AAFP
AMERICAN ACADEMY OF FAMILY PHYSICIANS

Statement of the American Academy of Family Physicians

By

Jennifer D. Gholson, MD
Member, Commission on Federal and State Policy
American Academy of Family Physicians

To

Health Subcommittee,
United States House Committee on Ways and Means

On

"The Collapse of Private Practice: Examining the Challenges Facing Independent Medicine"

May 23, 2024

AAFP Headquarters
11400 Tomahawk Creek Pkwy.
Leawood, KS 66211-2680
800.274.2237 • 913.906.6000
fp@aafp.org

AAFP Washington Office
1133 Connecticut Avenue, NW, Ste. 1100
Washington, DC 20036-1011
202.232.9033 • Fax: 202.232.9044
capitol@aafp.org

Chairman Buchanan, Ranking Member Doggett, and distinguished members of the committee, thank you for the opportunity to testify today. My name is Jennifer Gholson, MD and I am a family physician from Summit, Mississippi. I am a member of the American Academy of Family Physicians' (AAFP) Commission on Federal and State Policy and I am honored to be here today representing the more than 130,000 physician and student members of the AAFP. My remarks today are made in my capacity as an AAFP representative and do not reflect the opinions of my employer or any other organizations with which I am affiliated.

As a former solo practice owner, I applaud the Committee for holding today's hearing to examine one of the most pressing issues impacting all sectors of health care. It was not long ago that the vast majority of primary care was delivered by physicians in solo or independent practice who were uniquely embedded in and connected to the community they served. However, over the last few decades, we have propped up a health care system with misaligned incentives that directly rewards consolidation and perpetuates underinvestment in primary care. **Every system is perfectly designed to achieve the results it gets, and our current system is designed to ensure the death of independent medicine.** As a result, only 21 percent of family physicians today report having any ownership role in their practices, compared to 37 percent in 2011.[i]

In my testimony today, I would like to illustrate the confounding factors that are fueling this consolidation of primary care practices by sharing my story. However, my story is not simply mine. It is also the story of countless other family physicians across the country who have been forced into a false choice of either selling their practice, often for pennies, or closing their doors entirely to avoid economic ruin. Thankfully, Congress has an opportunity to take meaningful action and advance policies that will ensure the success of practices of all sizes and ownership types, not just large practices owned by health systems and health plans with substantial capital. This includes policies such as:

- Improving Medicare reimbursement for primary care and providing prospective, sustainable revenue streams to allow physicians to tailor their practices to their patients' needs;
- Addressing misaligned incentives such as site of service payment differentials that encourage consolidation;
- Minimizing the mountain of administrative burden that independent primary care practices are subject to;
- Banning the use of overly-restrictive noncompete agreements; and
- Increasing federal regulators' enforcement authority of anticompetitive practices.

My Practice Story

I have practiced primary care for more than 20 years, serving in various clinical and non-clinical roles throughout my career. In 2011, I opened my own brick and mortar family medicine practice in my community, where there had previously been a void of any other primary care practices. Summit, Mississippi is by every definition a rural town, boasting just under 1,500 residents. Despite being advised by many that starting a solo practice would be a hard and potentially unsuccessful undertaking, I felt the need to serve patients by meeting them where they were. To help supplement my practice revenue, I also continued to work as the medical director at a health plan.

To say that running my own practice was hard would be an understatement, but it was also rewarding and fulfilling. I was an early adopter of value-based payment through participation in an accountable care organization (ACO), where we achieved shared savings while providing quality care to patients. I am grateful that I had the opportunity to participate in an ACO. There was at least one year when the shared savings payment helped keep my practice doors open. When the pandemic hit in early 2020 and Mississippi required us to stop seeing patients in-person, we were able to pivot to providing care via telehealth the very next day. As an independent practitioner, I

was able to cultivate meaningful, trusted relationships with my patients, many of whom became like family, while maintaining my own clinical autonomy and decision-making authority.

