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Introduction

Chair Buchanan, Ranking Member Doggett, and members of the Subcommittee thank you for inviting me to participate in this hearing. I am a practicing physician who has spent much of my clinical career caring for Veterans in the VA Healthcare System. I also serve as the Dean of the Brown University School of Public Health and as a Professor there. In these capacities, I have witnessed the collapse of small physician practices and how this has impacted both patients and providers.

Healthcare is changing very rapidly. For much of the 20th century, healthcare was delivered in small private practices and individual hospitals where care was intimate and patients knew their doctors for years if not decades. Over the past 30 years, medicine has changed. As a result of scientific advancement, people are living longer, healthier lives.¹ They are also living with complex chronic conditions, disability, and frailty — conditions that would have killed them 50 years ago. Today, thanks to modern medicine, more Americans can continue to enjoy life despite these conditions. But of course, caring for a sicker, more chronically ill, and more frail population is much more complicated. This seismic shift in medicine has made it more difficult, though not impossible, to deliver care using the same structures we have used for decades. From a physician's perspective, the rapid proliferation of scientific knowledge has made it challenging to coordinate care across multiple specialists while keeping track of thousands of new medicines and doses, and how medications interact, to name just a few challenges.

Over the past 20 years, as a response to this growing complexity in medicine, there has been a set of clinical and policy solutions that have been largely bipartisan. For example, there has been strong, bipartisan support for the use of Electronic Health Records (EHRs) in hospitals and doctors' offices. There is no question that these systems have made a difference, improving safety and quality, but they have also made life in a small practice harder. These small offices often do not have an IT staff, making it more difficult to get support when something goes wrong with the EHR. These systems often need upgrades and other types of maintenance, which can be expensive and difficult for small practices to manage. Last but certainly not least, many of the EHR systems designed for small practices are less advanced, more clunky to use, and have placed new burdens on physicians in terms of documentation and difficulty of use.

There are additional burdens as well, as I lay out below, from contracting with private insurers to managing complex requirements for reporting on quality, to dealing with prior authorization when trying to provide good care. So it is no surprise that in the last decade, practice ownership has shifted dramatically, with the share of physicians working in private practice declining from 60% in 2012 to 47% in 2022.² Correspondingly, the past decade witnessed a fall of doctors in practices with ten or fewer physicians, dropping from 61% to 52%, while those in practices with 50 or more physicians continue to grow.² The shift toward employment by large corporate entities is stark – nearly 4 out of 5 physicians are now employed by a hospital, health system, or

other large corporate body.³ A vast majority of physicians who have sold their practice reported that both better salaries and less administrative complexity were critical to their decision.⁴

There are numerous factors driving trends of small physician groups selling their practices to hospitals, other private corporations, or private equity, and these factors are all interrelated. Below, I lay out the major factors that drive the demise of small, independent physician practices and how they are interrelated. Then, I will lay out critical policy solutions if we want to protect independent practice and allow physicians to thrive.

I. Facility Fees and Hospital Acquisitions of Private Practices

A major driver of the declining small physician practice is hospitals and health systems purchasing these practices. As of 2022, over half (52%) of physicians were employed by hospitals and health systems, a number that has doubled over the last decade.⁵ What is driving this rapid acquisition? In large part, it is our payment policy. Medicare, as well as more private insurers, pay more when a patient receives the same care at a “hospital” than if they receive that care in an independent practice. These additional “facility fees” have had predictable results: hospitals will acquire practices and direct physicians to refer "downstream" services away from community providers and to hospitals, where Medicare and commercial insurers pay higher rates for the same service. For example, Medicare currently pays a facility fee of \$127 for an MRI done in a non-hospital setting, and \$233 for the same procedure done in a hospital.⁶ For chemotherapy, an infusion in a hospital can cost nearly three times more than in a physician’s office, with the same quality of care.^{7,8} These changes in referral patterns substantially increase Medicare spending, incentivize hospital purchases of independent physician practices, and leave the taxpayer worse off while providing zero benefits to patients and generally physicians. Critical preventative care procedures including mammograms, colonoscopies, and cardiac tests have been affected by facility fees, as Medicare paid hospital rates (which include the fees) for more than half of funded chemotherapy services in 2021.⁹ This was a little more than one-third a decade ago.¹⁰ These additional facility fees put increasing pressure on physicians as they further incentivize hospitals to buy up private practices to increase reimbursements.¹¹

In the last year, some states have passed laws to limit facility fees. A provision in Indiana’s House Bill 1004 banned facility fees for clinics in locations off the campuses of the state’s largest nonprofit health system.¹² Colorado’s HB23-1215 requires more transparency on facility fees and prohibits them for telehealth services. Connecticut’s PA 23-171 prohibits hospitals from charging facility fees for certain outpatient services.¹³ Maine’s LD 1795 establishes a task force on facility fees to make recommendations on protecting consumers.¹⁴ These actions, while limited in scope, are productive steps to limiting site visit fees.

