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Rationale Against Physician-Owned Hospitals Receives Further Scrutiny

In 2015, there were approximately 250 hospitals across the United States that were completely or partially physician owned.[1] These *physician-owned hospitals* (POHs) can offer a variety of services, from general care to specialty services, such as cardiovascular or orthopedic care. Despite the prevalence of POHs, healthcare providers and policymakers have not reached a consensus regarding the effects of POHs on the healthcare industry, which include: (1) concerns regarding POHs "*cherry-picking*" the most profitable patients; (2) questions over the quality of care offered at POHs; and, (3) conflicts of interest due to the financial incentive for physician owners to refer patients to their POHs.[2] Such concerns have led to policies restricting the purview of POHs in their communities, such as limiting the application of POH exceptions in the Stark Laws and the Anti-Kickback Statute.[3] However, recent studies published in academic journals, including: the *British Medical Journal* (BMJ);[4] the *Journal of Arthroplasty*;[5] *Contemporary Economic Policy*;[6] and, the *Journal of Healthcare Finance*,[7] challenge the assumptions that led to these policy restrictions, and suggest that a significant difference in the quality of care provided and the type of patients treated between POHs and non-POHs does not exist. This *Health Capital Topics* article will explore the extent to which recent research supports or debunks the central arguments underlying regulatory policies concerning POHs, and how those findings may influence future policy governing the operation of POHs.

The primary argument of POHs that critics cite is that those hospitals select healthier and wealthier patients in order to increase their revenue.[8] However, a 2015 BMJ study found no significant differences between patient mix at POHs and non-POHs that lends credible support to critics' objections.[9] Although the BMJ article did note some indication that POHs may treat healthier patients compared to non-POHs, no evidence suggested that POHs specifically selected patients belonging to a particular socioeconomic demographic in order raise profit margins.[10] Likewise, a 2013 study from the University of Pennsylvania found that physician non-owners actually referred slightly healthier patients than owners, indicating that the physician owners were not selecting patients based on expected profits or case of patient care.[11] This study estimated that less than 30 percent of the variation in patient mix at POHs can be explained by the selections of physician owners.[12] These recent studies stand in contrast to a 2008 *Health Affairs* article, which determined that physician owners are more likely to refer well-insured patients to their POHs, and refer Medicaid patients to non-POHs.[13] Similarly, a 2006 *Medicare Payment Advisory Commission* (MedPAC) report to Congress argued that POHs tended to have lower shares of Medicaid patients than competitor non-POHs, and that POHs generally admitted less severe cases concentrating on relatively more profitable types of care (e.g., care for less severely ill patients).[14] On the whole, recent research suggests that claims asserting that POHs "*cherry-pick*" certain patients in order to generate profits are, at a minimum, unreliable.

Arguments related to a perceived reduction in care quality by POHs have also faced scrutiny in recent years. For example, the 2013 University of Pennsylvania study estimated that the 90-day mortality risk at POHs was 1.2 percentage points less than the approximately 6.4 percent average across all hospitals in the study.[15] Although this decline in mortality risk is not drastic, such decline contrasts with the argument that POHs offer lower quality care than non-POHs. Additionally, the 2015 BMJ study compared POHs to non-POHs across a variety of quality of care metrics (e.g., process measures, mortality rates, and readmissions rates), and determined that POHs generally performed equal or better on many quality of care metrics than non-POHs,[16] although the differences between the two types of hospitals were not statistically significant.[17] Reinforcing these inconclusive findings, a 2014 *Health Policy* article reviewed 46 previous studies on the performance of POHs, and similarly concluded that POHs and non-POHs share negligible differences in quality of care.[18]

The quality of care provided is not the only metric that patients consider when evaluating their interactions with providers. It is worth noting that POH patients generally report higher satisfaction with POH amenities than non-POH amenities.[19] Many POHs specialize in one type of medicine (e.g., cardiology or orthopedics), and such tailored focus has the potential of reducing patient volume and improving the care-giving environment experienced by patients through private treatment rooms, lower noise levels, and more amiable waiting areas than those found in non-POHs.[20] A 2016 study published in *The Journal of Arthroplasty* found that nearly 91 percent of POH patients strongly recommended the hospital at which they received treatment, compared to fewer than 69 percent of non-POH patients giving a similar

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endorsement.[21] Further, the study reported that POHs scored significantly higher in *hospital consumer assessment of healthcare providers and systems* (HCAHPS) scores than other hospital types.[22]

The conflict of interest for physicians who have a financial stake in patient referrals is another common criticism of POHs by those opposed to them. For instance, a 2006 *Health Affairs* article reported a positive relationship between ownership and physician referral to a specialty POH; yet, the relationship varied by specialty type and ownership stake, and suggested that the majority of physicians do not base referrals on financial gain.[23] For example, the study found that among physicians who owned less than half of a percent of the shares in a POH (which accounted for approximately a third of all physician owners of POHs) only one-tenth of those physicians referred greater than 50 percent of patients to their POH.[24] In comparison, half of physicians who owned greater than one percent of the shares in a POH referred greater than 50 percent of patients to their facility.[25] Additionally, MedPAC's 2006 report observed that communities with POHs specializing in cardiology experienced a statistically significant increase in the rate of cardiac surgeries.[26] In contrast to these results, various academic studies from 2003 to 2016 demonstrate that physicians provide higher quality medical care and more beneficial outcomes, and are better able to meet patient demands when physicians have both an operational and financial stake in the facilities where they are providing care to their patients.[27] The aforementioned studies by the University of Pennsylvania and BMJ, which observed relatively equal or better quality of care provided at POHs compared to non-POHs, demonstrate that academic research continues to undermine the supposed ramifications of MedPAC's findings. Therefore, the increase in surgical recommendations observed/documented by MedPAC could be a result of enhanced ability to provide better quality care, rather than a consequence of a conflict of interest leading to more POH referrals. The contradictory results among these studies illustrate the lack of consensus in existing research.

Likewise, research does not suggest that the alleged financial incentive for physician referrals has a negative impact on patient costs.[28] For example, the 2015 BMJ study found that patients with acute myocardial infarction, congestive heart failure, and pneumonia, had similar costs and payments at POHs and non-POHs.[29] In addition, a 2014 article in the *Journal of Healthcare Finance* found that from 2005 to 2014, a 34.1 percent increase in the number of specialty hospitals, such as POHs, resulted in a 10.1 percent decline in cost per patient admission.[30] Similarly, a 2011 *Contemporary Economic Policy* article suggested that metropolitan areas with POHs pay approximately 1 percent less in expenditures per patient than areas without POHs, though the difference was not statistically significant.[31] Therefore, even if recent research did not challenge the idea that physician owners make referrals based on their own financial interests, studies suggest that any pecuniary benefit gained from those referrals does not increase the healthcare costs for patients at POHs.

Research regarding the effect of POHs compared to non-POHs on the health of the communities they serve does not produce conclusions that are heavily in favor of, nor heavily opposed to, POHs. Yet, the general policy trend continues to restrict the influence of POHs due to unsubstantiated biases surrounding the methods that POHs use to recruit and care for patients.[32] As studies continue to investigate the validity of the common criticisms alleged against POHs, policymakers may want to consider the rationale underlying POH restrictions and consider treating POHs as an equal market alternative to non-POHs.

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