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CON Basics in Michigan

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Preamble

The State Bar of Michigan Health Care Law Section published the first edition of this publication in 2014. This paper is intended to serve as a preliminary research tool for attorneys dealing with Certificates of Need (CON) in Michigan. The paper should be viewed as a first-tier resource to obtain a perspective on the CON process in Michigan. It is not intended to be a treatise, nor should it be used as the sole basis for making critical business or legal decisions regarding CONs, business decisions, or legal decisions. The paper does not constitute, and should not be relied upon, as legal advice.

Introduction

Certificate of Need laws were a significant milestone in Congress's decades-long campaign to federalize health care and reduce public expenditures on it. Michigan's CON program imposes state control over the creation and acquisition of many health care services and facilities. Its current authorization is found in Part 222 of the Public Health Code, MCL 333.22201, *et seq*. This article summarizes the history, structure, and operation of the CON system in Michigan.

History of Certificate of Need in Michigan

Michigan owes its CON program to a repealed federal law, the National Health Planning and Resource Development Act of 1974, PL 93-642 (NHPRDA). That Congressional initiative threatened to withhold federal support for state Medicaid reimbursement to health facilities operating without an appropriate CON, and thus drove states and territories, including Michigan, to enact NHPRDA-compliant statutes. Stated generally, NHPRDA required a state to balance

factors of cost, quality, and access issues in disposing of an application to incur a capital cost for a new or expanded health facility. States were empowered to tailor those factors to meet their own perceived values, within limits set by the federal law.[1]

NHPRDA was a creature of the Medicare and Medicaid "cost-based" provider reimbursement systems that had paid institutional Medicare and Medicaid providers since the programs' establishment.[2] Less than a decade after their creation, those programs were under political attack as wasteful and inflationary in their administration. Cost-based reimbursement systems paid participating hospitals and nursing homes their audited ("allowable") capital and operating costs, consisting generally (but not exactly) of all costs attributable to patient care under GAAP.[3] They contained little incentive to provide care efficiently and economically because they insulated providers from the consequences of unregulated capital expansion to a significant degree.[4] A pre-NHPRDA federal program limiting Medicare reimbursement to "needed" capital costs, the "Section 1122" program, had little more effect on federal healthcare costs and did not apply to Medicaid or the private sector.[5] Congress also had limited Medicare and Medicaid cost-based payments to capital costs only, then capped all allowable operating and capital costs.[6]

Eventually, both public and private health insurers gave up trying to rescue the cost-based payment system and moved toward today's payment methods, such as hospital prospective payment (flat fee per admission) and subcontracted managed care, in which private managed care companies contract with the providers. Because the paying agencies thus gained more control over their payment obligations, actual provider costs lost their significance to them. Section 1122 and NHPRDA were repealed in 1986. Today, the actual capital and operating costs of only the most unavoidably inefficient services, like small-volume essential rural hospitals, are considered

in their reimbursement, and in return for that benefit, they operate under quite restrictive federal requirements.

The repeal of NHPRDA withdrew the last federal support for the state CON programs that states had created.[7] Some states' CON programs have been maintained, however, including Michigan's own.[8] The state Medicaid agency continues to support the legislation, and coalitions of employers and providers continue to seek the protection that the program can give to their disparate interests. Medicaid and the employers believe the program will manage the supply, and therefore indirectly suppress the use and cost, of health services. Others view it as a barrier to a truly open marketplace, in which price and service competition would intensify.

The Basics

The CON law requires approval of capital expenditures exceeding $3,492,500[9] by hospitals, nursing homes, inpatient psychiatric programs, and freestanding surgical outpatient facilities. It also requires approval for initiation, acquisition, expansion or, in some cases, physical movement of the following, regardless of costs:[10]

- Acute Care Hospital Beds
- Inpatient Psychiatric Beds
- Nursing Home and Hospital Long-Term Care Unit Beds
- Neonatal Intensive Care Unit Beds and Special Care Nursery Services
- Air Ambulance
- Bone Marrow Transplantation
- Computed Tomography (CT)
- Cardiac Catheterization
- Heart, Lung, and Liver Transplantation
- Magnetic Resonance Imaging (MRI)
- Megavoltage Radiation Therapy (MRT)
- Open Heart Surgery
- Positron Emission Tomography (PET)
- Surgical Services
- Urinary Extracorporeal Shockwave Lithotripsy (UESWL)

The issuance of a CON for any of these services is based on both statutory and administrative criteria. The statutory criteria are very nonspecific and are generally implemented through administrative enactments with impact similar to administrative rules but identified as CON Review Standards. Standards define what constitutes "need" for a project and how a project must be implemented, maintained and operated. Compliance with the Standards, which seldom leave room for interpretation, is largely dispositive of an application. Few applications are disapproved for noncompliance with the statutory criteria.

