Policy Position Paper: Healthcare Affiliation Among Physician Organizations

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Introduction

New alignments and, in some cases, hospital systems have formed among providers as they see to both consolidate and expand their geographic reach. Because California's corporate practice of medicine law prohibits hospitals from directly employing physicians (Johnson, 2019), pricing optimization systems and the expected effects of health reform have pressured providers and some hospitals to sponsor medical foundations to align with physicians. Under the Medical Practice Act, Business and Professions Code section 2052 of California: California is the only state in the country that has a ban on hospital employment of doctors. While Ohio, Iowa, Texas, and Colorado have similar prohibitions, they are not as well enforced as California's.

The California Medical Association fears that if hospital administrators can hire physicians, they also will tell them which patients to admit and what tests to order based on the need to fill beds and payment expectations rather than medical necessity. Even though California Code, Business Professions Code BPC2401, subsection b, paragraph 2 states, “the clinic shall not interfere with, control, or otherwise direct the professional judgment of a physician and surgeon in a manner prohibited by Section 2400 or any other law”(codes.findlaw.com, 2020), underinsured and Medicaid patients could get more inadequate care. The CMA also believes that those same hospitals will refer well-insured patients to their doctor employees rather than to competitors in the community. The physician would be put into a challenging situation of being forced to admit a patient who doesn't need to be or not to accept a patient who does because the hospital would lose money.

In contrast, more small and non-hospital-based safety-net hospitals struggling in 2008 continue to fight, and some in the latter group face potential closure. According to the California Hospital Association (Van Alfen, 2014), areas defined as rural make up 75% of California's

geography and have high numbers of underinsured but have 30% fewer physicians and surgeons than metropolitan Los Angeles or the San Francisco Bay Area. Most practitioners and specialists spend years getting their medical degrees, four years undergraduate, four years of medical school, and five years residency. They do not finish their training until their early 30s. Although they may earn high compensation, most are also paying off hundreds of thousands of dollars of student loans. With a declining supply of doctors willing to practice in inner-city, rural, or district hospitals, doctors cannot make a living or improve the health and life of only Medi-Cal (Medicaid) patients. In a concurrent optimization of business economics, current and planned hospital construction raises concerns about some hospitals being able to manage medical expense funding and adding to excess inpatient capacity. These are particular concerns as information record infrastructure moves forward, given that intelligent care transactions for inpatient services are expected to decline, and the transfer of services from personal emergency response settings is expected to accelerate.

Healthcare Affiliation Among Physician Organizations Group Practice

According to Schneider & Barbera (2014), dramatic changes have occurred in affiliations among physician organizations and, in some cases, hospital systems. As the Bay Area is densely populated and divided by geographic barriers, the distances and directions people are willing or able to travel for health care are limited. As a result, healthcare policies for controlling expenditures remain within local submarkets. Kaiser Permanente and Sutter Health remain the dominant hospital systems in the Bay Area, accounting for about a quarter of inpatient discharges. Sutter has seven hospitals across 11 campuses in the five-county area, and Kaiser has 10. Kaiser's overall market share significantly understates its globalization and development with specific market segments since commercial enrollees of Kaiser Permanente Health Plan

comprise a vast majority of Kaiser hospitals' patient base. Bay Area safety net providers such as those participating in Healthy San Francisco are making strides in implementing regulatory and policy requirements and analytic approaches to care coordination.

Despite the link between market orientation and business performance, many key characteristics that define the Bay Area health care market remain constant. These include an abundant supply of hospital beds, physicians, nurses, and other health practitioners compared to other California markets. Multi-specialty groups tend to employ a mixture of generalists and specialists. The PCPs often serve as a referral source for specialists in multi-specialty groups, who, in turn, offer the PCPs a convenient resource for consults and help to maintain continuity of care between services. While there are advantages to multi-specialty groups, there's also the question of a path to partnership. How clear is the path, and is true partnership attainable for new physicians? Offering physicians the ability to share assets and associations can provide an excellent combination of autonomy, cost-sharing, and professional support.

