures, releasing physicians from non-compete clauses, removing restrictive covenants in employment contracts, and bans on actions against physicians that depart the merged entity.[55] In sum, antitrust enforcement against harmful mergers involving hospitals and IPPs reflects a below-average record of merger enforcement. However, it is clear that the complaints that were filed recognize the mechanisms through which harmful mergers limit competition and adversely affect consumers and physicians. These issues are now front and center in assessing the highly consolidated hospital-physician practice landscape in U.S. health care.

VII. MEDICARE REIMBURSEMENT POLICY INCENTIVIZES VERTICAL INTEGRATION

A. The Exploitation of Site-of-Service Payment Differentials

Medicare Part B covers the costs for physician services, including those in a freestanding clinic, an ambulatory service center (ASC), and a hospital outpatient department (HOPD). However, as noted earlier, payments for physician services provided in a freestanding practice are paid at a lower rate through the physician fee schedule relative to if the service was provided in an ASC or in a HOPD, which is paid through the outpatient prospective payment system (OPPS).[56] Different payment rates for identical services provided at different locations are reflected in facility fees under the Medicare regulatory payment system.[57]

HOPDs can charge an even higher facility fee than ASCs. The original intent of facility fees was to help cover the additional overhead costs associated with ASCs and hospitals. However, this does not make sense for HOPDs that are separate but located near the hospital (i.e., "on campus").[58] For example, Medicare considers an HOPD to be on campus when it is "located within 250 yards of the main buildings, and any other areas determined on an individual case basis."[59] On-campus HOPDs receive the higher Medicare payment, as if they had the same overhead requirements as a full hospital.

Both on- and off-campus HOPDs appear similar to freestanding physician practices and are usually indistinguishable to a patient. The higher payment rate for hospitals for services provided at an on-campus HOPD, as compared to freestanding physician practices, creates powerful and perverse incentives. One is for hospitals to find ways to provide services on campus, and the second is to integrate more HOPDs into the hospital system. Establishing additional clinics with lower overhead is a savvy business move to increase revenue from Medicare payments, at the higher payment rate. Hospital systems develop new clinics, acquire established clinics, and expand their current clinics to achieve this goal.

Reining in the exploitation of differences in site-of-service payments has been piecemeal and difficult. In 2015, for example, Congress enacted legislation to address the discrepancy in payments based on site-of-service in the Bipartisan Budget Act.[60] The legislation aligned payments for services provided at an off-campus HOPD with payments made to a freestanding physician practice. However, it also created certain exemptions to the alignment of payments, including for ASCs and hospitals.[61]

In 2019, CMS expanded site neutrality to more services provided by exempted off-campus HOPDs. Yet, the off-campus HOPDs exemption remains.[62] The 21st Century Cures Act of 2016

created additional exemptions for off-campus HOPDs that were in construction at the time of the bill's passage.[63] But despite the attempts to better align payments, nearly two-thirds of HOPDs are considered on campus and, therefore, still receive the higher payment.[64] These hospitals are strategically expanding their services to include services traditionally provided in a freestanding physician practice.

A 2023 analysis by the Medicare Payment Advisory Commission (MedPAC) recommended aligning payments across settings by classifying services under one of four categories.[65] The first is services that can only reasonably be provided in HOPDs (e.g., emergency care) and should be exempt from site-neutral payment reform. The other three categories cover services provided in the highest volume at: freestanding clinics (paid at the lower physician fee schedule rate); ASCs (paid at the ASC rate of the OPPS); and HOPDs (paid at the OPPS rate).

MedPAC estimated the realignment of these services would save Medicare $6.0 billion in 2021 and remove financial incentives for hospitals to acquire freestanding physician practices.[66] A limitation of the payment alignment, however, is apparent in communities without an ASC where MedPAC recommended that services be paid at the OPPS rate. While this change would impact rural hospitals, MedPAC found they have access to other financial support through safety net hospitals, critical access hospitals, and sole community hospitals.

B. The Battle Over Site-Neutral Payment Reform

The powerful effects of site-of-service payment differentials on spurring vertical integration of hospitals and physician practices have generated debate and controversy in the health care policy community. Opponents of site-neutral payment reform argue the higher payment is necessary due to the higher costs of operating a hospital and maintaining essential services such as emergency departments.[67] Reform will, the argument goes, induce hospitals to limit or terminate services.

These arguments fail on numerous grounds. For example, the cost of physician services reasonably provided in a clinic was never intended to cover the cost of operating a hospital. The cost of covering essential services is an important, but separate, conversation from site neutrality as it applies to HOPDs. Opponents also claim the proposed changes to site-neutral payment reform will have an outsized impact on small and rural hospitals.