Need criteria in the Standards vary widely with the type of service. For example, the Standards for nursing homes establish county-by-county limits on the number of nursing home beds that may be operated. The limit is based historical use rates for different age cohorts and patient population projects for those same cohorts in the county. On the other hand, need for surgical services is demonstrated through written commitments of "excess" surgical cases performed within twenty miles of the newly proposed service. (To guard against duplicative commitments, an elaborate cross check system is in place.) A new surgery service may be established only if nearby surgery services are exceeding a stated minimum number of surgery cases per operating room per year. Both methodologies have the effect of protecting existing facilities, usually without regard to their utilization or quality. Medicaid program participation is a requirement of CON approval in all cases except for nursing home and hospital long-term care beds. A robust consultancy industry has arisen to assist project owners in understanding and applying Standards.

Certificate of Need Commission and the Standards

The eleven-member CON Commission is responsible for creation and maintenance of the

CON Standards. It is appointed by the Governor and must include two members representing hospitals and one member representing each of several other categories of physicians, nursing homes, nurses, Blue Cross Blue Shield of Michigan, labor unions, and businesses.[11] The Department of Health and Human Services provides administrative support for the Commission and its subordinate workgroups and committees. It is advised by the Office of Attorney General. It does not participate in the evaluation of any individual CON application.

The Commission may modify the CON Standards and add or remove some types of services from coverage.[12] It reviews each set of Standards at least once every three years. After Commission action, the modified Standard is sent to the Legislature and Governor to review it and either one may veto it within forty-five days (including nine legislative session days).[13] The Commission may appoint advisory Standards Advisory Committees (SACs) and "workgroups" to review CON Standards and propose changes. SAC composition and function are dictated by the CON statute.[14] Members are appointed by the Chair of the CON Commission and must include representatives of most stakeholder groups. Although SAC recommendations are only advisory, the CON Commission very rarely deviates from them.

Workgroups are less formal. They have no formal membership or voting and are more commonly used to address a concern or issue where consensus building is more likely to succeed. Workgroups historically have been open for all interested parties to participate. The chair of the workgroup reports the products of the workgroup to the Commission. Because the recommendations typically represent consensus, the Commission rarely deviates from workgroup recommendations.

Program Operation

The Michigan Department of Health and Human Services (MDHHS or the Department) administers the CON program, applying the statute as well as the Standards that the Commission establishes. It issues the administrative rules for the program (most recently revised effective February 4, 2014), which detail the process for filing and reviewing CON applications, implementing approved projects, amending projects after approval, and appealing denials, but do not set approval criteria for any specific type of project.[15] There are two sections within the Department that have primary responsibility within the program: the CON Policy Section and the CON Evaluation Section. The CON Policy Section largely staffs the Commission's activities, while the CON Evaluation Section processes and decides individual applications.

The CON Application Process

The CON application process begins with the filing of a letter of intent (LOI), which is processed by the Department within fifteen-days of receipt.[16] The LOI provides the Department with basic information about what service is being requested, who is requesting it, and where it is proposed to be provided. This information allows the Department to request the appropriate and relevant forms in the application. A letter of intent expires one year after processing if an application has not yet been filed.

Application Review

There are three different types of CON review: non-substantive, substantive, and comparative. Substantial fees are required for all types. Non-substantive reviews are typically for acquisitions, replacements, and/or relocations of existing facilities and/or services, where the project capital costs do not exceed the capital expenditure threshold (currently set at

$3,492,500).[17] A non-substantive application takes forty-five days to review after the application is deemed complete and can be submitted on any day of the month.

Substantive review is applied to initiation or expansion of a covered clinical service, as well as projects exceeding the capital expenditure threshold.[18] These reviews take 120-days after the application is deemed complete (typically thirty days after submission). They are deemed to be submitted on the first business day of the following month, regardless of the day they are delivered to MDHHS unless submitted on the first business day of the month.

