California's Ban on Physician Employment by Hospitals

BERKELEY RESEARCH GROUP

MARCH 16, 2022

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EXECUTIVE SUMMARY

California's Corporate Practice of Medicine (CPOM) Ban, which effectively prevents corporations and other artificial entities from practicing medicine, has been in place for over a century. Although it has wider applications, the CPOM Ban now most commonly refers to a ban on the employment of physicians by hospitals to provide professional services, so references to the CPOM Ban will be used in this paper to refer only to the employment of physicians by hospitals.

As applied in California, the CPOM Ban prevents most hospitals and health systems in the state from employing physicians to care for patients.

According to a 2007 report from the California Research Bureau, "The policy rational for the CPM Doctrine can be summarized as follows:

- A profit motive will lead to commercial exploitation of physicians and lower professional standards.
- An employed physician's loyalty will be divided between his/her patient and employer.
- Lay persons should not have control over professionals."[1]

Since the CPOM Ban was created, the practice of medicine has changed dramatically both nationally and in California, calling into question the continuing need for the Ban on physician employment by hospitals and raising questions regarding its possible negative impact on patients' access to care and the quality of that care.

Outside of California, there has been a growing trend toward physician employment by hospitals, driven by the move toward integrated care and physicians' increasing preference for employment in the face of increased administrative overhead, regulatory burdens, and financial pressures that buffet their bottom lines. While California nonetheless continues its broad Ban on physician employment, it has been forced to create numerous exceptions to the Ban to address changes in the health care landscape and the needs of the state's population – raising further questions about the current value and practicality of the Ban in today's healthcare landscape.

The impact of the CPOM Ban in California cannot be viewed in isolation.

- There is a shortage of physicians in the state, both primary care and specialty providers, that is expected to increase over time, given the aging of the state's physician population and other factors.
- These shortages are exacerbated by the current maldistribution of physicians within the state: 20 percent of California's population lives in an area that presently suffers from a serious shortage of primary care providers. This maldistribution is likely to get worse, as young physicians are disinclined to

practice in many of the geographic areas suffering from the greatest physician shortage.

- The number of physicians who wish to be employed, rather than practice independently, is increasing, prompted by the administrative costs of maintaining a private practice, the burdens of regulatory compliance and insurance billing, the difficulty of negotiating complex value-based contracts with health plans, and the challenges of obtaining access to necessary capital, as well as lifestyle preferences.
- Nationally there is an increased trend towards physician employment, driven by the move to integrated care, physicians' desire to be employed, and the fact that other states do not restrict it as California does.

As these larger trends towards physician employment continue, California's CPOM Ban will place the state's hospitals at a competitive disadvantage in recruiting and retaining an adequate physician workforce. These challenges may become particularly stark in underserved areas that already have difficulty recruiting physicians to meet patient needs.

Although it has been claimed that physician employment by hospitals will lead to lower quality of care, this conclusion is not supported by the research to date. National quality data and research examining the impact of employment on quality metrics like mortality has found no substantial differences in quality outcomes when physicians are employed by hospitals. In addition, the increase in physician employment by hospitals may lead to greater clinical integration and access to care for patients – a premise that warrants additional study.

The CPOM Ban does not serve the goals it was originally created to achieve. There are other means of assuring that physicians' professional judgment remains independent, that have, in fact, been expressly incorporated into many of California's existing exceptions to the Ban. Other states have successfully moved away from the Ban. Even the American Medical Association (AMA) does not endorse it: it is the policy of the AMA that physicians be free to enter into mutually satisfactory contractual arrangements, including employment with hospitals.[2] Continuing the CPOM Ban in California will only place California's hospitals, and by extension its citizens, at a competitive disadvantage as they seek to maintain a world class health care system in the future and ensure that all Californians have access to it.

KEY FINDINGS AND CONCLUSIONS

Physician Shortages in California

- Many of California's residents reside in Health Professional Shortage Areas (HPSA). By 2030, California is projected to have a shortage of 32,669 physicians.[3] This trend is

influenced by demand factors such as a growing elderly and overall state population (148 percent and 112 percent growth, respectively).

- There continues to be disparate primary care access by region in California, with some areas of the state having significantly fewer primary care providers than recommended based on population.

Trends in Physician Employment

- Increased administrative costs – among other factors – drive the trend for physicians to choose employment by hospitals and others over private practice.
- Many physicians are consolidating their practices to stay financially afloat, to meet regulatory requirements, to negotiate complex value-based contracts with health plans, and to access capital for expensive health information technology (HIT).
- Fewer physicians wholly own their practice. In 2020, around 49 percent of doctors worked in a private practice, which marks a 5 percentage-point drop from 2018, according to AMA data.
- COVID-19 has accelerated existing physician employment trends. Many independent physicians said that due to COVID-19, they were considering partnering with a larger entity, selling their practice, or becoming employed.
- 45 percent of medical residents surveyed prefer hospital employment as their first practice setting rather than any other type of setting.
- These trends may lead to a greater recruiting advantage for those states that allow hospital employment.

CPOM in California

- While the CPOM Ban in California has changed over the years, with exclusions being granted to certain types of organizations, it remains the most restrictive ban in the nation.
- The exclusions that have developed over time create a disparate ability for organizations to recruit and retain physicians, putting those organizations still subject to the Ban – which includes most hospitals and health systems – at a competitive disadvantage.
- As trends toward physician employment continue, this competitive disadvantage will continue to harm these hospitals and limit their ability to meet their mission.

CPOM in Other States

- Some states have never had a CPOM Ban in place.
- In those states that have had some form of the ban, it generally has either not been rigorously enforced or has been modified over time to no longer apply to hospital

employment of physicians – through a mixture of legislation, case law, Attorneys General opinions, or medical board licensure decisions.

- Even among the handful of states that substantially limit hospitals' ability to employ physicians, California's CPOM Ban is recognized as being the most restrictive.
- To address concerns that hospitals and other corporate entities may try to inappropriately interfere with physicians' clinical decision-making, many states that allow hospitals to employ physicians specify that the employer may not interfere with the independent medical judgment of the physician. A prohibition is incorporated into virtually all of California's exclusions from the CPOM Ban.
- Significantly, BRG has not found evidence of higher quality outcomes in states with CPOM Bans versus those that do not have them.

Review of Medicare Quality Data

Based on a review of Medicare Shared Savings Program (MSSP) and Merit-based Incentive Payment System (MIPS) data, BRG concluded the following:

- Nationally, hospital-owned MSSP Accountable Care Organizations (ACO) have similar (if not slightly higher) MIPS scores than non-hospital owned ACOs.
- University of California hospitals, with large employed (faculty) practices, outperform the overall national average and non-hospital owned national average MIPS' scores for MSSP ACOs.

Impact of Physician Employment on Quality

- Combining physician practices with hospitals has not had a negative impact on the quality of care at hospitals
    - One study assessed the performance of 4,438 hospitals on 29 quality measures reported on Hospital Compare from 2008 to 2015. The authors found hospitals with employed physicians performed similarly as hospitals that did not employ physicians on all quality measures and performed better on two of them.[4]
    - This study found no association between conversion to an employment model and subsequent changes in composite mortality, readmissions, length of stay, or patient satisfaction.
- Physician employment can provide better access to care
    - It provides access to employed specialists for low-income patients, especially those with Medicaid coverage, who historically have had poor access to independent specialists.

OVERVIEW OF CPOM BAN IN CA

The CPOM Ban has historically prevented lay (unlicensed) individuals, organizations, and corporations from practicing medicine. This includes employing physicians to provide medical services. The original purpose of the CPOM Ban was to prevent the "conflict between the professional standards and obligations" of medical professionals "and the profit motive of the corporate employer."[5]

Over the years, California has created by statute or recognized (through judicial decisions or opinions of the California Attorney General) several exceptions to the CPOM Ban that apply in limited circumstances. These exceptions are summarized at pages 24 to 26 below. But notwithstanding these exceptions, most California hospitals remain unable to employ physicians. As a result, some physicians and hospitals have been forced to create "work arounds" to allow them to achieve some of the benefits of an employment relationship without actual employment. Some of these work arounds are discussed at pages 27 to 28 below.