Still, a significant proportion of physicians remain in small, independent practices that participate in the Health Maintenance Organization (HMO) contracting through Independent Practice Associations (IPA). In 2011, Brown and Toland merged with Alta Bates Medical Group (Johnson, 2019), the most massive IPA in the northwest Alameda County market centered on Oakland. The IPA admits primarily to Sutter hospitals, most notably Alta Bates Summit. The merger allowed Brown and Toland to gain 600 physicians and 30,000 commercial HMO patients. In an independent practice, physicians decide how they wish to practice, the types of patients they see, the hours they work, the fellow professionals they employ, what payers they contract with, and, most importantly, how they treat patients. However, it's also true that even the most accessible practice is not 100 percent autonomous in today's healthcare industry. If you

treat Medicare patients or contract with managed care companies, you will not be able to set your fees. Also, contracting with payers who impose treatment protocols may further lessen your ability to make clinical decisions autonomously.

The demand for safety-net outpatient services poses challenges to a historically stable and extensive network of community health centers (CHCs) and clinics. San Francisco's comprehensive and permanent safety-net primary care clinics include SFGH's on-campus general medicine and internal medicine clinics. With demand rising from low-income patients, many San Francisco CHCs have increased capacity without expanding their physical facilities, such as by extending hours and increasing their nurse-practitioner workforce. While financial performance has varied across clinics and CHCs in this region, FQHCs generally have been able to support expansions through federal grants from the 2009 stimulus package and, more recently, the federal health reform law. Also, in Alameda County, FQHCs have received significant funding increases through the Low Income Health Program (LIHP), as they must be reimbursed at their FQHC payment rate. In contrast, San Francisco FQHCs are not included in the LIHP network and do not receive those revenues.

Several years ago, it was believed that the staff model HMO might become more pervasive. Many Bay Area physicians continue to practice in the extensive medical groups aligned with Kaiser, Sutter, UCSF, and John Muir. The largest market is Kaiser's, The Permanente Medical Group, with more than 2,600 physicians. Sutter maintains separate medical foundations in San Francisco, the East Bay, and the South Bay, each with its own exclusively contracted medical groups. Physicians working in an HMO setting are paid employees and may receive bonuses based on production, utilization of resources, and patient satisfaction scores.

HMO physicians provide care only to patients enrolled in the HMO and often develop and require adherence to a specific set of practice protocols.

Policies Associated With Healthcare Affiliation Among Physician Organizations

The corporate practice of medicine doctrine exists within a broader set of policies meant to protect patients by eliminating or reducing conflicts of interest.

1. The California Code, Business and Professions Code-BPC2401: (b) Notwithstanding Section 2400, a clinic operated under subdivision (p) of Section 1206 of the Health and Safety Code may employ licensees and charge for professional services rendered by those licensees. However, the clinic shall not interfere with, control, or otherwise direct the professional judgment of a physician and surgeon in a manner prohibited by Section 2400 or any other law.
2. The Medical Practice Act, Business and Professions Code section 2052 of California: Any person who practices or attempts to practice, or who holds themself out as practicing [medicine] without having at the time of so doing a valid, unrevoked, or unsuspended certificate...is guilty of a public offense" (California Legislative Information, 2020; JUSTIA, 2020)
3. The Federal Anti-Kickback Statute (42 U.S.C. Section 1320a-7b) became law in 1972. It prohibits "offering, paying, soliciting or receiving anything of value to induce or reward referrals or generate Federal health care program business."
4. In 1989, Congress passed the Stark Law (42 U.S.C. Section 1395nn, with revisions in 1993 and 1994), focusing on physician self-referrals for Medicare patients. The Stark Law prohibits:

- A physician from referring Medicare patients for designated health services to an entity with which the physician (or immediate family member) has a financial relationship.
- The named health services entity from submitting claims to Medicare for those services resulting from a prohibited referral.

Position Statement

I support the policies of the California Code, Business and Professions Code-BPC2401, Medical Practice Act, Business and Professions Code section 2052 of California, Stark Law, and the Anti-Kickback Statute. Neither motivated nor distracted by competing interests, the physician is responsible for recommending and applying the most appropriate, science-based treatments for the patient’s circumstances and medical conditions. Though a doctor may not be in a position to save his patient's life at all times, he is expected to use his specialized knowledge and skill in the most appropriate manner keeping in mind the interest of the patient who has entrusted his life to him. Thus, a patient's right to medical attention from doctors is primarily a civil right. Hospitals do not practice medicine; physicians do. It must always be kept in mind that a doctor is a noble profession, and the aim must be to serve humanity, not the hospital's bottom line. I support the California Code, Business and Professions Code-BPC2401, Medical Practice Act, Business and Professions Code section 2052 of California.