Around 2021, though, the tides started to change. As a small practice, we had a lean staff that included a two clinic nurses, one chronic care management nurse and two nurse practitioners (NPs). Together we handled all of the day in and day out that managing a practice required. This included trying to understand and submit prior authorization requests for over ten different payers we contracted with and navigating ever-changing prescription drug formularies to understand what would or wouldn't be covered for our patients. Getting paid started to become harder, as well. My practice provided lab services for our patients, but suddenly the payment we were receiving from health plans started to shrink. While getting paid $3 less per lab may not sound significant, it certainly starts to add up. Physician practices already get paid less for services than hospitals, who are able to charge patients facility fees and therefore often get paid two to three times as much for a service than if it were delivered in a physician's office.

Primary care is at its best when it's delivered by a physician-led *team*. However, because of the higher payment and overall increased capital and resources, it was extremely hard for my practice and other physician practices in the community – which had grown to include three other primary care practices since I started mine – to compete with hospitals for the same staff. They can offer signing bonuses, higher base salaries, financial contributions toward student loan debt, and an array of technology and other resources that is often infeasible for physician practices to offer.

Eventually, the draw of hospital employment with its higher salaries and more support staff became too alluring for my staff. A nurse practitioner I hired to help support the growth in patients left two months after I had invested time and resources to train her. The hospital's offer was too good for her to turn down. I had the privilege of working with an incredible nurse - the nurse who I spent almost my entire career working with and recruited to my practice shortly after I opened. She ended up leaving because, as she put it, "primary care had become too hard and she couldn't do it anymore." She went to work for a hospital-employed pulmonologist. We both cried when she left. Within what seemed like a few months' time, both of the NPs on my team decided to leave as well – one of them going to a hospital owned practice closer to her home and the other to a job with a subcontractor for managed care companies that offered more flexibility.

Following their departures, I tried to make things work but the hits kept coming and burnout seemed inevitable. For example, health plans started clawing back money that they had already paid me because of minor billing mistakes, such as using the wrong site of service code, instead of allowing me to resubmit claims with the correct code because their time frame to resubmit had elapsed. Eventually, for the sake of myself and my patients, I had to reevaluate whether keeping my practice doors open was in fact the right choice. I knew that it would take upwards of six months to try and replace my staff, and the mountain of administrative complexity that I faced each day further eroded the amount of time I was able to dedicate to patient care. In the decade that had passed since I established my practice, a pharmacy, an urgent care, and a physical therapist had also opened in my small town. The presence of my practice had made a positive economic impact on the community and, most importantly, a positive personal impact on my patients. I decided to close my practice and sell the brick-and-mortar space in the summer of 2022.

What's Driving Consolidation in Primary Care?

Since closing my practice, two of the other three independent primary care practices in my community closed with one physician going to work at a local hospital and the other moving out of state to work for a large hospital system. The principal factors fueling the consolidation of primary care practices with health systems, plans, and other corporate entities are financial instability, staffing challenges, administrative burden, and the need for more resources and capital. Physicians are often forced to choose between the stability offered by health systems, payers, or

other physician employers, and the autonomy and community focus of independent practice. Increasingly, family physicians like me report that independent practice is simply unsustainable. The available evidence supports our experiences: our current environment is driving and rewarding consolidation while at the same time draining resources from primary care.

A 2017 study found that from 2010 to 2016, the share of primary care physicians working in organizations owned by a hospital or health care system increased by a dramatic 57 percent—while the shares in independent solo practice or organizations owned by a medical group decreased.[ii] A subsequent study published in 2020 found the share of primary care physicians affiliated with vertically integrated health systems increased from 38 percent to 49 percent from 2016 to 2018. In 2018, more than half of all physicians were affiliated with a health system.[iii]

Similar data shows that hospitals and corporate entities, including health plans and private equity, now own over half of physician practices (hospitals own 26.4 percent and other corporate entities own 27.2 percent). From 2019 to 2021, there was a 43 percent increase in the number of corporate-employed physicians and an 86 percent increase in the percentage of corporate-owned physician practices.[iv] In 2021, UnitedHealth Group – which already owns the nation's largest commercial heath plan – became the largest employer of physicians in the country through its subsidiary company, Optum.[v]

The proportion of family physicians who are employed continues to grow each year, with 73 percent of all AAFP members and 91 percent of new family physicians (one to seven years post-residency) working as employees in a wide range of organizations from small independent practices to Fortune 100 employers. This shift is dramatic considering only 59 percent of AAFP members reported being employed in 2011.