PHYSICIAN EMPLOYMENT IN OTHER STATES

California's expansive application of its CPOM Ban to prevent the vast majority of the state's hospitals from employing physicians makes it an outlier among the other 49 states and the District of Columbia. Almost all of these other 50 jurisdictions permit at least most, and many permit all, hospitals to employ physicians.

How these other 50 jurisdictions arrive at this result varies widely. Some do not now and never have recognized a ban on the corporate practice of medicine. Most, however, do recognize some form of prohibition on the corporate practice of medicine as a result of state statutes or regulations, judicial rulings, opinions of the state's Attorney General, position statements and/or disciplinary actions of state licensing boards, or some combination of these. But even those that have such a ban on the books vary widely in applying it: some simply do not enforce it at all; some interpret it in such a way as not to apply to hospitals and/or other licensed health care entities; and others have created explicit exceptions allowing hospitals (and other entities) to employ physicians, often subject to express requirements that the employer not exercise control over an employed physician's independent professional judgment concerning the practice of medicine.[6]

In 1991, the federal Department of Health and Human Services (DHHS) Office of the Inspector General reported, based on a survey of hospital emergency room administrators, that only 5 states prohibited hospitals from employing physicians: California, Colorado, Iowa, Ohio, and Texas.[7] The report acknowledged that even in those five states, the prohibition did not apply in all situations. Thirty years later, three of

those five states – Colorado, Ohio, and Texas – have all made substantial changes that serve to relax their CPOM Ban by, among other things, permitting all or many more hospitals to employ physicians.

Colorado

In 2016, Colorado enacted Colorado Revised Statutes 25-3-103.7 allowing a wide range of health care business entities to employ physicians subject to certain specified limitations. Specifically, this statute allows a "health care facility" as defined to employ physicians subject to specified limitations, with "health care facility" defined to mean a hospital, hospice, community mental health center, federally qualified health center, school-based health center, rural health clinic, Program for All-inclusive Care for the Elderly (PACE) organization, or a long-term care facility.[8] The statutory limitations on such employment are:

- The health care facility cannot exercise control over the physician's independent professional judgment concerning the practice of medicine, diagnosis, treatment or require physicians to refer exclusively to the health care facility or to the health care facility's employed physicians.
- The health care facility may not offer physicians any percentage of fees charged to patients by the health care facility or other financial incentive to artificially increase services provided to patients.
- The medical staff bylaws or policies or the policies of the health care facility cannot discriminate against credentials or staff privileges based on whether a physician is an employee, a physician with staff privileges, or a contracting physician with the health care facility.

Ohio

Prior to 1994, Ohio recognized and enforced a CPOM Ban. But beginning in 1994, statutory changes were enacted that changed this historical prohibition, permitting corporations to provide professional services.[9] Ohio's CPOM Ban now "appears to be all but extinct."[10] Indeed, in 2012, the State Medical Board of Ohio issued a public statement on the corporate practice of medicine with the announced purpose of "clarify[ing] that Ohio law does not prohibit an Ohio licensed physician from rendering medical services as an employee of a corporation or any other form of business entity," while noting that "no matter the business entity, a physician must exercise professional judgment to render medical services based on the best interest of the patient and within the minimal standards of care of similar practitioners under the same or similar circumstance."[11]

Texas

Texas has had a strong history of outlawing the corporate practice of medicine. But beginning in 2011, it enacted statutory exceptions to its CPOM Ban that allow a variety of hospitals, among others, to employ physicians subject to certain requirements. The entities thereby allowed to employ physicians include:

- a hospital meeting certain requirements that primarily provides medical care to children younger than 18 years of age;
- critical access hospitals;
- sole community hospitals as defined or that are located in a county with a population of 50,000 or less; and
- 19 specified hospital districts.

The requirements these hospitals must comply with include:

- "enforc[ing] policies to ensure that a physician . . . exercises the physician's independent medical judgment" and establishing a process for complaints regarding interference with that judgment.[12]
- "giv[ing] equal consideration regarding the issuance of medical staff membership and privileges" to physicians employed by the hospital and those who are not.

The purpose of modifying the Ban was to attract more physicians to rural areas. It also suggests that state legislators may eventually lift the Ban on the corporate practice of medicine altogether in Texas. Many believe the Ban impedes clinical integration that is integral to federal healthcare reform and ignores the evolution of medical practice away from solo practitioners.[13]

Many states do not have a CPOM Ban at all or, like Ohio, have almost entirely removed it. States that do not have a CPOM Ban include Alabama, Alaska, the District of Columbia, Florida, Hawaii, Idaho, Indiana, Mississippi, Missouri, Montana, Nebraska, New Mexico, Utah, Vermont, Virginia, and Wyoming.

Idaho is an example of a state that previously adhered to the CPOM doctrine. However, in 2016, the Idaho Board of Medicine affirmatively rejected the doctrine and stated that it would no longer discipline their licensees for practicing in a corporate structure.[14] In formally abandoning the corporate practice of medicine doctrine, the Board declared:

> "In the past, occasionally the Idaho State Board of Medicine has disciplined physicians for aiding and abetting the unlicensed practice of medicine by working for unlicensed entities or persons, sometimes known as the 'corporate practice of medicine doctrine.' The Idaho State Board

> of Medicine hereby formally disavows and rejects the 'corporate practice of medicine doctrine.' The Idaho State Board of Medicine will not discipline physicians or physician assistants solely because they practice medicine in association with or for unlicensed entities or persons."[15]

Given the variations across states, the change in CPOM Bans over time, the exceptions granted to the Bans both in California and nationally, it is clear that the prohibition on employment of physicians by hospitals is outdated. Maintaining such a Ban has the potential to place hospitals in those states that maintain it at a significant disadvantage when it comes to recruitment and retention of physicians.

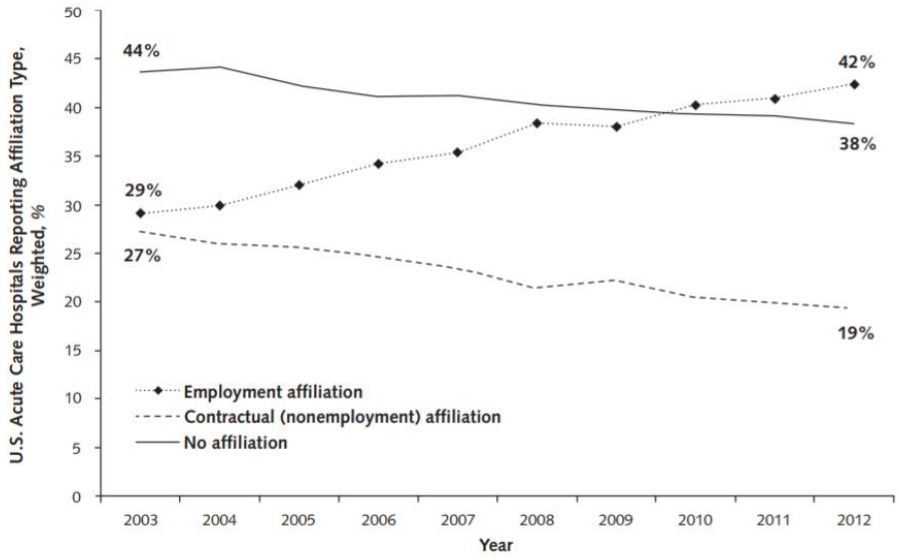
NATIONAL TRENDS IN PHYSICIAN EMPLOYMENT

Within the past decade, an important shift has occurred in the relationship between U.S. hospitals and physicians. **For the first time in recent history, hospitals in the United States as a whole are more likely to employ physicians than to enter any other kind of affiliation or relationship with them.**[16]

A study by the Annals of Internal Medicine examined changes in U.S. hospital–reported affiliations with physicians. The study examined 803 so-called "switching" hospitals (that is, those that switched to an employment-type arrangement) compared with 2,085 non-switching control hospitals between 2003 and 2012. The study found that **not only has the proportion of hospitals employing physicians increased, but this model now is the most dominant arrangement that hospitals form with physicians**. The study noted that large nonprofit teaching hospitals were more likely to have embraced this tightly integrated relationship.