Although I support the Stark Law; protecting patients from unnecessary services and being steered to less convenient, lower quality, or more expensive services because of a physician's financial self-interest, it has not evolved with Medicare and private markets that have implemented value-based healthcare delivery and payment systems to address unsustainable cost growth in the current volume-based, healthcare system. As a vital component of value-based

care, in its current state, the Stark Law in its current state deters hospitals from paying incentives to providers when they meet specific quality measures and from penalizing other providers who don't achieve specific agreed-upon goals. No physician who is a member of a group practice should not receive compensation that directly or indirectly takes into account the volume or value of their referrals. However, I believe physicians must be permitted to coordinate patient care and refer their patients to other health care providers if it best meets their healthcare needs. Providers must be incentivized to quantify health care processes, improve the health of populations, and experience care using information that comes directly from the patient, the structure of the organization's capacity to provide care, and resources used to assess the cost of care.

In my proposed modifications to the Stark Law, safeguards need to be in place to meet the objective of the Federal Anti-Kickback Statute, which I support. As we transition to value-based care (Key & Ferneini, 2015), how do we get practitioners to comply with the Electronic Medical Records (EMR) mandate of the Affordable Care Act? Under the broad scope of the Anti-Kickback Statute (Oig.hhs.gov, 2019), any person or entity who knowingly and willfully receives, pays, offers, or solicits anything of value to induce or reward the ordering or referral of products and services covered by Federal health care programs, including Medicare and Medicaid is guilty of a felony. Involving at least a technical violation of the stature, interoperability in EHR requires the close coordination and collaboration of various stakeholders, including patients, providers, software vendors, legislators, and health Information Technology (IT) professionals. Providing more than $35 billion in incentives to promote and expand the adoption and use of EHRs by eligible hospitals and health care professionals, it is critical to scrutinize the Health Information Technology for Economic and Clinical Health (HITECH) Act

(Trinckes, 2012) for payments and marketing activity involving physicians for the risk of falling within the anti-kickback prohibition. The HITECH Act further broadened the scope of privacy and security under HIPAA, encouraged providers to adopt EHR, and increased the legal liability of non-compliant covered entities. Subsequently, the HITECH Act introduced the concept of the meaningful use of EHR and incentivized eligibility of the Centers for Medicare & Medicaid Services (CMS) program (Young & Kroth, 2017).

To address the following payment or business practices, Congress in 1987 authorized the Department to issue regulations designating specific "safe harbors" for various payment and business practices that, while potentially prohibited by the law, would not be prosecuted. These safe harbor initiatives include:

- Investments in underserved areas; practitioner recruitment in underserved areas
- Obstetrical malpractice insurance subsidies for underserved areas; sales of physician practices to hospitals in underserved areas
- Investments in ambulatory surgical centers; investments in group practices; referral arrangements for specialty services
- Cooperative hospital service organizations.

As consumers and Centers for Medicare & Medicaid Services demand quality care for less, establishing billing requirements for unanticipated medical billing and unforeseen coverage gaps of patients for out-of-network emergency services received from nonparticipating providers creates an opportunity to succeed within the Value-Based Landscape. Compared to a bureaucratic approach at the point of referral, price transparency as an additional safeguard could empower patients to discuss costs with their physicians at the end of care.

Impact of Healthcare Affiliation Among Physician Organizations

Clinical affiliations with brand-name organizations are often terminated in hospitals that enter into mergers, particularly when community hospitals and smaller systems merge into larger systems. The value of a national alliance is often diminished when an organization is affiliated with a more extensive operation. Thus, these relationships are relatively unstable in a consolidation environment because the broader strategic issues typically overwhelm the more limited benefits of clinical affiliation. Intended to create distance between hospital administration and physicians while allowing coordination between the two groups, the future where the economic incentives of alignment around value-based health plans will govern behavior more effectively than any merged system governance where physicians might have to admit privileges at a hospital, and physician groups may contract with hospitals directly to provide services. Influencing a physician's professional judgment, the outcome for patients in physician-owned practices would seem to undermine the goal of healthcare integration, greater coordination, and efficiency leading to better patient outcomes.

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