A rise in facility fees has driven policymakers and experts across the political spectrum to call for site-neutral payments, where tests, visits, and procedures would be reimbursed a similar

amount regardless of where they are performed. Policy favoring a move towards site-neutral payments has been supported by both Democratic and Republican administrations.^{15,16} A provision in the Bipartisan Budget Act of 2015 established site-neutral payments for a limited set of services for Medicare-enrolled at new off-campus hospital outpatient departments.¹⁷ The policy was limited to outpatient departments that began construction after the passage of the bill and did not apply to many other location types, therefore not having much of an impact. Introduced in 2018, the Centers for Medicare & Medicaid Services' Hospital Outpatient Prospective Payment System Final Rule expanded site-neutral payments to clinic visits at all off-campus hospital outpatient sites.¹⁸ This made progress but did not address many of the procedures with the highest gaps in payments across sites. Continuing on this progress could be beneficial to saving healthcare costs. An analysis from the Committee for a Responsible Federal Budget uses payment rates and national health expenditure data to find that a site-neutral payment reform policy could have long-lasting and wide-ranging impacts on individual and governmental health spending, reducing Medicare spending by \$153 billion from 2021 to 2023 and the federal budget deficit by an estimated \$217 to \$279 billion.¹⁹ If a site-neutral policy were to be expanded to commercial insurance payments as well, a similar analysis found that commercial premiums could be reduced by \$386 billion and the federal budget deficit could be reduced by \$117 billion. As the U.S. spends more per capita and as a percentage of GDP on healthcare than any other peer nation, reducing health expenditures through the adoption of site-neutral payments could help curb overall costs.²⁰ Despite the benefits of site-neutral payments on consumers, recent actions that Congress has taken this year around the issue have faltered. In December, the House passed the *Lower Costs, More Transparency Act*, a landmark bipartisan piece of legislation concerned with lowering the cost of healthcare, including through site-neutral payment policies. However, the act has not yet advanced to the Senate. In February, Congress decided not to include a Medicare site-neutral payment policy in a government funding package. Such a policy has garnered bipartisan support, including from two former Health and Human Services secretaries.²¹

II. Insurers Consolidating Practices

Beyond hospitals, other major corporate entities have also gotten into the game of buying up physician practices. In the last few years, Amazon acquired One Medical, CVS Health acquired Oak Street Health and Walgreens acquired VillageMD, to name just a few. In the past five years, the number of physicians employed by corporate entities has increased from 375,000 to over 500,000.²² Optum Health, which is part of UnitedHealth Group, announced at the end of 2023 that it employs 90,000 doctors after adding 20,000 physicians in 2023 alone. Another way to think about it? One in ten doctors in America is now employed by UnitedHealth Group.

What's driving all this acquisition? Of course, the reasons vary from acquisition to acquisition — but the growing complexity of healthcare delivery and the explosion of rules and reporting requirements place a large burden on individual physicians. Selling your practice can allow

physicians to often improve their income while spending less time dealing with administrative and reporting burdens — which the new owner usually takes on. However, there are real costs to this approach. As more Americans get their care from these corporate-owned primary care practices, those who are uninsured or on Medicaid could be further left behind.²³ Further, these corporate entities often amass enough practices to substantially increase their market power, allowing them to negotiate higher prices from private insurance companies. And obviously, physicians often lose the autonomy to practice medicine as they see fit.

Over the last 15 years, the relatively lenient enforcement of antitrust rules across the healthcare system has meant massive consolidation in the private insurance market. The largest insurers now represent 50% of the total health insurance industry market share, and UnitedHealth Group comprises 15% alone.²⁴ That has meant that independent physicians have to negotiate with these behemoths who have little incentive to reimburse physicians adequately or make issues such as administrative burdens simpler. Frustrated, a lot of physicians have given up and sold their practice to organizations — whether it be Optum or a system — to deal with the complexity.