In 2003, approximately 29% of hospitals employed members of their physician workforce, a number that rose to 42% by 2012.

Figure 1: Physician-hospital affiliation trends, 2003 -2012



Source: Scott, K., Orav, J., Cutler, D., & Jha, A. (2017). Changes in Hospital–Physician Affiliations in U.S. Hospitals and Their Effect on Quality of Care. Annals of Internal Medicine. http://annals.org/pdfaccess.ashx?url=/data/journals/aim/935961/ by Kevin Rosteing on 01/13/2017.

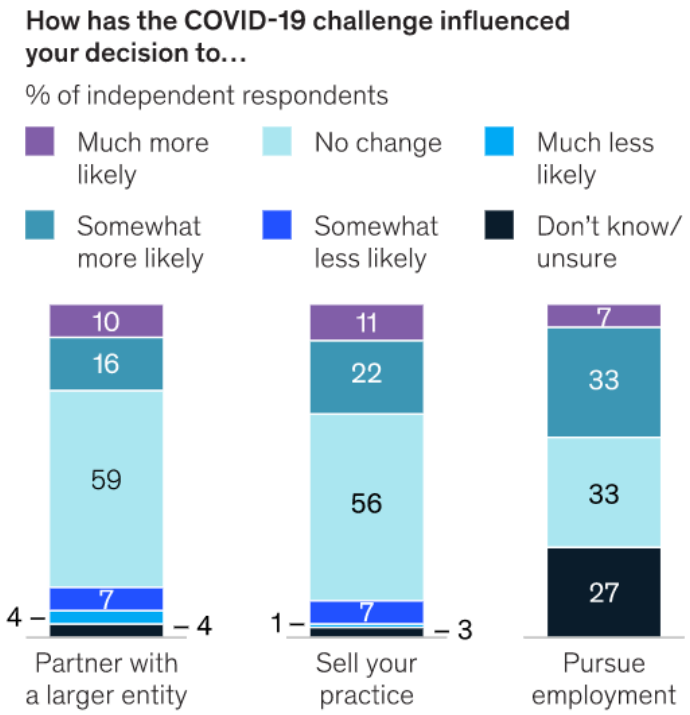
Fewer physicians wholly own their practice. Around 49 percent of doctors worked in a private practice in 2020, which marks a 5 percentage-point drop from 2018, according to American Medical Association data.[17]

The COVID-19 pandemic has also led many providers and physicians to consider how to maintain clinical quality standards and financial stability. McKinsey launched a national survey of general and specialty physicians in 2019, which it repeated six weeks into the pandemic. During the first wave of COVID-19, more than half of respondent physicians reported that they were worried about their practices closing.[18] While autonomy has remained a priority for physicians, respondents indicated that they will consider partnerships or joining a health system because of financial uncertainty resulting from the COVID-19 pandemic. In McKinsey's 2019 survey, around 40 percent of employed physicians cited both personal and practice finances as influencers in their decision to become employed.

New financial pressures resulting from the COVID-19 pandemic may also increase physician interest in being acquired or employed. Six weeks into COVID-19, 53 percent of all independent physicians reported that they were worried about their practices surviving the COVID-19 challenge. Almost half of all independent physician practices said they had less than four weeks of cash on hand, and 68 percent of those respondents looking for partners ranked financial support as their number-one reason for doing so. A third of small independent physician practices reported that they

believe working for a larger practice may provide greater benefits. Of the physicians surveyed, 40 percent of them indicated that they were much more likely or somewhat more likely to pursue employment due to COVID-19.

Figure 2



Source: McKinsey COVID-19 Physician Survey, May 2020

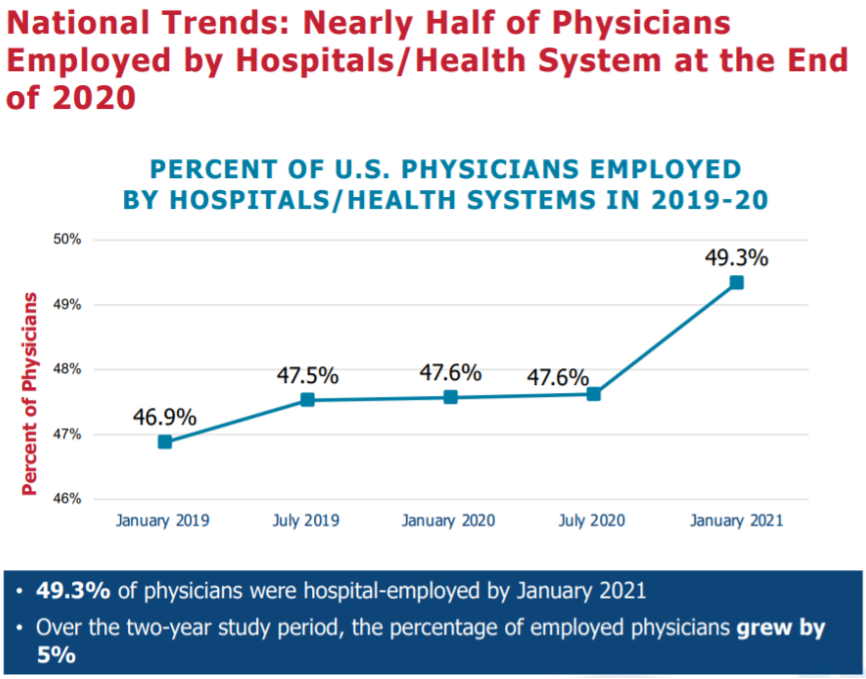
Avalere Health researchers studied the two-year period between January 1, 2019, and January 1, 2021(which encompasses the first nine months of the COVID-19 pandemic), to examine whether physician practice acquisition continued during this timeframe.[19] Avalere looked at two key related integration trends:

- Acquisitions of physician practices by hospitals/health systems and "other" corporate entities such as insurers and private equity firms
- Physicians leaving independent medical practices for employment with hospitals/health systems and corporate entities

Avalere's findings include:

- 49 percent of physicians were hospital-employed by January 2021
- Over the two-year study period, the percentage of employed physicians grew by 5 percent

Figure 3



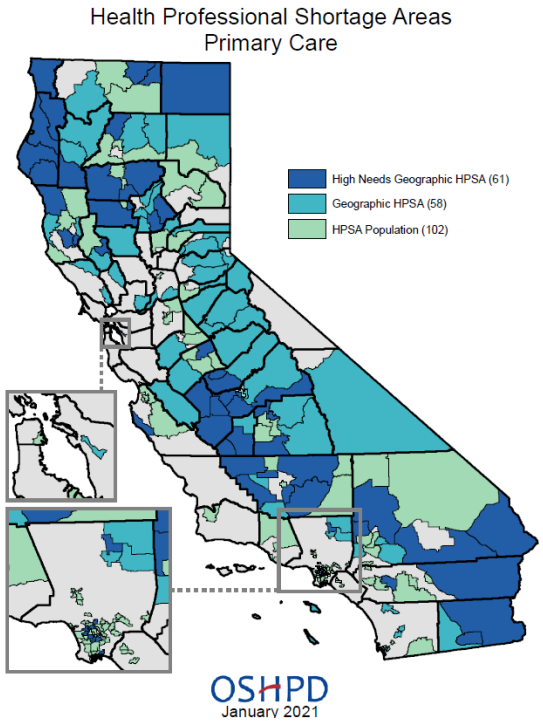
Source: Revised-6-8-21_PAI-Physician-Employment-Study-2021-FINAL.pdf (physiciansadvocacyinstitute.org)

PHYSICIAN SHORTAGES AND MALDISTRIBUTION IN CALIFORNIA

California currently has serious challenges meeting the physician needs of its population, particularly in primary care. This challenge is even more pronounced in certain areas of the state, with 28% percent of California's population living in a HPSA, defined by the United States DHHS as a "geographic area, population, or facility with a shortage of primary care, dental, or mental health providers and services."