However, policy proposals would limit the impact on vulnerable providers by exempting or limiting the reduction in payment for categories of hospitals (e.g., critical access and rural emergency) and utilizing savings to increase support for vulnerable providers such as hospitals with a disproportionate share of Medicare and Medicaid patients.[68] While making exemptions or limiting the reduction in payments for at-risk hospitals helps protect these providers, it does not remove the powerful incentive created by site-of-service payment differentials for hospitals to acquire physician practices and bill for high payments for services provided at on-campus HOPDs.

The fact remains that for patients, it is hard to distinguish between an on-campus HOPD, an off-campus HOPD, and a freestanding physician practice. If a patient selects an on-campus HOPD, they may have inadvertently

and unknowingly increased their cost-sharing responsibility.[69] Site-neutral payments could save patients more than $10 billion per year in premiums and cost sharing.[70] In addition, the savings to the Medicare program could save the federal budget $210 billion between 2026 and 2035.[71] These savings would ensure a more sustainable Medicare program and prevent automatic cuts once the Hospital Insurance Trust Fund (i.e., the funding for the Medicare program) is depleted.

As Americans continue to struggle to pay for health care, it is essential to find policies that allow for lower-cost care without sacrificing quality. If a service can be provided safely in a lower-cost, high-quality environment, the health care system should incentivize it. Site-neutral payment reform is a key policy for removing incentives for hospitals to acquire physician practices that have led to higher prices and limited health care access for U.S. consumers.

VIII. STATE REGULATIONS GOVERNING HOSPITAL ENTRY EXACERBATE VERTICAL INTEGRATION OF HOSPITALS AND PHYSICIAN PRACTICES

Two major regulatory policies for state-supported oversight exacerbate hospital incentives to acquire IPPs — certificate of need (CON) and certificate of public advantage (COPA) laws. COPA laws shield hospitals from antitrust liability for engaging in anticompetitive mergers and acquisitions through the development of a collaborative agreement. State CON laws required health facilities to receive permission from the state before expanding services or making major capital expenditures. The sections below unpack COPA and CON laws. The analysis focuses on how state-level regulation interferes with competition and exacerbates incentives for vertical integration.

A. The Complexity of Certificate of Need Laws in the U.S.

CON laws are a regulatory mechanism for the state, or its designated regulatory authorities, to review changes in the health care landscape before they happen. Nearly all states adopted a health care CON law between the late 1960s and early 1980s due to a federal mandate.[72] CON laws were initially enacted with the goals of containing costs, increasing access, and improving the quality of care by granting the state authority to limit what facilities are built and services provided.

For example, if a hospital wants to increase the number of beds or add a new physician practice, it is required to seek approval from the state. After the National Health Planning and Resources Development Act was repealed in 1984, many states followed suit and repealed their CON laws.[73] Currently, 36 jurisdictions still have an active CON law, with 29 jurisdictions regulating the type of facilities relevant to PPI's analysis, including hospitals, ASCs, HOPDs, or freestanding physician clinics.

PPI reviewed CON laws to better understand their potential role in spurring vertical integration. As shown in Figure 4, 57% of jurisdictions have a CON law to regulate hospitals, 45% have a law for ambulatory surgery centers, 27% for HOPDs, and 16% for freestanding physician clinics. For the jurisdictions with CON laws, the majority also have a CON law that regulates certain activities involving these facilities. As shown in Figure 5, these include 53% with a CON law for establishing a new facility and 25% with a law that regulates changes in ownership or acquisitions. Hospitals are the most regulated

type of relevant facility, and the development of new facilities is the most regulated activity for these facilities.