Providing high-quality, patient-centered primary care requires a multi-disciplinary team, technology that facilitates advanced data aggregation and population health analytics, and practice management staff to support traditional practice management functions such as patient communication, scheduling, and billing. All of this requires practices to make significant financial investments and commitments to remain competitive. While large health systems with revenue streams from multiple service lines may be able to afford these escalating practice costs, many independent primary care practices struggle to make ends meet as the physician payment system has failed to keep pace with the escalating demands and costs placed on primary care practices.

I know of many physician colleagues in independent practice who have not taken home a paycheck themselves so that they could pay their staff and overhead expenses to keep the lights on. Ultimately, many of their stories have ended like mine: they either close their doors or succumb to acquisition to avoid financial ruin. While some family physicians have reported positive experiences with being acquired by a health system or corporation, citing access to advanced tools and technology, additional administrative support, and other experts, many more physicians experience moral injury as they cope with loss of clinical autonomy and requests to prioritize organizational priorities over those of their patients.

The motivation behind the acquisition of primary care practices is the same for both hospitals and insurers – control of cash flow. Vertical integration can allow primary care to become a leverage point to maximize savings or profit somewhere upstream. For payers, controlling primary care allows them to oversee and manage care across a patient's care team and settings. For hospitals, it allows them to refer patients to their other employed specialists or seek treatments in their facilities that produce higher profit margins while also ensuring the patient's care (and costs) stay within a defined health system. In both situations, these organizations use primary care to meet other financial goals, redirecting revenue away from primary care and failing to invest in the primary care teams that patients benefit from most. Both hospitals and insurers are achieving their

financial goals, but the patients and their primary care physicians, in many instances, are not benefiting from these financial windfalls.

There may be circumstances in which market integration is beneficial. However, the research on the impact of these trends and consolidation more broadly has become increasingly clear. Evidence has shown integration leads to higher prices and costs, including insurance premiums, without improving quality of care or patient outcomes.[vi] One study found that hospital-owned practices incurred higher per-patient expenditures for commercially insured individuals when compared to physician-owned practices.[vii]

Site-of-service payment differentials play a significant role in these inflated costs. Currently, hospitals are directly rewarded financially for acquiring physician practices and other lower cost outpatient care settings. Medicare and other payers allow hospitals to charge a facility fee for providing outpatient services that can be safely performed in the ambulatory setting. However, there is little evidence that these additional payments are reinvested in the acquired physician practice, many of which are primary care practices. Thus, the hospital increases its revenue by acquiring physician practices and beneficiaries are forced to pay higher coinsurance.[viii]

In March 2024, the AAFP conducted a survey of members requesting information about their experiences with health care consolidation. When asked specifically about the impact on compensation and benefits, responses were mixed, with 40 percent saying their compensation and benefits were somewhat or much better, 29 percent reporting no change, and 25 percent claiming compensation was worse or much worse after the transaction. Respondents who sold their independent practice to a hospital generally felt compensation improved because their salary was now more reliable, compared to experiences in independent practice when they were unable to draw salary due to economic events (such as the COVID-19 pandemic or delayed payments, including the recent cyberattack on Change Healthcare). A 2021 study found that physicians in independent primary care practices acquired by a hospital or health system saw, on average, no difference in income after integration.[ix]