HPSAs can be defined due to a shortage of providers for an entire group of people within a defined geographic area (geographic) or a shortage of providers for a specific group of people within a defined geographic area (population). Each designation denotes a deficit of critically needed providers to care for the community.

Figure 4



Source: Bureau of Health Workforce, HRSA

There are three categories of population-based HPSA designation, based on the health discipline that is experiencing a shortage: (1) primary medical, (2) dental, and (3) mental health. The primary factor used to determine a HPSA designation is the number of health professionals relative to the population with consideration of high need. Federal regulations stipulate that, to be considered as having a shortage of providers, an area must have a population-to-provider ratio above a certain threshold. For primary medical care, the population-to-provider ratio must be at least 3,500 to 1 (3,000 to 1 if there are unusually high needs in the community) to be considered a HPSA. [20]

California HPSAs

- Although California meets the minimum threshold for primary care providers statewide, substantial disparities exist across counties and regions of the state, with some areas below the recommended threshold.
- For primary care, California has a total of 643 HPSAs across 115 geographic areas, 96 population groups, and 432 facilities.[21] The designated HPSAs have a total population of 7,800,038.
- **To remove all primary care HPSA designations by eliminating these primary care provider shortages, California currently needs another 1,402 such providers in HPSAs alone.**[22]
- **California currently has only ~46 percent of the primary care providers needed for its population.**[23]

Having a sufficient number of primary care providers is critical to support the health of the population. Primary care providers (including physicians, nurse practitioners, physician assistants, and certified nurse midwives) can develop sustained relationships with patients and practice in the context of family and community. Having a designated primary care provider is associated with a higher likelihood of receiving appropriate care and lower mortality. Having greater access to primary care providers can provide better health outcomes and save lives.[24]

The California Health Care Foundation has also looked at physician shortages, both for primary care and for specialists in California.

Primary Care:

- The Federal government recommends an average of 60-80 primary care doctors per 100,000 people. As of 2020, California had 60 per 100,000, but only due to a saturation of such physicians in the Greater Bay Area.[25]
- Although meeting the minimum recommended threshold statewide, large geographic areas within the state are well below the recommended number.
- A UC San Francisco study projects California will need 4,700 additional primary care providers in 2025 to accommodate demand for services.[26]

Specialty Care:

- The Federal government recommends an average of 85-105 specialty providers per 100,000 people.
- Two regions, San Joaquin Valley and Inland Empire, have fewer than the recommended base of specialty physicians for the population with others only slightly over the recommended minimum number.[27]

Figure 5

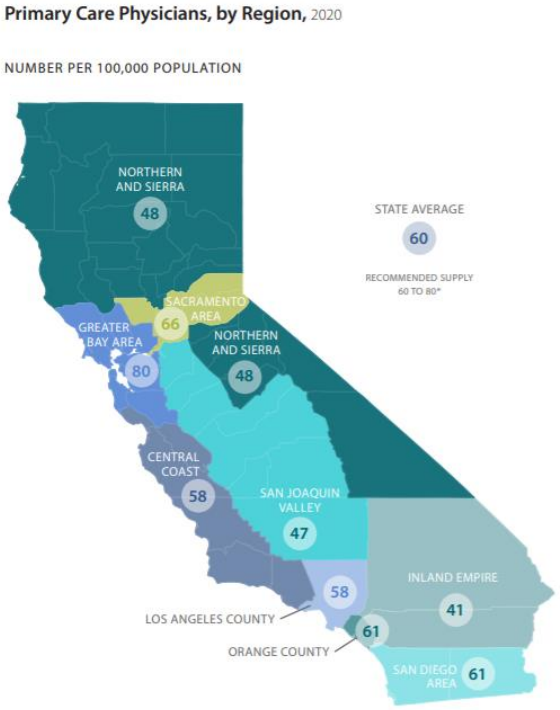


Figure 6

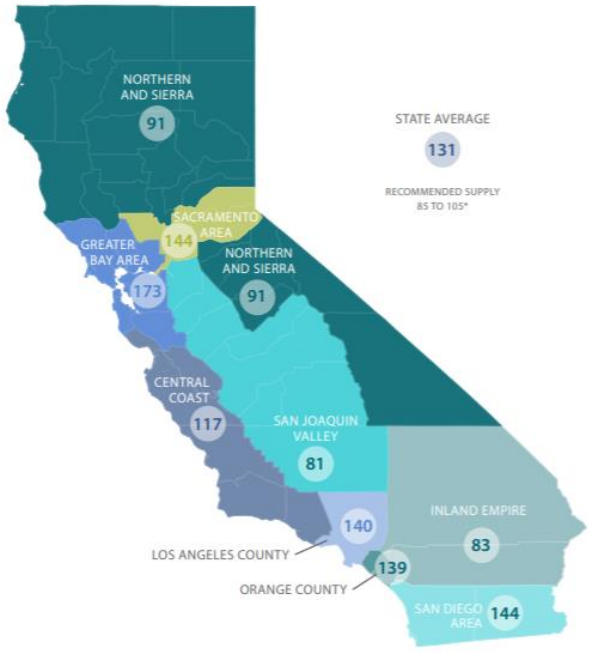


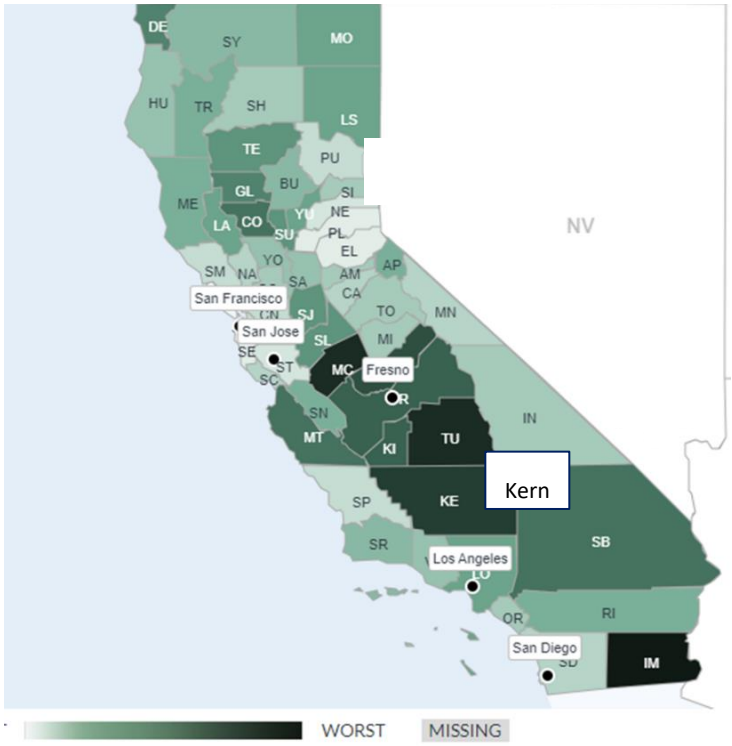
Figure 5 - 6 Source: https://www.chcf.org/wp-content/uploads/2021/03/PhysiciansAlmanac2021Q

Although statewide California meets the minimum recommended thresholds for providers, this masks the underlying inequities across the state. While the Greater Bay Area, for example, has an adequate number of primary care providers, other parts of the state such as Northern and Sierra and Inland Empire are substantially below the recommended number.