FIGURE 4: PERCENT OF STATES WITH A CON LAW: BY TYPE OF FACILITY

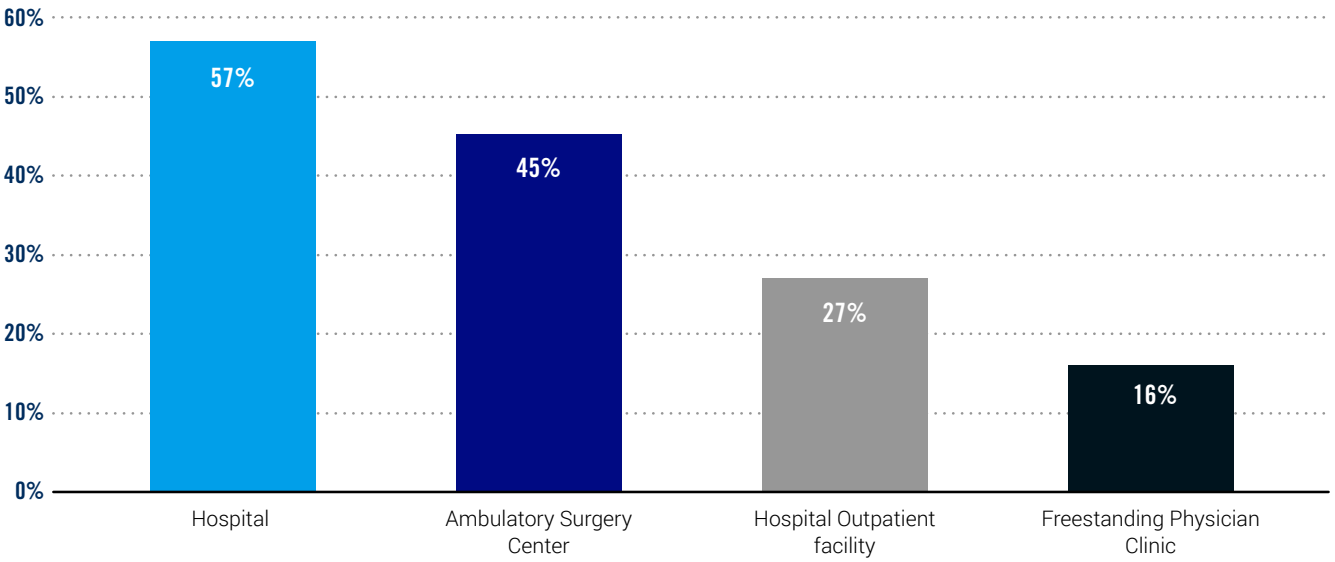
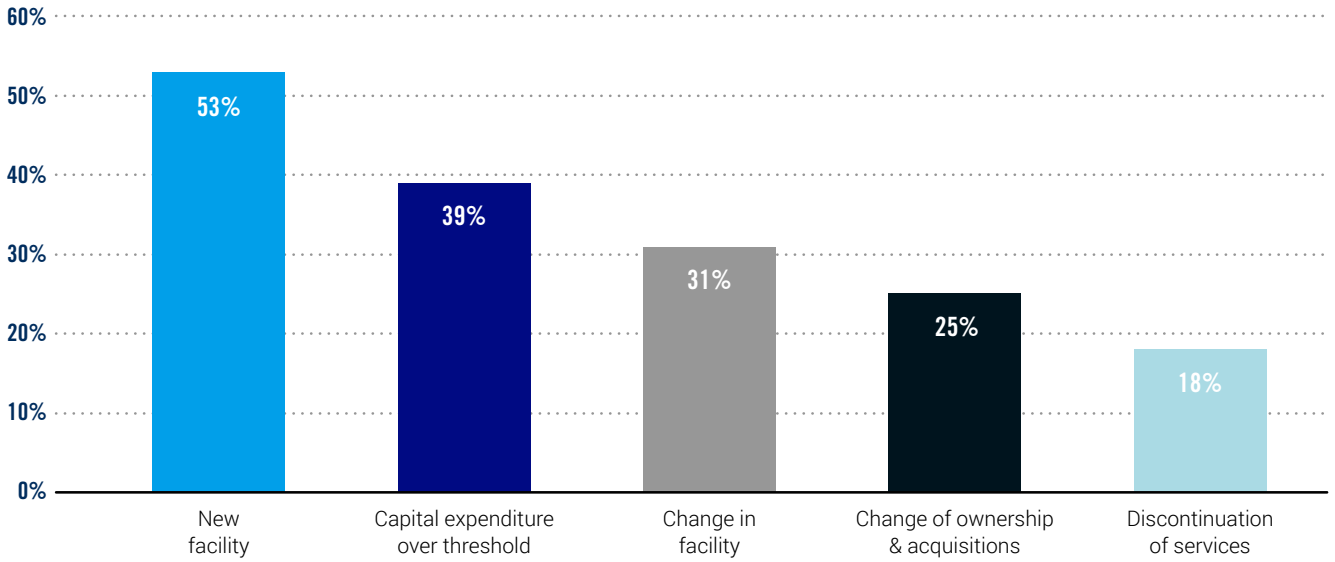


FIGURE 5: PERCENT OF STATES WITH A RELEVANT FACILITY CON LAW: BY TYPE OF ACTIVITY



Providers that hold a CON benefit in multiple ways. A CON raises barriers to entry for potential entrants and also increases the attractiveness of existing CON-holders to pursue mergers and acquisitions. CONs can potentially facilitate hospital integration with IPPs that risks anticompetitive effects, especially in highly concentrated markets featuring a dominant hospital or medical specialty. CON laws allow incumbents to challenge new entrants through appeals, lobbying efforts, and securing seats on authorities that review new applications, as we see in Michigan, Vermont, and North Carolina.[74]