III. Private Equity

With consolidation already posing significant challenges to the viability and functionality of private medical practices, a relatively new entity has entered into the healthcare landscape in a very substantial way: Private Equity (PE). While PE has had a role in healthcare for some time, what has happened over the past decade is unprecedented.²⁵ In 2021 in the United States, PE spent over \$200 billion acquiring healthcare organizations, more than five times the deal value in 2010.²⁶ The estimated influx of nearly \$1 trillion in PE funds in a relatively short period of time has contributed to the reshaping of the American healthcare landscape. Hundreds of PE healthcare acquisitions are happening every year.²⁷ PE acquisitions are pervasive; they are not limited to a specific specialty — with primary care, cardiology, dermatology, ophthalmology, urology, mental health, women’s health, and many others attracting a lot of PE attention. PE penetration casts a wide geographical net but is, at least right now, especially concentrated in Florida, Arizona, and some parts of the Northeast.²⁸

The extent of PE involvement in healthcare, and specifically its purchases of independent practices, is not fully understood. The numbers laid out above are likely underestimated, largely because we have little to no formal reporting requirements when PE purchases individual practices.²⁹ There are some organizations that try to track PE acquisition and, using their data, researchers have made efforts to understand both why PE is buying practices and the impact of those acquisitions. While every acquisition is different and the effects of acquisition vary, there are a few pieces of evidence that are worth noting. First, the effects of PE on healthcare costs are relatively consistent — PE is associated with increased prices across several specialties.^{30,31} The impact on quality is a little more nuanced. In 2021, a study found that PE acquisition of nursing homes was associated with increases in ambulatory care-sensitive emergency department visits

and hospitalizations as well as higher Medicare costs for residents.³² This year, researchers found that PE ownership increased the mortality rate of nursing home residents by 11%.³³ A study from 2023 found that after hospitals were acquired by PE, the increase in patient adverse events and hospital-acquired infections— harms from mistakes in the hospital – increased compared to a group of similar hospitals that were not acquired by PE.³⁴ Conversely, a 2022 study examining PE-acquired hospitals actually showed some association between PE acquisition and improvement in mortality among Medicare beneficiaries hospitalized with acute myocardial infarction.³⁵ Better transparency and reporting are needed to more clearly understand the impact of PE acquisition on care quality and health outcomes.

Since 2019, PE firms have accounted for more than half of all physician practice acquisitions.³⁶ Recently, the Federal Trade Commission brought action against the U.S. Anesthesia Partners, a PE-backed firm that had purchased a series of private anesthesia practices in Texas and gained enough market power to negotiate meaningfully higher prices from insurers. More broadly, there are real concerns that PE firms are using their market power to drive up prices, skimp on care for certain vulnerable populations, and impose cost-cutting measures that can lead to understaffing and increased burden for the health workforce.³⁷ Recent research estimates that PE firms charge insurance nearly 20% more on average, which may be associated with upwards of a 32% increase in costs for providers and patients.^{30,38}

For physician practices, selling to PE firms has some advantages and disadvantages. While many physicians find their take-home income can rise and administrative burdens of running a practice can offloaded, welcome benefits to be sure, they also lose autonomy, find that some long-standing patients can no longer see them (if the PE firm decides to not contract with that patient’s insurer) and that over time, their practice and billing patterns can be affected.

On the policy end, the big problem is rapid (and opaque) ownership changes, concerns around sustainability, and the wide-scale consolidation that typically accompanies PE acquisitions.

IV. The Growth of Medicare Advantage

The challenges for independent physicians introduced by increased healthcare consolidation – namely limited market and negotiating power — are exacerbated by the commercial takeover of Medicare over the past decade. Medicare Advantage (MA) comprised 24% of all Medicare beneficiaries in 2010 but doubled to 51% of eligible beneficiaries in 2023 – with significantly higher enrollment rates in some states and geographic regions (including Florida, for example, where the penetration rate is 58%).³⁹ This seismic shift in Medicare — from largely traditional Medicare to MA, has had profound effects on independent physicians as well, with the top five insurers controlling 68% of the MA market share.³⁹

Medicare represents 26% of physician and clinical service payment funds.⁴⁰ When most of those patients are in traditional Medicare, most practices have a pretty straightforward path to getting reimbursed: the physician fee schedule is set by CMS (I lay out the issues around inadequate payments below) and physicians receive payments directly from CMS. The system is predictable, transparent, and largely easy to manage.