Over 33 percent of all active physicians in California are over 60 years old and within 5 years of retirement – higher than the nation-wide figures (the national level is ~30 percent). Similar trends in shortages exist for advanced practice providers such as physician's assistants and nurse practitioners. The anticipated shortage is also influenced by demand factors such as a growing elderly and overall state population (148 percent and 112 percent growth, respectively). Concerted efforts are needed to address these shortages to adequately meet the needs of California's population as a whole.

HEALTH INEQUITIES

Figure 7: Percentage of adults reporting fair or poor health (age-adjusted) in California by County.



Source: https://www.countyhealthrankings.org/app/california/2021/measure/outcomes/2/map

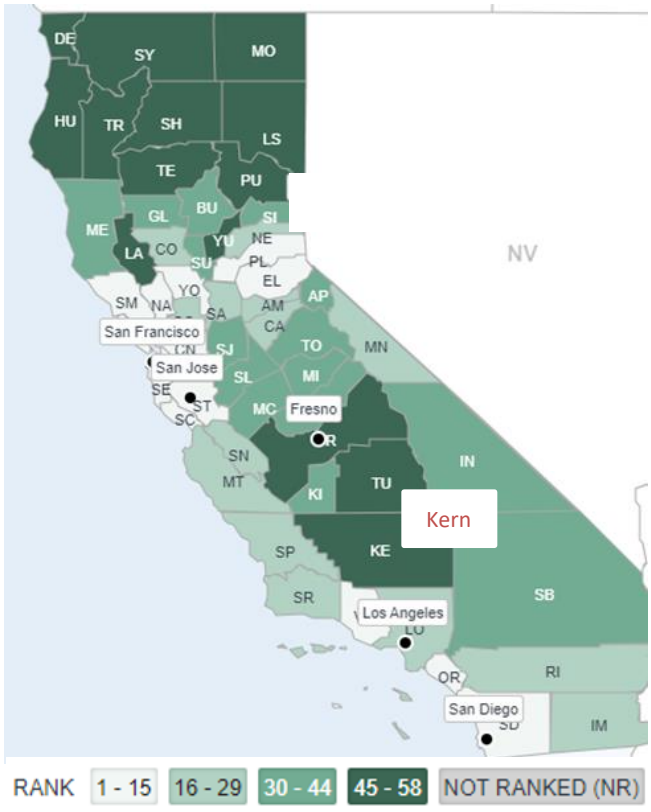
Note: The 2021 County Health Rankings used data from 2018 for this measure

Figure 8: Counties with 100% of the Population in a HPSA

Counties with 100% of their population in an HPSA	
County	**Total Population**
Alpine County	1,155
Calaveras County	45,585
Colusa County	21,477
Del Norte County	27,948
Glenn County	27,914
Humboldt County	136,373
Lake County	64,382
Mariposa County	17,676
Modoc County	9,109
Nevada County	99,696
Tehama County	63,411
Trinity County	12,870
Tuolumne County	54,349
Imperial County	181,827
Kings County	151,366
Madera County	157,672
Merced County	274,765
Tulare County	465,861

Source: https://www.chcf.org/publication/shortchanged-health-workforce-gaps-california/#related-links-and-downloads

Figure 9: Overall Health Outcomes in California by County



Source: https://www.countyhealthrankings.org/app/california/2021/rankings/outcomes/overall

The maps (Figures 7 and 9) show the health outcomes of the population by county as well as the adults experiencing fair to poor health in each county. For example, Kern County located in the San Joaquin Valley has an average of only 47 primary care providers for 100,000 people, compared to the federally recommended average of 60-80 primary care providers; Kern County also has the worst ranking for poor health and overall health outcomes in the state.

While 20 percent of the U.S. population lives in a rural area, only 9 percent of the nation's physicians serve that population.

This problem, impacting both rural and urban underserved areas, can be attributed to multiple factors including inadequate reimbursement rates for primary care services, medical school debt load, geographic isolation, lifestyle preferences, and lower rates of health insurance coverage in rural and inner-city areas.[28]

There is significant evidence that optimal health care outcomes and optimal health system efficiency are demonstrated when at least 40-50 percent of the physician workforce is composed of primary care physicians.[29] For example, a recent Government Accountability Office report concluded that over-reliance on specialty services results in a less efficient health care system.[30] For each incremental primary care physician, there are 1.44 fewer deaths per 10,000 persons. Patients with a regular primary care physician have lower overall health care costs than those without one.[31]

The report also concluded that preventive care, care coordination for the chronically ill, and continuity of care can achieve cost savings and improve health outcomes. A *Health Affairs* report found that established surrogate markers for health care outcomes in the U.S. are improved at considerably lower expense in states that have a high supply of primary care physicians.[32] In addition, socioeconomic and racial disparities in health

care outcomes are dramatically reduced when there is an appropriately sized primary care workforce.

PHYSICIANS – WHY DO THEY WANT TO BE EMPLOYED?

For decades, physicians have been burdened with increases in the cost of attending medical school, duration of training, cost of licensure/maintenance of board certification, and the cost of malpractice insurance. Additionally, increased administrative costs of operating a private medical practice – among other factors – has driven a trend for physicians to move from private practice to employed positions.[33]

Physicians are increasingly choosing employment over private practice because it allows them to focus on patient care, rather than the administrative challenges and economic uncertainties of running a business. Specific concerns drive this desire by private-practice physicians to be employed.

Market Forces

- Private-practice physicians are held captive to government regulations dictating fixed payment structures, and they have little power to negotiate favorable pay rates from private insurers.
- On the other hand, because hospitals and hospital systems recognize the critical role physicians serve in providing patient care and the increasing physician workforce shortage, they have incentives to employ physicians to ensure access to care is not jeopardized. Consequently, physicians who seek hospital employment can capitalize on these market forces to negotiate favorable compensation terms.

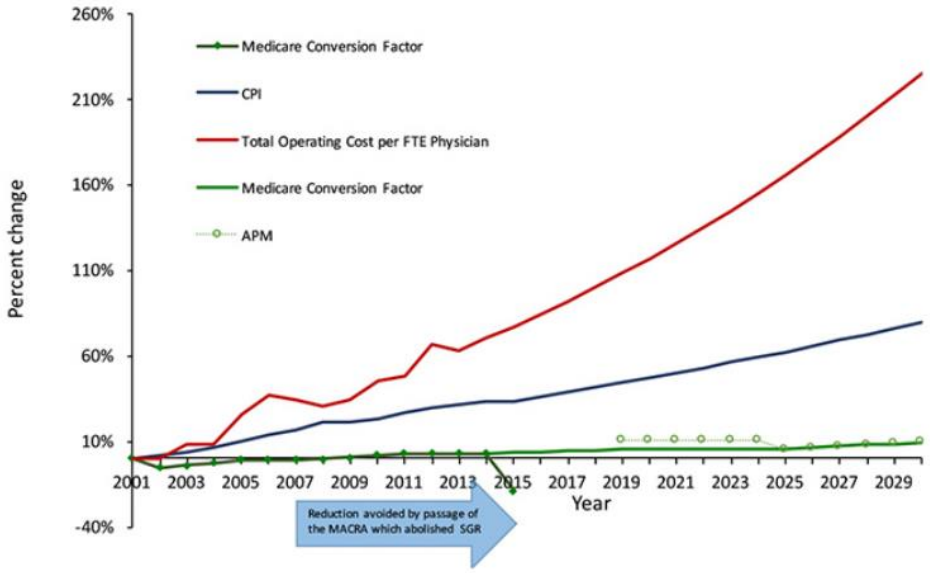
Inflationary Pressures

In the last 20 years, administrative, personnel and supplies costs in the health care sector have all risen significantly – beyond the general inflation rate. Over the same time, however, Medicare reimbursement rates have declined dramatically when adjusted for inflation.