Both the DOJ and FTC have determined that CON laws are anticompetitive. The DOJ has opined that CON laws create the opportunity for established hospitals to game the market and regulatory system through procedural delays and entering into unlawful agreements.[75] The FTC, which has performed decades of research, public hearings, and reviews of specific state laws, has been consistent in opposing CON laws. The Commission finds, for example, that CON laws "prevent the efficient functioning of health care markets" by creating barriers to entry and expansion, allowing competitors to exploit the laws to protect their own interests, and prevent effective antitrust remedies.[76]

Despite the evolution of some CON laws, they have not kept up with changes in the health care markets. With myriad changes in health care business models and the competition landscape in hospitals and related markets, the initial goals of CON laws have proved elusive. The laws were developed when health care reimbursement was connected to provider cost. However, reimbursement has been replaced with global Medicare and Medicaid rates and negotiated private rates.

More recent economic studies find that CON laws have negative impacts on health care costs and an inconclusive impact on the quality of care. For example, 44% of studies of CON laws show an association with lower quality of care; 72% of studies show an association with reduced availability of services; and 60% an association with higher spending due to a supply restriction.[77] For underserved and rural populations, there is no evidence that CON laws protect health care access.[78]

There is also a strong connection between large hospital systems and CON laws. For example, large health systems are present in 90% of jurisdictions. In states without a hospital CON or physician practice CON law, there is a higher than average number of top ten hospital systems, as compared to states with CON laws. This supports the idea that states without regulation attract more competition than states with regulation. While factors such as population size and health care utilization rates also affect the number of hospital systems in a state, CON laws distort markets by creating regulatory protections for incumbent hospitals and higher barriers to entry, strengthening incentives for further consolidation.

B. Independent Physician Practices Have a Higher Survival Rate in States Without CON Laws

PPI asked how the presence or absence of a CON law relates to the status of IPPs. The analysis focuses on practices that remained independent in 2017 and 2024 (i.e., "stable" IPPs), relative to hospital-acquired practices. A second analysis looks at IPPs that entered the market between 2017 and 2024, relative to hospital-acquired practices.[79] These proportions, or ratios, indicate how an incremental change

in hospital ownership of physician practices is associated with changes in IPPs. Higher ratios indicate relatively more stable IPPs between 2017 and 2024, or the entry of new IPPs, relative to hospital acquisitions, during the period.

The results are revealing. For example, between 2017 and 2024, there are 2.3 stable IPPs for each hospital-acquired practice across all states. However, states without CON laws have a ratio of 2.9, significantly higher than the ratio of 2.1 in states with CON laws. The ratio of new IPPs to hospital-acquired practices tells a similar story. The ratio for states without CON laws is 2.2, higher than in states without CON laws, or only 1.4.[80] While ratio analysis does not imply causality, the results show that the absence of CON laws is associated with more IPPs — both stable across 2017 to 2024, and new entrants within the period.

Additional analysis takes a deeper look at ratios based on specific CON laws enforced by the states that are particularly relevant to the acquisition of IPPs by hospitals. These include CONs that regulate hospitals, HOPDs, freestanding physician practices, and acquisitions and specific activities carried out by those facilities. Results are shown in Figures 6 and 7. For example, in states without a CON law regulating acquisitions by relevant regulated facilities, there are about 2.4 stable IPPs per hospital-acquired practice, while in states with a CON law, there are only 1.9 stable IPPs per hospital-acquired practice. Similarly, in states without a CON law that regulates a hospital facility, there are 1.9 new independent practices per hospital-acquired practice, while there are only 1.4 new IPPs per hospital-acquired practice in states with a CON low.

FIGURE 6: THE STATUS OF STABLE INDEPENDENT PHYSICIAN PRACTICES IN STATES WITH AND WITHOUT CON LAWS (2017 TO 2024)