The survey also asked about impact on other aspects of practice, including staffing, management, clinical autonomy, access to resources such as health IT infrastructure, and administrative requirements. Overall, most physicians felt some positive impact on their ability to access resources such as health information technology, billing and patient portals, and telehealth tools. However, these benefits come at a high cost, including diminished clinical autonomy and reduced job satisfaction. Survey responses included:

- Examples of how post-transaction administrative policies prevented them from offering necessary patient care. For example, comments described scheduling mandates that prevent physicians from providing same-day visits to acute patients and result in month-long (or more) wait times for appointments.
- Several physicians felt that while their own personal productivity metrics increased, overall access and availability to patients decreased.
- Physicians also cited frustration with restrictions on referrals outside the health system.
- Other commenters noted that acquisition by a health system resulted in centralized management decisions made without local primary care physician or practice input, resulting in increased administrative burdens, reduced quality, or in some cases, both.

Our survey results align with other external reports indicating physicians experience a drop in clinical autonomy and feel patient care declines post-acquisition. A 2023 survey conducted by NORC found that more than half of employed physicians experienced reductions in the quality of patient care as a result of a practice acquisition.[x] Nearly half of survey respondents attributed the changes to reduced clinical autonomy and requirements that prioritize financial performance. The same survey found 61 percent of physicians felt they had moderate to low autonomy to make

referrals to care outside the health system, which is reinforced by research showing hospital ownership of a physician practice dramatically increases the likelihood a patient will be admitted to the owning hospital.

Opportunities to Support the Future of Independent Medicine

As I noted in my introduction, this Committee has the chance to reverse these concerning trends by advancing policies that allow practices of all sizes to flourish. If we want to protect the viability of current and future independent family medicine practices, it requires Congress to meaningfully overhaul how we pay for primary care, minimize administration burden, and reform our existing policy environment that is propelling consolidation.

Appropriately paying for primary care: One of the key drivers of financial instability for primary care practices is the United States' continued, systemic underinvestment in primary care. Evidence has shown time and time again that improving access to longitudinal, coordinated primary care reduces costs, improves utilization of recommended preventive care, and reduces hospitalizations. Yet only five to seven percent of our total national health care spending is on primary care.[xi] The consequences of this underinvestment are particularly pronounced in rural communities – like Summit – which represent nearly two-thirds of primary care health professional shortage areas (HPSAs) in the country.[xii]

In particular, the piecemeal approach fee-for-service (FFS) payment takes to financing primary care undervalues the whole-person approach integral to primary care and hinders the ability of family physicians to provide care in a way that is organic and responsive to our community. Primary care services are relatively undervalued in the Medicare Physician Fee Schedule, which leads to further devaluation across virtually all other payers who peg their payment rates to Medicare's or use Medicare's relative values to set their rates.

The retrospective, volume-based nature of FFS also fails to account for the costs of longitudinally managing patients' overall health. It does not provide practices with the time and flexibility to invest in the care management staff and population health tools that enable practices to efficiently and effectively meet patients' individual evolving health needs.

Rural communities like mine are disproportionately impacted by insufficient FFS payments and the other pressure points fueling consolidation. We have smaller patient volumes that are older and more likely to have chronic illnesses, multiple health concerns, and be low-income. We see higher rates of uninsured and Medicare and Medicaid patients, meaning significantly lower payment rates and more expensive, uncompensated care. Because of the less-profitable patient population, studies have indicated that market concentration is higher in low-income areas.[xiii] For some small, rural practices and hospitals, the effects of consolidation may be different. Mergers and acquisition can play an important role in preserving existing sites of care (and oftentimes, the only site) with insufficient margins. However, it also often results in the closure of service lines not deemed highly profitable – including primary care – and may worsen access to care in these communities.[xiv]

For these reasons, the AAFP has long advocated to accelerate the transition to value-based care using alternative payment models (APMs) that provide prospective, population-based payments to support the provision of comprehensive, longitudinal primary care. We strongly believe well-designed APMs provide primary care a path out of the under-valued and overly burdensome FFS payment system that exists today, and in turn will better enable the Medicare program to meet the needs of its growing and aging beneficiary population in new and innovative ways. Unfortunately, a dearth of primary care APMs and the inadequacy of FFS payment rates that often underlie APMs are undermining the transition to value-based care. Because most APMs are designed based on FFS payment rates, modernizing FFS payment for primary care is one essential strategy to support physicians' transition into value-based care.