- For example, Medicare physician reimbursement for orthopedic surgery procedures fell an average of 28 percent between 1992 and 2007, when adjusted for inflation. And while private-payer data are not as readily available, general correlations in reimbursement exist so one can assume a similar pattern across the spectrum of payer sources.[34]

Figure 10

Chart 2: Cumulative percent change in operating expenses for physician-owned, multispecialty with primary care only groups, the Consumer Price Index, and Medicare physician payments; APM scenario (2001-2030)



Data sources:
- Change in operating expenses: MGMA DataDive for Revenue and Expense; Operating expense values for 2015 to 2030 are moving average projection
- CPI is the actual annual value 2001 through 2015, then increased by 2% as projected by CBO
- 2006 CMS Conversion Factor is actual amount published by CMS; 2007-2014 conversion factors reflect adjustments of the 2006 value by the annual physician update published by CMS

Source: https://www.healthaffairs.org/do/10.1377/hblog20170127.058490/full/

Geographic Considerations and Practice Setting

A Merritt Hawkins' 2021 Survey of Final-Year Medical Residents found that:

- Geographic location was the most important factor residents consider when examining a job opportunity, followed by adequate personal time and lifestyle considerations.
- Figure 11 shows that in 2021, none of the medical residents surveyed would prefer to live in a community of 10,000 people or less, and only 3 percent would prefer to live in a community of 25,000 people or fewer, a worrisome sign for rural communities in need of physicians.

Figure 11: Practice Location Preference Based on Population

	2021	2019	2017	2014	2011
10,000 or less	0%	1%	1%	1%	>1%
10,001 – 25,000	3%	1%	2%	2%	4%
25,001 – 50,000	5%	5%	5%	4%	2%
50,001 – 100,000	14%	10%	9%	10%	10%
100,001 – 250,000	16%	18%	15%	16%	15%
250,001 – 500,000	15%	23%	20%	20%	21%
500,001 – 1 million	17%	22%	24%	23%	20%
Over 1 million	30%	20%	24%	24%	28%

Source: merritt-hawkins-2021-resident-survey.pdf (merritthawkins.com)

Figure 12 shows what practice setting survey respondents preferred, with **45 percent of medical residents preferring hospital employment as their first-choice practice setting over any other type of setting**. Notably, only 1 percent of medical residents would prefer a solo setting in their first practice, signaling the further decline of traditional private practice.

Figure 12: Physician Employment Preferences from 2021 Survey of Final-Year Medical Residents

	2021	2019	2017	2014	2011
Hospital Employee	45%	45%	41%	36%	32%
Partner With Another Physician	10%	7%	8%	20%	28%
Single Specialty Group Employee	18%	20%	18%	11%	10%
Multi-Specialty Group Employee	12%	16%	16%	14%	10%
Locum Tenens	1%	2%	2%	2%	1%
Solo	1%	2%	1%	2%	1%
Association	N/A	N/A%	N/A	2%	>1%
HMO	N/A	N/A%	2%	1%	>1%
Urgent Care Center	1%	1%	1%	N/A	N/A
Community Health Center (CHC)	2%	3%	5%	N/A	N/A
Unsure	10%	4%	5%	2%	9%
Other (Student Health, Corporate, etc.)	N/A	N/A	2%	10%	10%

Source: merritt-hawkins-2021-resident-survey.pdf (merritthawkins.com)

HOSPITALS – WHY ARE THEY EMPLOYING PHYSICIANS?

Nationally, hospitals and multi-hospital systems are acquiring medical groups and physician practices as part of a strategy to build integrated delivery systems capable of providing the full range of professional, facility, laboratory, and pharmaceutical services to patients. There is potential in this type of clinical integration to lead to greater coordination of care, less duplication of tests and treatments, a substitution of low-cost for high-cost settings where appropriate, and as a result, lower total expenditures for care.

Additional reasons hospitals choose to hire physicians include:

- Many hospitals in rural areas have no choice but to employ physicians. Retiring independent physicians are leaving large gaps in care in their economically challenged communities. Consequently, hospitals that do not step in to fill the gaps are in danger of losing physicians, being unable to provide needed care, and closing.[35]

- Inner cities also have a difficult time attracting physicians, compelling the hospitals to employ them (when state law permits) to meet the needs of the communities. For example, placing primary care physicians in urban areas is especially challenging. Demand is extremely high, but the reimbursement can be less than the suburbs and even lower in the inner city where there is a higher proportion of patients with public insurance like Medicaid.

- Employing physicians better positions the organization for capitated, or value-based payment, in which purchasers of health care (such as the government and employers) and payers (public and private) hold the health care delivery system at large (hospitals, physicians and other providers) accountable for both quality and cost of care. This is different than the traditional reimbursement system that has historically been utilized whereby providers are paid for each service they provide. These value-based payment models are typically more complex and involve financial risk for participating providers. Better clinical integration and care coordination can increase the probability of success under these models.

- Building an in-house staff of physicians has streamlined coverage for 24/7 hospital services such as the emergency department, the intensive care unit, and diagnostic services like radiology and pathology.[36]

As hospitals employ larger numbers of physicians, many are also giving physicians a greater role in governance and management. Hospital executives believe giving physicians a larger leadership role helps improve the clinical effectiveness of care and enhances physician loyalty."[37]

POTENTIAL BENEFITS OF PHYSICIAN EMPLOYMENT

Improved Quality of Care Through Increased Clinical Integration

Hospital-physician alignment is a key strategy to create clinical integration across the care continuum, thereby improving the quality of care for patients while also controlling healthcare costs. The need for hospital-physician alignment was accelerated by the Affordable Care Act (ACA), which creates value-based payment models that require greater provider accountability for cost and quality outcomes.

Many U.S. policymakers believe that increased integration between hospitals and physicians may foster better care and potentially decrease health care spending. The logic is that when physicians are employed, they can focus on patient care rather than the need to generate revenue and manage the myriad operational details of running a practice. Furthermore, as hospitals increase their efforts to improve the quality of patient care, the presence of a physician workforce that is tightly integrated with the hospital will make it easier to incentivize these clinicians to focus on quality metrics, share common information systems (which is critical to efficient care coordination), and comply with clinical guidelines that are designed to provide improved patient care.[38]

Support among policy makers to move toward greater integration between hospitals and physicians has had the effect of encouraging hospitals to employ physicians – the tightest form of "vertical integration" – and acquire medical practices.

An employer–employee relationship between hospitals and physicians can improve outcomes by:

- bolstering coordination efforts by operating under a single electronic health record, supporting a more complete view of the patient's care;
- increasing continuity of services by providing for the full continuum of services between primary, specialty, and acute care;
- improving access to capital to support necessary clinical investments such as electronic health records;
- boosting physician satisfaction; and
- augmenting accountability for clinical performance (such as through bonuses and withhold pools).[39]

One of the more prominent ways to promote integrated care delivery is through the creation of accountable care organizations (ACOs), under which some component of provider fees is under financial risk if patient care costs exceed the expenditure target.[40]

Medicare ACOs were created due to the passage of the ACA and the launch of the Medicare Shared Savings Program (MSSP). These innovative models seek to reward providers if they can reduce the cost of care year over year while also improving the

quality of care being provided. These models have evolved over time to include greater amounts of financial risk for providers. There has been a similar expansion of these types of models being utilized by commercial and Medicaid insurers nationally. Providers are also measured as part of the Merit-based Incentive Payment System (MIPS) on a range of measures including cost and quality.