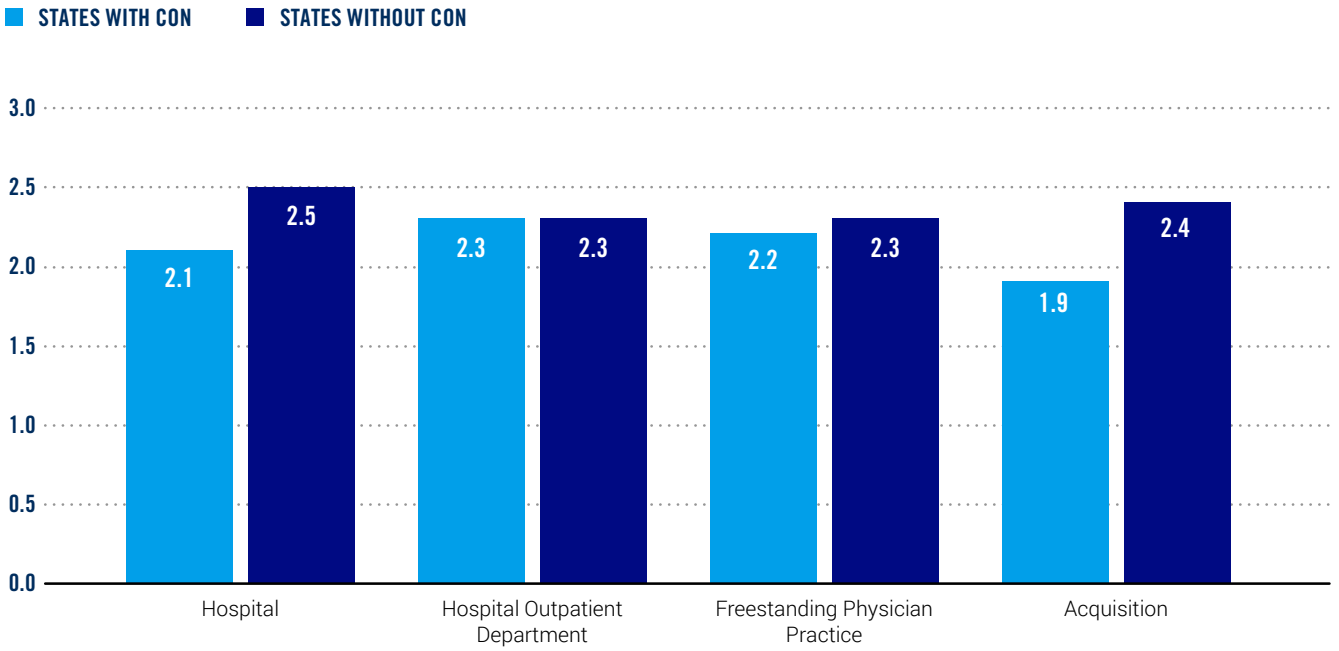
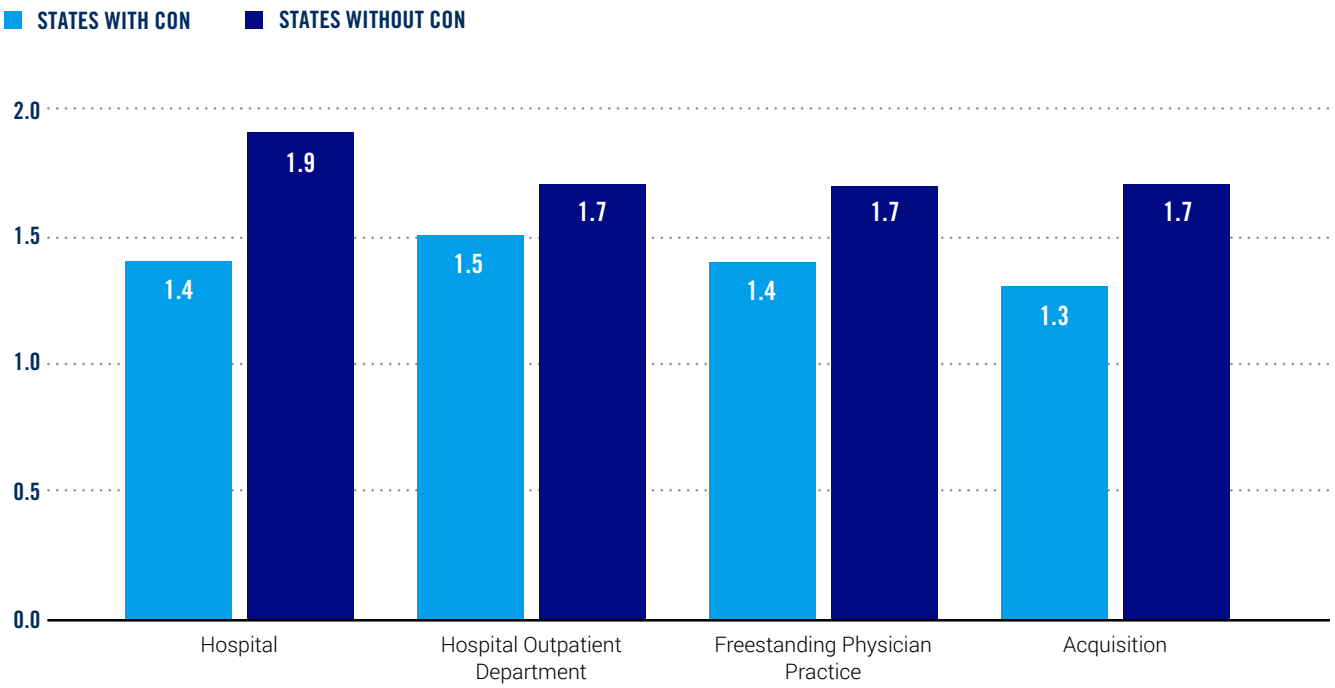