Physician practices that struggle to keep their doors open cannot possibly transition into APMs or hire care managers and behavioral health professionals. Practice transformation and quality improvement require significant investment in practice capabilities including technology, people, and new workflows. Therefore, the Academy continues to urge the Committee to advance legislative solutions, including reforms to the Medicare Access and CHIP Reauthorization Act (MACRA), that would address unsustainable FFS payment rates for physicians and alleviate some of the associated administrative burden for practices, while promoting patients' access to continuous, comprehensive primary care. This includes greatly needed reforms to existing budget neutrality requirements, which pit physician specialties against one another in a fight for scarce resources and hinder CMS' ability to appropriately pay for all the services a beneficiary needs.

Alleviating geographic payment differences: In addition to already being insufficient, Medicare payments to physicians in rural areas are generally less than in suburban and urban areas, as reflected in the geographic adjustment factors associated with the Medicare Physician Fee Schedule (MPFS). This current structure of low payment can prevent physicians from being able to feasibly accept as many patients as urban and suburban physicians, further disadvantaging individuals living in rural areas and consequently reducing their access to primary care services. For this reason, the AAFP supports the elimination of all geographic adjustment factors from the MPFS except for those designed to achieve a specific public policy goal (e.g., to encourage physicians to practice in underserved areas). I appreciate that Congress has temporarily extended the floor of 1.0 for the physician work Geographic Practice Cost Index (GPCI) through the end of this year and continue to encourage consideration of a more permanent solution to more fairly value the work of rural physicians.

Further, MACRA requires CMS to apply payment adjustments to Medicare Part B fee-for-service payments based on an eligible clinician's (EC) performance in the Merit-based Incentive Payment System (MIPS). ECs with a MIPS final score above the performance threshold receive a positive adjustment while those below the threshold receive a negative adjustment. The adjustments must be budget neutral – meaning the positive adjustments are equal to the negative adjustments. As such, both the positive and negative adjustments are made on a sliding scale with the exception that those in the bottom quartile automatically receive the maximum negative adjustment for the year.

We are concerned that the current design of MIPS, which focuses on individual clinician performance using largely process rather than outcomes measures, is not driving care improvements as much as it is adding administrative complexities that detract from patient care and unfairly penalizing small and rural practices. While most physicians have met or exceeded the MIPS performance threshold, physicians in small and rural practices consistently have lower than average MIPS scores. As the performance threshold increases, it will become more difficult for small and rural practices to avoid a negative adjustment. MIPS has effectively used the negative payment adjustments from the majority of clinicians in small practices to fund positive adjustments for clinicians working in large health systems. These estimates demonstrate that the MIPS program is not driving continuous quality improvement and is instead on a path that will accelerate the closing and consolidation of small physician practices. Based on these concerns and the recognition that the overarching goal of the Quality Payment Program (QPP) is to drive toward well-designed value-based payment, a broader overhaul of the entire program must be considered.

Addressing site of service payment differentials: Facility fees are one of the clearest advantages that hospitals had over my practice. As mentioned, it generates them significantly more revenue for providing the very same services I did and affords them the capital to give staff higher salaries, signing bonuses, and additional financial compensation such as contributions toward student loan payments. Patients should not be subject to higher costs simply because a

hospital owns the outpatient office they visited, and physician practices should not be effectively penalized financially for remaining independent.

The AAFP has long supported the advancement of thoughtful site neutral payment policies that would establish payment parity across care settings and even the playing field for physician practices, with careful consideration as to not unintentionally accelerate consolidation. We have supported the Lower Costs, More Transparency Act (H.R. 5378), which Chairman Smith has championed. We appreciate that it would ensure payment for physician-administered drugs provided in an off-campus hospital outpatient department (HOPD) will be the same as those delivered in a physician's office. We have urged Congress to swiftly pass this measure, while also continuing to advocate for additional action to build upon and advance more substantial site neutral payment policies.