Figure 13

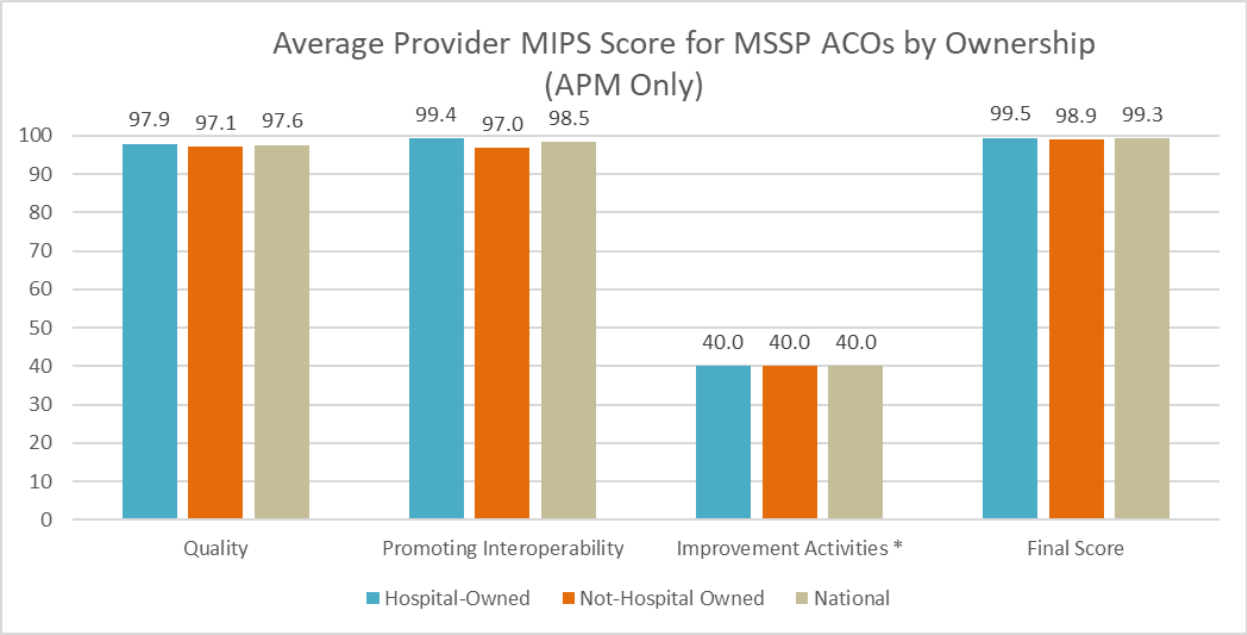


Figure 13 shows a condensed view of scores solely by ownership type (hospital-owned or non hospital-owned). Collectively, hospital-owned ACOs exceed the national ACO average score across Quality, Promoting Interoperability, and Final Score domains. Non hospital-owned ACOs report slightly lower scores (0.5 points lower in Quality, 1.5 points lower in Promoting Interoperability, and 0.4 points lower in Final Score).

Nationally, hospital-owned MSSP ACOs have similar (if not slightly higher) MIPS scores than non hospital-owned ACOs. BRG also specifically looked at the performance of the University of California hospitals, with large employed (faculty) practices, and found that they outperformed the overall national average and non-hospital owned national average MIPS scores for MSSP ACOs.

In addition to the above analysis, BRG reviewed existing literature to determine if studies had examined the correlation between physician employment and associated quality outcomes. In a study published in the *Annals of Internal Medicine*, the authors compared those physicians that had switched from an independent model to an employment model (switchers) and those that had remained independent. In comparing switching with non-switching hospitals in the same region, **they found no association between conversion to an employment model and subsequent changes in**

composite mortality, readmissions, length of stay, or patient satisfaction[41] – in other words, common measures of quality of care remained consistent after physicians became employed.

Access to Care

Physician employment also has the benefit of ensuring access to needed services for the communities the hospital serves. The problem of ensuring that patients have access to needed care is particularly acute in rural or other areas that have difficulty attracting a sufficient physician workforce. In the absence of physician employment, hospitals are compelled to turn to contracting for on-call coverage (which raises the overall cost of health care) and providing additional subsidies to physician groups for providing services in underserved areas that can't otherwise sustain needed services.

Subsidy arrangements with physicians are essential for hospitals to ensure they have adequate coverage for service lines with relatively low volumes that are insufficient to support a physician's practice or to address the needs of a payor mix that includes greater numbers of Medicaid patients (for whom physicians receive relatively low compensation) and uninsured patients.

Hospitals face serious practical and economic challenges in getting sufficient call coverage to meet patient needs, sometimes forcing them to reduce services. Being able to hire physicians to provide call coverage helps to solve these problems, insuring patients' access to necessary services. On-call coverage arrangements with physicians are essential in managing any emergency department or acute care hospital service line. Given the uninsured population in the United States and the burden and expense of ensuring adequate access, the shortages in the physician supply have created significant challenges for hospitals trying to secure physician coverage.

A study conducted by Sullivan, Cotter and Associates surveyed 142 hospitals and other organizations across the country to determine trends in physician on-call pay rates and practices. Their key findings include:[42]

- Hospitals are more likely to have to pay independent physicians for call coverage than pay employed physicians. According to the survey, 82 percent of hospitals pay some independent physicians to provide call coverage. Additionally, hospitals are more likely to have to compensate independent physicians for being called in than employed physicians.
- On-call pay is expected to grow. One-fifth of survey participants indicated they plan to start paying more physicians for on-call services within the next six months. The reasons cited were:
    - Shortages of physicians willing to provide on-call coverage in certain specialty areas, primarily surgical specialties and intensivists.

- Desire to increase the amount of coverage provided in certain specialty areas.
- Demands from medical staff.
- Physician expectations have increased as more specialties receive on-call pay.

Physician employment is a strategy to alleviate the need for expensive call coverage and to ensure access to needed services.

CPOM EXCLUSIONS IN CA

Beginning in 1968, California began creating limited exceptions to the CPOM Ban in response to specific policy needs, court decisions or federal requirements.

Examples of specific exclusions from the CPOM Ban:

Business and Professions Code Section 2401 creates the following five exceptions to the Ban on physician employment.

- *Clinics Operated for the Purpose of Medical Education by Certain Medical Schools (Business & Professions Code Section 2401(a)*[43]
    - Medical schools are not subject to the Ban. Today, thousands of physicians are employed through academic appointments across the California's public and private medical schools. Further, Business and Professions Code Section 2401(a) permits "a clinic operated primarily for the purpose of medical education by a public or private nonprofit university medical school, which is approved by the board or the Osteopathic Medical Board of California, [to] charge for professional services rendered to teaching patients by licensees who hold academic appointments on the faculty of the university, if the charges are approved by the physician and surgeon in whose name the charges are made."
- *Nonprofit Research Clinics (Business & Professions Code, Section 2401(b); Health & Safety Code, Section 1206(p))*
    - These clinics, which conduct research in such areas as prostate cancer and cardiovascular disease, also provide healthcare services to patients in conjunction with the research being conducted. These clinics may employ physicians and charge for their professional services. Addressing the lay control and other concerns underlying the CPOM Ban, this exception expressly requires that "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 provision."