FIGURE 7: THE STATUS OF NEW INDEPENDENT PHYSICIAN PRACTICES IN STATES WITH AND WITHOUT CON LAWS (2017 TO 2024)



Notably, the magnitude of ratios is almost always higher for states without CON laws for both stable and new practices. But the gap between ratios for states with and without CON laws are significantly larger across the board, for new entry. These results reinforce the idea that the absence of CON laws may play a large role in promoting the stability of IPPs and entry of new IPPs. Perhaps this is why between 2019 and 2024, 27 jurisdictions made legislative changes to their CON programs.[81]

C. How Certificates of Public Advantage Shield Hospitals from Antitrust Scrutiny

A COPA agreement is a legal mechanism between merging entities to allow a merger, in exchange for certain concessions or oversight.[82] These agreements work to shield market participants such as hospitals from antitrust liability for potentially harmful mergers.[83] COPA laws vary by state and also by the type of merger protected by an agreement. Generally, either the state department of health, health supervisory board, or state attorney general oversees the requirements of the COPA laws that facilitate agreements. Oversight of COPA agreements is resource-intensive for states.[84] States must be able to engage in review, approval, and oversight of the merging entities to ensure COPA agreements are developed and executed as intended.

COPA laws are intended to support collaboration among health care providers. Hospitals argue that COPA laws facilitate mergers that support their financial stability amidst evolving health care reforms and challenging patient flow concerns.[85] In addition, they contend COPA-supported mergers facilitate support for population health efforts and minimize

duplicative services.[86] Hospitals also argue that in the event that an immunized merger does harm competition, the ability of states to impose regulatory guardrails on COPA mergers is a way to mitigate potential adverse effects.

The case for COPAs is unpersuasive. For example, the FTC already considers financial status when reviewing potential mergers, as well as the impact of duplicative services on the market. In addition, population health has traditionally been implemented at the individual hospital and community level rather than the health system level. Therefore, mergers are not necessary or beneficial for implementing this objective.

The FTC opposes COPA agreements on the grounds that competition is more effective at mitigating harm than COPA agreements or regulatory guardrails, which distort competition.[87] Driving this concern are Commission findings that hospital mergers result in higher prices and reduced quality. For example, in evaluating hospital mergers in nine states, the FTC identified "significant challenges of trying to regulate a hospital with substantial market power in perpetuity," as is required by COPA agreements.[88] For these states, COPA oversight that results in higher prices and lower quality is likely due to the lack of competition.[89]

Studies show that COPA laws worsen the problem of hospital consolidation, and in many instances are linked to higher commercial inpatient prices without commensurate improvements in quality of care. COPA laws have also been shown to reduce patient access to services, increase incentives to resist value-based delivery and payment models, and lower wages for hospital employees from the loss of employment options.[90] Moreover, claimed efficiencies such as lower costs and improved quality of service do not materialize from mergers where the merging parties seek a COPA agreement.[91]

The mergers of the hospital systems that created Ballad Health highlight the competition problems, intensive resource needs, and coordination necessary for COPA laws.[92] Both Tennessee and Virginia required a form of COPA agreement, and both states acknowledged the merger could reduce competition involving third-party payers, workers, and independent physicians.[93] Six years later, Ballad Health was failing across most state-required quality measures[94] and a Tennessee Health Commissioner acknowledged that the merger may have caused more harm than good.[95] The outcome of the Ballad Health merger is not dissimilar to other COPA retrospectives.

The Mission Health case is an example of gaming COPA laws to immunize a merger, then advocating for the removal of the law to expand even further.[96] A merger of two hospital systems in North Carolina was approved under an agreement shortly after the COPA law was passed. Twenty years later, the hospital system persuaded state legislators that the COPA agreement had outlived its usefulness, and was repealed. Two years later, the system was acquired by HCA Healthcare, one of the largest hospital systems in the U.S.[97]

The merger did not improve the cost, quality, or accessibility to health care in North Carolina but instead helped a large hospital system create a monopoly. Moreover, it highlights a key concern with COPA laws: they cannot simply be repealed because they leave behind entities with

significant market power and strong incentives to exercise it.[98] Moreover, since COPA laws are intended to apply to individualized agreements, unwinding different agreements is both complex and could have varying market impact.