Reigning in utilization management processes: Administrative functions and regulatory compliance overburden family physicians at the point of care and after patient care hours. These functions include activities such as electronic health record (EHR) documentation, submitting claims to get paid, reporting on quality and performance measures, and navigating prior authorization and step therapy requirements. Studies have estimated that primary care physicians spend nearly 50 percent of our time on cumbersome administrative tasks.[xv] When my staff left my practice, the administrative burden was the straw that broke the camel's back.

Utilization management processes by health plans are one of the greatest sources of administrative burden for physicians. Payers that use protocols such as prior authorization (PA) frequently describe them as a cost-control mechanism. However, repeated evidence has shown that many use prior authorization inappropriately, causing care delays and worsening patient outcomes and satisfaction. A 2022 report from the Department of Health and Human Services (HHS) Office of Inspector General (OIG) confirmed that Medicare Advantage (MA) plans sometimes deny prior authorization and payment requests that meet Medicare coverage rules by using clinical criteria not in Medicare coverage rules and requesting unnecessary documentation, as well as making errors.[xvi] From my own experience working at health plans, the criteria may not be the same from one health plan to another creating confusion for physicians who are simply trying to help their patients.

In an American Medical Association (AMA) survey of physicians, 94 percent reported that prior authorization delays access to care, while 80 percent reported that it led to patients abandoning their treatment and 33 percent reported that it had led to a serious adverse event for their patient.[xvii] Additionally, 86 percent of surveyed physicians reported that prior authorization sometimes, always, or often leads to higher overall utilization of health care resources, such as additional office visits, emergency department visits, or hospitalizations.

The AAFP applauded CMS for finalizing a regulation earlier this year that will streamline prior authorization processes, implement electronic prior authorization, and improve transparency across all of its payers, as well as address inappropriate coverage denials. However, we continue to advocate for the passage of legislation to enshrine these necessary reforms into statute. Specifically, the Academy continues to push for reintroduction and passage of the Improving Seniors' Timely Access to Care Act, which passed the House last Congress and would codify many of the regulatory provisions by requiring implementation of an electric prior authorization program in MA and streamlining and standardizing of PA processes.

Additionally, when insurers change medication coverage, we are often only told that the medication is not covered – we are not given any additional information, such as a list of alternatives that *are* covered. This means we spend a lot of time going back-and-forth with the pharmacy trying to figure out what medicine is covered by a patient's plan. We often find ourselves prescribing a medication that is not covered, or not preferred by the patient's insurance company,

which can lead to the patient not taking the prescribed medication. I appreciate that this Committee passed the Real-Time Benefit Tool Implementation Act (H.R. 7512), which requires prescription drug plan sponsors to implement at least one electronic real-time benefit tool to allow physicians to see drug costs before prescribing. I urge the full Congress to follow suit and ensure its enactment.

In closing, thank you again for the opportunity to provide this testimony and share my story. On behalf of the AAFP and as a family physician, I look forward to working with the Committee to advance policies that invest in the viability of independent medicine and ensure that physicians can organically choose whether they are independent or employed, rather than being forced down one path to avoid financial ruin.

Founded in 1947, the AAFP represents 130,000 physicians and medical students nationwide. It is the largest medical society devoted solely to primary care. Family physicians conduct approximately one in five office visits -- that's 192 million visits annually or 48 percent more than the next most visited medical specialty. Today, family physicians provide more care for America's underserved and rural populations than any other medical specialty. Family medicine's cornerstone is an ongoing, personal patient-physician relationship focused on integrated care. To learn more about the specialty of family medicine and the AAFP's positions on issues and clinical care, visit www.aafp.org. For information about health care, health conditions and wellness, please visit the AAFP's consumer website, www.familydoctor.org.