- *Narcotic Treatment Programs (Business & Professions Code, Section 2401(c); Health & Safety Code, Section 11839, et seq.)*
    - Narcotic treatment programs, which are operated under Section 11876 of the Health & Safety Code, may employ physicians and charge for professional services rendered. Narcotic treatment programs currently employ 108 physicians throughout the state. Addressing the lay control and other concerns underlying the CPOM Ban, this exception expressly requires that "the narcotic treatment program 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 provision."
- *Specialty Pediatric Hospital (Business & Professions Code, Section 2401(d))*
    - A hospital owned and operated by a licensed charitable organization, that offers only pediatric subspecialty care, and that meets requirements including the following, may employ physicians and charge for their services: (1) prior to January 1, 2013, it employed physicians on a salary basis; and (2) it had not, as of that date, charged for professional services rendered to patients. (These requirements are such that it applies only to Shriners Children's hospitals.) Addressing the lay control and other concerns underlying the CPOM Ban, this exception expressly requires that "The hospital does not interfere with, control, or otherwise direct a physician and surgeon's professional judgment in a manner prohibited by Section 2400 or any other provision."
- *Critical Access Hospitals (Business & Professions Code section 2401(e), added by AB 2024 (Wood, 2016)*
    - This seven-year exception to the CPOM permits federally certified critical access hospitals to employ physicians and charge for the professional services rendered to patients, provided that, among other things, the medical staff concurs by an affirmative vote that the licensee's employment is in the best interest of the communities served by the hospital. Addressing the lay control and other concerns underlying the CPOM Ban, this exception expressly requires that "The hospital does not interfere with, control, or otherwise direct a physician and surgeon's professional judgment in a manner prohibited by Section 2400 or any other provision."

In addition to these, there are the following exclusions or exceptions to the CPOM Ban.

County Hospitals

- Though not delineated in statute, California courts have long recognized that the CPOM Ban does not apply to counties, and thus county hospitals may

employ physicians to provide medical services to patients.[44] There are 12 county-owned hospital systems in California that operate a total of 21 hospitals.

State Agencies (Government Code, Section 18500)

- The State of California has the authority to create a state civil service, including healthcare professionals. For example, the California Department of Corrections and Rehabilitation employs physicians, surgeons, psychiatrists, and dentists, among other types of medical professionals. As of December 2015, there were 534 physicians and surgeons, 631 psychiatrists and 284 dentists employed by the state.

University of California Hospitals

- By virtue of its constitutional creation as a unit of government (see Cal. Const, Art. IX, §9), the University of California is not subject to the CPOM Ban. This has been acknowledged by what is now the Medical Board of California, the agency charged with enforcing the CPOM Ban. Judicial decisions also acknowledge this status. See, *e.g. California Medical Association v. Regents of the University of California* (2000) 79 Cal. App. 4th 542, 548-550, and fn. 11.

Health Maintenance Organizations (HMOs) (42 U.S.C., Section 300e; Health & Safety Code, Section 1340, et seq.)

- HMOs have effectively been exempted from California's Ban on physician employment since Congress, as part of the HMO Act of 1973, preempted state laws that could inhibit HMOs, including the prohibition on employing physicians. But while employment relationships between physicians and HMOs are allowed, the only HMO model that directly employs physicians is the staff model, and there are few, if any, HMOs of this type today in California.

Certain Charitable Institutions, Foundations, or Clinics (Business & Professions Code, section 2400, California Code of Regulation, Title 16, Section 1340)

- The Medical Board of California may authorize the employment of physicians on a salary basis by licensed charitable institutions, foundations, or clinics if no charge for professional services rendered patients is made by that entity.

Post-Graduate Training Programs (Business & Professions Code section 2403)

- Physicians and surgeons or doctors of podiatric medicine enrolled in approved residency postgraduate training programs or fellowship programs may be employed.

NON-EMPLOYMENT MODELS FOR ACHIEVING HOSPITAL-PHYSICIAN ALIGNMENT IN CALIFORNIA

As noted above, hospital-physician alignment is critical to creating clinical integration across the care continuum, thereby improving the quality of care for patients while also controlling healthcare costs.

Hospital employment of physicians is a direct way to achieve such alignment, as salaries and bonuses can be used to incentivize physicians to achieve these quality and cost outcomes. But in California, where only a fraction of the state's hospitals can employ physicians because of the CPOM Ban, hospitals have had to develop other ways to align with physicians. Below are three examples that do not violate the employment Ban but do create a relationship between a physician and a hospital that can facilitate the goals of alignment: improved patient care at a reduced cost. Each of these examples, however, are workarounds that can be achieved only with additional administrative burdens and cost.

Medical Foundations

Health & Safety Code, Section 1206(l)

One way for hospitals to align with a group of physicians is to have a clinic operated by a non-profit medical foundation that can contract directly with physicians.

The following requirements must be met for a 1206(l) medical foundation:

- a clinic operated by a nonprofit corporation exempt from federal income taxation under paragraph (3) of subsection (c) of Section 501 of the Internal Revenue Code of 1954, as amended, or a statutory successor thereof;
- the clinic must conduct medical research and health education and provide health care to its patients;
- it must have a group of 40 or more physicians and surgeons, who are independent contractors representing not less than 10 board-certified specialties; and
- at least two-thirds of those physicians and surgeons must practice on a full-time basis at the clinic.

The medical foundation arranges for physician services through a professional services agreement with one or more medical groups or with individual doctors. The Palo Alto Medical Foundation, Dignity Health, and First Choice Physician Partners (created by Tenet Healthcare) are examples of medical foundations.

These strict requirements for medical foundations can prevent smaller hospitals from creating them. The California Health Care Foundation notes, for example, that "the complexity and costs of [establishing medical foundations] may preclude smaller, financially weaker, and rural hospitals from pursuing them, thus widening gaps between them and stronger, competing hospitals."[45]

In light of some of the challenges of using this medical foundation model, given its requirements, in 2019, California enacted AB 1037 (Gipson, 2019) which, among other things, allowed the Martin Luther King Jr. Community Hospital to create a medical foundation comprised of only 26 physicians practicing on a full-time basis at its clinic, rather than the 40 physicians required by Health & Safety Code §1206(l).

Hospital Outpatient Departments

Health & Safety Code, Section 1206(d)

Another strategy for physician alignment is to form hospital-based outpatient clinics which provide care outside of the four walls of the hospital, often treating patients with chronic or complex conditions. See Health & Safety Code, Section 1206(d) Because such clinics are owned by the hospital, they are not exempt from the CPOM Ban. But, under a professional services agreement between them, physicians agree to provide medical services (for which they generally bill third-party payers), while the hospital agrees to provide infrastructure, administrative assistance, and support services

Hospitals Purchasing Medical Practices

Though they may not employ physicians, California hospitals and health systems may purchase the physical assets (building, equipment, etc.) of physician practices and contract to manage the administrative and operational side of the practice while the physicians continue to be responsible for medical care, clinical decisions, and direct billing of insurers.

Although hospital-physician alignment models do exist outside of hospital employment, they are often expensive, administratively burdensome, and unresponsive to physician choices regarding employment.

CONCLUSION

California's ban on hospitals employing physicians is outmoded, well behind the laws and policies of virtually all other states. More importantly, it disregards the desires of physicians, the needs of hospitals, and the needs of California residents by creating unnecessary barriers to the state's ability to attract a sufficient number of physicians to provide adequate access to, and address inequities in, healthcare. It also is a major barrier to clinical integration, the goal of which is to facilitate improvements in the quality of care patients receive. While there are "work arounds" to attempt to achieve these goals, they are of limited application as well as burdensome and expensive to utilize.

APPENDIX

Methodology to analyze provider-level data for ACOs

- To determine whether hospital-owned ACOs performed at a similar overall level as non-hospital-owned ACOs, BRG used MSSP data from 2019 to create a list of ACOs to evaluate. ACOs were then categorized into "hospital-owned" or "non-hospital-owned" based on ownership status and exclusive participation with a hospital or health system. Only organizations that participated in the MSSP in 2019 were included in the review.
- BRG also coded whether ACOs were primarily based in California based on the ACO's self-reported states of operation. If California was the first state listed in the states of operation field, that ACO was coded as operating primarily in California. If California was listed in any other position or not at all, that ACO was determined to be operating in "any other" state.
- BRG then matched the identification number from MSSP data to the Merit-based Incentive Payment System (MIPS) data set and limited the scores to alternative payment models for quality outcome data. MIPS was created under the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 to measure the quality of care being provided based on specific domains – quality, promoting interoperability, improvement activities, and cost. Eligible providers are required to report to the federal government on these measures on an annual basis.

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