Applications for a facility or service which the Standards allow to exist only in limited numbers (hospital beds, inpatient psychiatric beds, nursing home and hospital long-term care unit beds, and transplantation services at this time) are subjected to comparative review if the applications filed exceed the allowable limits, which are established by the Standards applicable to each project type.[19] Applications potentially subject to this review are deemed submitted on the first business day of February, June, and October.[20] They take 150-days to review after an initial thirty-day period in which MDHHS staff determines whether a comparative review actually is required. If a comparative review is not required (the combined applications do not exceed the applicable limit), then the separate applications are reviewed substantively.

An application can be submitted according to the schedules discussed above. During the first thirty-days after submission, the Department may request additional information, and the applicant may respond.[21] During the initial review of a comparative application for completeness, the Department will accept additional information and may also contact the applicant with questions. To assure fairness, no additional information is accepted after a comparative review has started unless all parties in the comparative group agree to allow the changes.[22]

Within the timeframes delineated for each review, the Department will issue a proposed decision. If it is a proposed approval, the Director has five days to sign it; if signed, it becomes a final agency action, within the meaning of the Administrative Procedures Act (APA), MCL 24.201 *et seq.*, and authorizes the action approved. If it is a proposed denial, the applicant may pursue an administrative appeal and, if still unsuccessful, judicial review.

Appeals

A denied applicant has the right to an administrative appeal of its denial.[23] Once a proposed decision has been issued, the applicant has 15 days from the date of the proposed decision to submit a written request for hearing to the Michigan Office of Administrative Hearing and Rules as well as the Director of the Department. The request for hearing must include a statement of the grounds for a hearing, a clear and concise statement of the facts, law relied on, and relief sought.[24] The applicant must serve the request for hearing upon the applicable regional CON agency. If the request for hearing is filed by an applicant in a comparative review, the request must be served on all other applicants in the comparative group.[25]

The filing of a request for hearing shall stay the issuance of any final decision of the Department.[26] This also means that any proposed projects of the approved applicant in the proposed decision will be stayed until the issuance of the final decision. This avoids the possibility of an approved applicant committing funds and creating a facility later deemed in an administrative appeal to have been wrongly approved.[27] Once the request for hearing is received, the hearing shall commence within 90 days, unless otherwise waived by the parties in writing.[28] Appeals can take several months at the administrative level alone.

The appeal is conducted as a contested case under the Administrative Procedures Act

by a hearing officer appointed under authority of MDHHS.[29] Additionally, appeal hearing procedure is governed by Part 9(c) of the Michigan Administrative Hearing System, Uniform Hearing Rules. The scope of a CON appeal hearing is limited to demonstration that the application filed by the applicant meets the requirements for approval.[30] Defects in review procedure or substantive illegality of standards are not subject to administrative appeal, although cautious appellants raise those issues to preserve them for judicial review.[31] The applicant bringing the appeal bears the burden of proving that an error occurred.

Prior to the appeal hearing, the parties may engage in discovery and motion practice. The parties are generally permitted limited discovery.[32] For instance, parties may serve written interrogatories or request for admissions on a party upon stipulation. However, depositions will only be taken for the purpose of obtaining testimony at the hearing. The rules do not explicitly contemplate document production requests; however, additional discovery may be permitted by stipulation of the parties or upon order of the administrative tribunal.[33] An administrative tribunal may compel a party to provide discovery in its discretion.

In appeals involving comparative review, discovery may be limited if the approved applicant objects to being served with discovery requests. Although an approved applicant is a necessary party to the proceeding, a tribunal may refuse to allow discovery to be served upon the approved applicant on the basis that it did not influence the aggrieved party's application. As discussed, the purpose and scope of the aggrieved applicant's appeal is to show that its application meets the requirements for approval. A tribunal may decide that serving discovery upon the approve applicant does not satisfy that purpose. However, there is an argument that Mich Admin Code, R 792.10908(7) broadly permits discovery on all parties, which includes the approved

applicant. Ultimately, whether the aggrieved applicant is entitled to any discovery will likely depend on the facts giving rise to the appeal and whether the parties are willing to stipulate to discovery.