---

[i] White B. The state of family medicine. Fam Pract Manag. 2012 Jan-Feb;19(1):20-6. PMID: 22335379.
[ii] Fulton B. Health Care Market Concentration Trends In The United States: Evidence And Policy Responses. 2017. Available at: https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.0556
[iii] Furukawa et al. Consolidation Of Providers Into Health Systems Increased Substantially, 2016–18. Available at: https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2020.00017.
[iv] Avalere Health, "COVID-19's Impact On Acquisitions of Physician Practices and Physician Employment 2019-2021." April 2022. Accessed at: https://www.physiciansadvocacyinstitute.org/PAI-Research/PhysicianEmployment-and-Practice-Acquisitions-Trends-2019-21.
[v] Tepper N, "Vertically integrated payer-provider groups raise antitrust concerns." *Modern Healthcare*. March 22, 2022. Available online at: https://www.modernhealthcare.com/operations/insurers-pave-new-vertically-integrated-provider-model.
[vi] Schwartz K et al. "Issue Brief: What We Know About Provider Consolidation," Kaiser Family Foundation. September 20, 2022. https://www.kff.org/health-costs/issue-brief/what-we-know-about-providerconsolidation/
[vii] Robinson JC, Miller K. Total expenditures per patient in hospital-owned and physician-owned physician organizations in California. JAMA. 2014 Oct 22-29;312(16):1663-9. doi: 10.1001/jama.2014.14072. PMID: 25335148.
[viii] Pst, B et al. Hospital-physician integration and Medicare's site-based outpatient payments Avaialble at: https://onlinelibrary.wiley.com/doi/abs/10.1111/1475-6773.13613
[ix] Physician Compensation In Physician-Owned And Hospital-Owned Practices, Christopher M. Whaley, Daniel R. Arnold, Nate Gross, and Anupam B. Jena, Health Affairs 2021 40:12, 1865-1874, https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2021.01007
[x] "The Impact of Practice Acquisitions and Employment on Physician Experience and Care Delivery." Survey conducted by NORC at the University of Chicago for Physicians Advocacy Institute, November 2023. https://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/PAI-Research/NORC-Employed-Physician-Survey-Report-Final.pdf?ver=ylnykkKFPb3EZ6JMfQCelA%3d%3d
[xi] Centers for Disease Control and Prevention. National Center for Health Statistics. Ambulatory Health Care Data. National Ambulatory Medical Care Survey (NAMCS). 2016. https://www.cdc.gov/nchs/ahcd/index.htm. Accessed February 9, 2023.
[xii] U.S. Department of Agriculture, "Rural America At A Glance: 2019 Edition" (Washington: 2019), available at https://www.ers.usda.gov/webdocs/publications/95341/eib-212.pdf; CAP analysis of data from U.S. Department of Health and Human Services Health Resources and Services Administration, "HPSA Find," available at https://data.hrsa.gov/tools/shortage-area/hpsa-find.
[xiii] Yerramilli P, May FP, Kerry VB. Reducing Health Disparities Requires Financing People-Centered Primary Care. *JAMA Health Forum.* 2021;2(2):e201573. doi:10.1001/jamahealthforum.2020.1573
[xiv] O'Hanlon CE et al. "Access, Quality, And Financial Performance of Rural Hospitals Following Health System Affiliation," Health Affairs. December 2019. https://doi.org/10.1377/hlthaff.2019.00918

[xv] Berg S. (2020). Physician Burnout: Which medical specialties feel the most stress. AMA. Retrieved from https://www.ama-assn.org/practice-management/physician-health/physician-burnout-which-medicalspecialties-feel-most-stress

[xvi] Grimm CA, "Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care." U.S. Office of the Inspector General, April 2022. Available online at: https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf

[xvii] American Medical Association, "2022 AMA prior authorization (PA) physician survey." Accessed online at: https://www.ama-assn.org/system/files/prior-authorization-survey.pdf.