IX. POLICY RECOMMENDATIONS

PPI's analysis of data from 2017 and 2024 sketches a stark picture of the loss of IPPs in the U.S. health care system to hospital owners and the eradication of the IPP as a vital health care delivery model. When viewed against the results of economic studies that show higher prices and increased spending, a loss of physician autonomy, and net negative effects across multiple metrics, PPI's call for comprehensive policy reform to address American consumers' loss of health care access takes on even greater urgency.

This under-recognized problem has, thus far, lacked a holistic perspective that taps into the various policy tools for stemming and managing the harm from anticompetitive vertical integration of hospitals and IPPs. The current incentive structure embedded in federal and state policies drives consolidation, without benefiting patients or the health care system.

PPI's analysis of hospital acquisitions of IPPs in the U.S. highlights the multiple policies that bear directly on facilitating vertical integration. These policies include payment differentials based on site-of-service, antitrust enforcement, and state-level regulation governing entry in health care markets and shielding hospital mergers from antitrust liability. Policymakers must to work to reform these policies to stop acquisitions that are anticompetitive and harm consumers.

Sweeping integration of physician practices into hospitals has slikely permanently changed the practice of medicine. And because of the lightning speed at which consolidation has occurred over the last two decades — and especially in the last eight years covered by the PPI study — policymakers are now working against the clock.

A. Pass Legislation for Site Neutral Payment Reform

Eliminating the major incentive for hospitals to acquire physician practices is an essential first step. Medicare site-of-service payment differentials for physician services that are provided in hospital settings versus in IPPs spur consolidation. Hospitals have capitalized on these payment differentials to shift services that would otherwise be performed in IPPs to hospitals where they can extract facility fees. Passing federal legislation for site-neutral payment reform would eliminate the ability to charge these fees and remove incentives for hospitals to acquire IPPs that have been shown, on balance, to raise health care prices.

PPI believes that the 2024 Cassidy-Hassan framework is, to date, the best proposal for achieving site-neutral payment reform. The legislative framework addresses the loophole created by the Bipartisan Budget Act, creates a regulatory process for designating what rate a service should be reimbursed, and addresses the impact on rural hospitals and communities.

PPI supports the universal application of site-neutral payment reform to all hospitals, ASCs, and HOPDs for both on-campus and off-campus facilities. This will ensure the facilities exempted from previous reforms will be treated the same

as new facilities. In tandem with the universal applications of facilities, the Cassidy-Hassan framework acknowledges that there is nuance in which services should be paid at each payment rate. By providing a regulatory process for designating services, this allows stakeholders to provide comments on specifics, and for more flexibility if the level of facility changes.

Perhaps the biggest sticking point in site-neutral payment reform is how to address the provision of medical services in rural areas and health care deserts where access is lower and costs are potentially higher. These hospitals are more reliant on Medicare and Medicaid reimbursement than other hospitals and, therefore, will likely be more affected while sustaining lower profit margins. Rural and high-need hospitals should not be exempt from site-neutral payment reform but should receive support through other financing systems. The Cassidy-Hassan recommendation for reinvestment would allow additional funding for certain hospitals while also providing support to transition to value-based reimbursement.

B. Strengthen Antitrust Enforcement

PPI's analysis indicates that there has been under-enforcement of mergers in the hospital sector and the ambulatory health services sector. While the rate at which these mergers are cleared to either the DOJ or FTC for review is above average, the rate at which transactions are investigated and challenged in federal court or in administrative proceedings at the FTC is well below average.

While many hospital acquisitions of IPPs are small, non-reportable transactions, PPI's analysis nonetheless reveals that only nine mergers were challenged by the FTC and/or state attorneys general. With economic evidence that vertical integration of hospitals and physician practices raises health care prices and results in other adverse effects, PPI urges antitrust enforcers to be vigilant in reviewing future transactions, using the stronger 2023 Merger Guidelines as guidance.[99] This is especially true for hospitals that buy large IPPs and multiple IPPs.

Given the advanced state of rapid consolidation of hospitals and IPPs, PPI encourages state, federal, and private enforcers to focus on opportunities to bring challenges against consummated harmful mergers. Enforcers should also focus on bringing monopolization cases if dominant hospitals that own physician practices are acting to foreclose competition in hospital or medical specialty markets.