Discovery may be further limited by privilege. Administrative tribunals have upheld the administrative "deliberative privilege" in CON hearings, and so pre-hearing deposition of decision makers is restricted, as is access to internal documentation of how a proposed decision was made. The only available decision rationale available to an appellant is that which the Department chooses to reveal in reports by its pre-decision internal Program and Finance Sections and provides to all applicants.

CON appeals rarely make their way to the final hearing stage. Most cases are disposed of on motion, sometimes supported by MDHHS affidavits asserting the Department's factual and legal positions. Proposed decisions are issued by the administrative law judge, and, after the disappointed party files exceptions, the proposed decisions are submitted to the Department Director. The Director is empowered to issue the final agency action, and thus position the case for judicial review.

As with other appeals from contested cases, judicial review is available as of right in the Circuit Court of Ingham County or the county of the appealing applicant's principal place of business. Under the APA the time limit for seeking judicial review is 60 days, but the CON statute limits that period to 30 days.[34] The judicial review process is otherwise governed by the APA and the Michigan Court Rules. Circuit court appeals from the Department's final decision will not stay the effect of the final decision.

CON Implementation

An approved applicant has twelve-months to "implement" an approved project by entering into an enforceable contract for construction or purchase of equipment.[35] One six-month extension may be granted by MDHHS if substantial progress is demonstrated.[36] Twenty-four months after approval, construction must begin and/or covered clinical equipment installed.[37] The administrative rules include provisions for extensions to those deadlines if circumstances justify the extension.

As a CON project is being implemented, the Department tracks progress through the filing of Project Implementation Progress Reports (PIPRs) by the CON holder. These are filed twelve-months after issuance of the CON, once construction has started (if applicable), once the project has been completely implemented, and periodically in the interim as requested by the Department.

If a project has changed significantly since approval, the applicant must file a request to amend the CON.[38] "Significant" changes include an increase in project costs beyond the standard allowance of fifteen-percent of project costs up to $1 million and ten-percent of all costs above $1 million.[39] Other significant changes could be a significant increase in square footage for a construction project, change to the make/model of a piece of covered clinical equipment, or a change in the number of beds being replaced or relocated. Two fundamental things absolutely cannot change during the review of a project or after CON approval – the applicant entity and the type of covered service.[40] There are provisions for changing the location of an approved but not yet licensed health facility, however the applicant must demonstrate that the project cannot be implemented at the approved site due to an unforeseeable event that occurred after approval of

the project and the new site would have been approvable in the original review of the application.[41]

Compliance

CONs often include ongoing conditions, usually contained in the Standards, aimed at assuring efficient use, open access and quality of service. MDHHS's CON Evaluation Section monitors compliance with approvals through its CON annual survey and compliance reviews. Historically the annual survey has almost exclusively monitored service volumes and facility occupancy, but in more recent years the Department has expanded the survey to address other requirements, notably minimum staffing, Medicaid participation, and accreditation requirements.

Most years the Department chooses two covered clinical services and/or bed types to review for compliance. MDHHS will start the compliance audit by sending questionnaires to all providers of the service across the state, requesting detailed review of project delivery requirements in the CON standards under which the service was most recently approved. Based on those responses along with information provided in the CON annual survey, the Department will often request meetings with providers who appear to have not complied with all conditions of CON approval to seek clarity on any outstanding questions and discuss plans for remedying any non-compliance. If a facility is felt by the Department to be non-compliant with its CON approval (commonly, by not performing the minimum number of procedures required for approval under the applicable Standards), the Department typically offers to enter into a compliance settlement agreement rather than officially declare non-compliance or revoke CON approval. The compliance settlement agreements often will include a plan to achieve compliance, as well as civil fine and a charity care undertaking. Because a CON service is held to the standards

in effect at the time of its approval, if a standard has been modified since approval, the compliance agreement will almost always bring the program under the most current standard and sometimes include provisions to allow the service to request the ability to come under a new standard if changes go into effect during the term of the agreement. We are not aware of any CON being rescinded after a project has been built, or services have been initiated.

The Department has a great deal of discretion when it comes to enforcement of the CON law. Its powers include revoking the CON, imposing civil fines, and/or requiring notification to all payers allowing them to require a refund of all monies paid for services provided outside of CON compliance.[42]

The Future of CON

The Legislature has taken a great deal of interest in the CON program over the past several years, much of it negative. As of the time of this writing, there are two legislative packages seeking reforms to the CON program. A Senate package would remove inpatient psychiatric beds and air ambulance services from the CON program as well as add members to the CON Commission and modify some of the requirements for forming Standards Advisory Committees.[43] A House package would add transparency and reporting requirements to MDHHS and the CON Commission processes.[44]

A strong case can be made against the effectiveness of CON as a cost control measure. While the CON barrier clearly does deny (or discourage) significant amounts of capital investment in health care each year, the abandonment of cost-based reimbursement supports an argument that the original purpose and fundamental function of CON programs have become irrelevant. Improvident capital investment may impose costs on the project owner, but payors are

no longer willing to cover those costs beyond their own estimate of reasonable compensation. The Federal Trade Commission has been hostile to CON laws for some time.[45]

Our view is that CON is secure in its place in the health care regulatory system in Michigan for the foreseeable future. It retains strong support from public and private payers, who subscribe to the hospital-in-the-desert parable and believe that oversupply of available services means excessive utilization (perhaps to compensate for loss of cost-based payment). It is also largely supported by existing providers, who, despite the program's potential for dramatic creation of winners and losers, appreciate the protection from new entrants into the market. On the other hand, it generally favors institutional ownership of health services in which physicians might otherwise invest on their own behalf, and so it is, at times, opposed by organized medicine.[46] All indications are, however, that Michigan will remain one of those 35 states that remain attached to the laws that Congress abandoned more than 30 years ago.

Endnotes:

[1] A few states, notably New York, had adopted Certificate of Need programs before enactment of NHPRDA.

[2] Cost-based Medicare payment systems for hospitals and other institutional providers were based on the then-current Blue Cross payment model.

[3] Private payment systems, like Blue Cross, also paid on the cost basis, and private costs were going up as rapidly as costs to the public systems, so payment reform was of interest to the employers paying insurance premiums for their workers.

[4] An illustrative parable in the health planning field recites that a new hospital stayed empty until a doctor moved in next door and filled it to capacity.

[5] Section 1122 of the Social Security Act was codified at 42 USC 1320a–1.

[6] Major private payors, like Blue Cross, usually followed the federal lead in reimbursing their participating providers.

[7] The National Council of State Legislatures reports that 35 states retain some form of CON regulation. See National Conference of State Legislatures, *Certificate of Need (CON) State Laws* <https://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx#:~:text=Currently%2C%2035%20states%20and%20Washington,state%20as%20of%20December%202021> (accessed September 27, 2022). The scope of covered services varies largely from state to state. In Ohio, for example, only the expansion or inter-county transfer of nursing home beds requires approval; all other investments or transfers that Michigan's program would regulate are unregulated.

[8] In light of the Supreme Court's longstanding recognition that even local health care services can affect interstate commerce, surviving state CON programs have been challenged under the "dormant" Commerce Clause analysis of *Pike v Bruce Church*, 397 US 137; 90 S Ct 844; 25 L Ed 2d 174 (1970). The cases, which necessarily are service-specific, have survived motions for summary judgment and judgment on the pleadings. See *Yakima Valley Memorial Hosp v Washington State Dep't of Health*, 654 Fed 919 (CA 9, 2011) and *Colon Health Centers of America, LLC v Hazel*, 733 F3d 535 (CA 4, 2013). There has been no such challenge in Michigan, to our knowledge.

[9] Adjusted annually according to the Consumer Price Index.

[10] See generally MCL 333.22209.

[11] MCL 333.22211.

[12] MCL 333.22211-22215.

[13] MCL 333.22215(4).

[14] MCL 333.22215(1)(l).

[15] Mich Admin Code, R 325.9101 *et seq.*

[16] Mich Admin Code, R 325.9201(1). The LOI is a holdover from NHPRDA, where it had a significant role in structuring the review process and notifying the public that a project was open to public comment and hearing. Today, it is the means by which an administrative file is opened, a number is assigned, and forms are designated for submission.

[17] Mich Admin Code, R 325.9206.

[18] Mich Admin Code, R 325.9207.

[19] Required by *Huron Hosp v State Health Facilities Comm,* 110 Mich App 236 (1981) and later written into the statute at MCL 333.22229.

[20] Mich Admin Code, R 325.9208.