C. Reform State COPA and CON Laws

PPI's analysis reveals that states without CON laws provide market environments that are more conducive to the stability of existing IPPs and the entry of new IPPs. Analysis of COPA agreements also supports the concern that state regulation works to limit competition and exacerbates hospital acquisitions of IPPs. In light of the FTC's and DOJ's concern that state regulation raises prices, erects barriers to entry, and distorts competition in markets, PPI suggests that the original justifications for these regulations be revisited in a comprehensive initiative.

While some states have repealed their CON and COPA laws, PPI also suggests that state lawmakers considering this step be cognizant of the complexity of reforming these laws. For example, repeal of COPA laws that allowed

harmful mergers to proceed on the basis of efficiencies will introduce market distortions that antitrust enforcers should be prepared to address. In the interim, further research and advocacy is important for educating state lawmakers about the effect of regulations that distort competition by controlling new entry and exacerbating hospital acquisitions of physician practices.

D. Protect Physician Autonomy and Prioritize Quality of Care

Physician practices that are acquired by hospital systems are subject to compliance with corporate financial objectives that can adversely impact medical decision-making. Moreover, a loss of physician bargaining power affects compensation structures and physician mobility, increasing the risk for consumers and physicians. PPI suggests that policymakers consider approaches for limiting the adverse impact of consolidation on physician autonomy.

These policy tools include, but are not limited to allowing incentive-based compensation based on quality of care versus volume and mandating physician leadership in governance. For example, the Stark law prohibits physicians from referring patients to entities with which they have a financial relationship for certain designated health services paid by Medicare or Medicaid.[100] Before the Affordable Care Act was passed in 2010, the Stark law allowed a "whole hospital" exception for physician-owned hospitals.[101] The ACA amended the Stark law to limit the "whole hospital" exception, a modification that essentially terminated the development of physician-owned hospitals, which is likely a major avenue for addressing physician concerns that prompt decisions to sell to hospitals.[102] PPI urges Congress to reconsider the ACA's physician self-referral laws to enable physician-led initiatives or physician-owned hospitals to increase competition.[103]

PPI also suggests that lawmakers revisit state corporate practice of medicine (CPOM) laws to ensure that they are "fit for purpose." The laws prohibit organizations from controlling medical practices to ensure physicians, not corporations, are making medical decisions for patients.[104] However, with the evolution of the health care industry since CPOM laws were enacted, they may have different impact. Much like state-level regulations, anticompetitive incentives that arise from some hospital acquisitions of physician practices encourage gaming of the CPOM laws.[105]

Finally, the COVID-19 pandemic highlighted the benefits of telemedicine to foster strong, consistent, autonomous relationships between physicians and patients. The impact of digital technologies that enable physicians to care for patients includes improved health outcomes, better access to care, and patient satisfaction while also being cost-effective.[106] Limitations of current policies supporting telemedicine work against these goals, including variation in rules based on payer, inadequate reimbursement, and state licensing schemes limiting physician access to their patients.[107] PPI urges consideration of new legislation or regulation that promotes quality telemedicine practices by allowing continuity of care to a patient by out-of-state physicians who have an established ongoing relationship.

E. Develop a Policy to Ensure Access to Health Care in Rural Areas

PPI's analysis reveals that rural areas generally, and parts of the U.S. with large rural populations such as the Midwest and parts of New England, are particularly affected by the loss of physician practices due to hospital acquisitions. The loss of independent practices in regions that already struggle to provide health care access is harmful to consumers and has disproportionate effects on the cost and quality of living for rural Americans. To be sure, some rural hospitals have business models that result in excellent access to health care. However, many rural hospital systems struggle to remain profitable, and any policy to address hospital-physician practice consolidation in rural areas, therefore, must be multifaceted.

PPI supports reinvesting in rural hospitals to ensure they remain accessible to their communities; however, this is not a long-term solution. Given the prevailing fee-for-service reimbursement system, rural hospitals will not be able to maintain the level of volume necessary to keep their doors open without additional funding from the federal government. In addition, continuing to create new hospital designations (e.g., rural emergency hospital, critical access hospital) to provide funding is not sustainable.

Policies intended to bolster health care in rural communities should support innovative business structures and technology use. For example, MaineHealth has developed a hub-and-spokes model to connect rural communities to the resources of hospitals in larger, urban communities.[108] This program increased access to primary care while decreasing readmission rates.[109] This type of innovative system requires innovative reimbursement and funding from payers and the government.

Reforming the health care systems in rural communities will, therefore, require a comprehensive rebuild with the goals of accessibility and financial stability in mind. As mentioned in the Cassidy-Hassan site-neutral payment reform framework, rural hospitals need support in moving to value-based care. Although there are many value-based reform models recommended by various stakeholders, it is beyond the scope of this project to analyze and recommend one model.

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