[21] If the application is non-substantive the Department will deem it complete and begin its review on the day it receives said response. If it is a substantive or comparative application, it will be deemed complete on the first business day of the following month. Mich Admin Code, R 325.9201(3).

[22] Mich Admin Code, R 325.9215(1)(c). One occasion for such a request is a change in Standards that occurs between filing and decision.

[23] See MCL 333.22232(1) ("The applicant may, within 15 days after receipt by the applicant of the bureau's proposed decision to deny the application or receipt of notice of reversal by the director of a proposed decision that is an approval, submit a written request for a hearing to demonstrate that the application filed by the applicant meets the requirements for approval under this part."); see also MCL 333.22232(3) ("If a hearing is requested under this section, chapter 4 of the administrative procedures act of 1969, Act No. 306 of the Public Acts of 1969, being sections 24.271 to 24.287 of the Michigan Compiled Laws, governs.").

[24] Mich Admin Code, R 792.10908(3).

[25] Mich Admin Code, R 792.10908(4).

[26] Mich Admin Code,R 792.10907(2).

[27] That was the remedy, and the outcome in *Huron Valley*, 110 Mich App 236.

[28] Mich Admin Code, R 792.10908(5).

[29] MDCH has arranged with the State Office of Administrative Hearings and Rules to conduct the hearings. The presiding officers act under authority delegated by the Director under the Public Health Code.

[30] Mich Admin Code, R 792.10909.

[31] The burden of proof is seldom addressed directly under the APA in CON hearings, but it lies with the applicant in practice. That view is based on text outside of the administrative appeal provision of MCL 333.22232(1). MDCH has argued in hearings and in court that because the statute requires an initial demonstration "to the satisfaction of the department" that need for the project has been shown (MCL 333.22225[1]), the appellant must also satisfy the hearing officer, thus, establishing a burden of persuasion: "MCL333.22225(1) makes clear that the applicant only needs to satisfy the Department that their proposed project meets the applicable CON

standards to be [approved]." Brief of Appellee Michigan Department of Community Health, *Medilodge of Oxford v Michigan Dep't of Community Health*, Oakland County Circuit Court, Docket No. 12-1300-41-AA, p 2, 12 (October 30, 2012).

The establishment of agency "satisfaction" of compliance, with statutory requirements for approval, perhaps independent of actual compliance, raises an ambiguity about the scope of hearings and burden of proof: it is unlikely that a denial by a "satisfied" review agency will ever produce an appeal. Cases raising the issue have been disposed of on other grounds by the courts, and so the issue has not been answered outside of the administrative hearing process.

[32] See Mich Admin Code, R 792.10912; Mich Admin Code, R 792.10910.

[33] This conclusion is derived from Mich Admin Code, R 792.10912(1), which provides that "[t]he same rights to discovery and depositions provided in the Michigan court rules applicable to civil cases shall apply to all hearings commenced and conducted pursuant to section 22201 to 22260 of the public health code, 1978 PA 368, MCL 333.22201 to 333.22260, and these rules."

[34] MCL 333.22231(9).

[35] MAC R 325.9403(1). Pursuant to Mich Admin Code, R 325.9103(b), some project types require performance of the first procedure or issuance of a license within one year of the effective date of the CON approval.

[36] Mich Admin Code, R 325.9403(2).

[37] Mich Admin Code, R 325.9417.

[38] Mich Admin Code, R 325.9413.

[39] Mich Admin Code, R 325.9415.

[40] Mich Admin Code, R 325.9413(5).

[41] Mich Admin Code, R 325.9413(4).

[42] MCL 333.22247.

[43] Senate Legislative Analysis, SB 181-183, 190 (S-1) (April 28, 2022).

[44] House Legislative Analysis, HB 5074-5077 (H-1) (March 3, 2022).

[45] See Federal Trade Commission and Department of Justice, *Federal Trade Commission, Department of Justice Issue Joint Statement on Certificate-of-Need Laws in Illinois* (September 12, 2008), available at <https://www.ftc.gov/news-events/news/press-releases/2008/09/federal-trade-commission-department-justice-issue-joint-statement-certificate-need-laws-illinois>.

[46] The program operates independently of the federal and state laws that prohibit or restrict physician ownership of some health care services. CON relief, if achieved, would not fully clear the way for unlimited physician ownership of non-physician investment in health services.