Medicare Advantage poses several large challenges to independent practices. While any licensed physician can become a Medicare provider, to be included in MA plans, you have to negotiate with the private insurer. Given the enormous market power of private insurance companies, many small, independent practices may find that they are not in a strong position to negotiate rates with plans, or may even find that MA plans may not wish to contract with them as they may be too small to help the plan meet minimum network requirements. This means that as MA grows, many physicians may find themselves locked out of the Medicare market. When independent practices can negotiate with the plans to be included in network, they often have to accept mediocre reimbursement and deal with a whole host of administrative complexities that are not part of traditional Medicare, such as prior authorization (see more on this below).^{41,42} Given that the average county has around eight different insurers offering MA plans, the administrative complexity of bargaining, contracting, and meeting the diverse reporting requirements across companies may be onerous.⁴³

Medicare overpayments to MA plans, a phenomenon that has been widely documented and which there is broad policy consensus, means that MA will continue to become a bigger and bigger part of the Medicare program. To the extent that MA poses unique and substantial challenges to independent practitioners, the growth of MA will make it difficult for independent practices to survive. As I lay out below in the solutions, we need an approach that both slows the growth of MA and most importantly, deals with some of the most pernicious effects of MA on independent practices.

V. Denial of Claims and Prior Authorization in the Private Insurance Market (including MA)

In recent years, there has been increasing attention paid to the complexity and problem-ridden nature of processing care authorizations, especially related to avoidable and incorrect authorization denials. Initial denials for care authorization overall have escalated rapidly since 2020, with an increase of over 40% in less than four years.⁴⁴ In 2022, a shocking 11% of all medical claims were initially denied. Not only is the overall initial denial rate increasing rapidly, but so too is each type of initial claim denial – especially prior authorizations. For prior authorization specifically, initial denials have more than doubled since 2020.⁴⁵

Nearly all (99%) of Medicare Advantage enrollees are in plans that require prior authorization for at least some services, especially for services related to mental healthcare.⁴⁶ If the physician

is working in a market with multiple insurers, each insurer might have its own protocol for prior authorization. Thus, MA introduces an extraordinary level of complexity into the prior authorization process – increasing the workload for physicians. In 2022, the Office of the Inspector General from the Department of Health and Human Services (HHS) found that 13% of MA plan denials were for benefits that would have been covered under Medicare.⁴⁷ Many of these denials are also described as improper, and are criticized for requesting additional documentation that places unnecessary burdens on patients and providers.⁴⁷

Some attribute this significant increase in authorization denials to the use of artificial intelligence (AI) for processing claims. As recently as November 2023, two separate lawsuits were filed against UnitedHealth Group and Cigna – accusing both of implementing AI to cut costs.⁴⁸ Such a rapid and extensive increase in denials impacts the provider as well due to the significant administrative burden required to deal with appeals. This has also prompted a general need to reduce administrative complexity for practices.⁴⁹

Even the Surgeon General has noted that this burden is overwhelming – suggesting that the management of prior authorizations has contributed to physician burnout. Providers themselves reify this claim — with 85% of physicians surveyed in a 2020 study describing the burden associated with prior authorizations as “high” or “extremely high.”⁵⁰

Solutions

In the broader landscape of a growing complexity of healthcare services being delivered to an older and sicker population, we have seen the traditional model of the small, independent physician practice be challenged. There are real, concrete actions that policymakers can take to begin to address many of these issues.

First and foremost, introducing site-neutral payments and removing facility fees eliminates a major motivation for hospitals to acquire physician practices. The current strategy of paying facility fees and other higher costs for care delivered at a “hospital-based” facility has a negative impact on the Medicare budget, harms consumers in private insurance (who often have to pay similar fees), provides no benefit to patients or physicians, and incentivizes consolidation. Congress can and should fix this. This is a solution consistent with the Medicare Payment Advisory Commission (MedPAC) recommendations in its 2023 report which recommends aligning rates across ambulatory settings.⁵¹ The commission noted that these site-neutral payments would remove the incentive for hospitals to acquire practices and protect independent physicians.

Second, transparency around ownership, strengthening antitrust enforcement policies, and implementing more robust patient protections in the form of minimum staffing requirements and fraud protections would help mitigate the impact of bad behavior by PE and other firms in

healthcare.⁵² These policy changes would decrease the profitability of PE acquisitions and make PE more appealing when their investments lead to more stable practices that can deliver better care.

Solving the challenges created by MA is complicated but there are key things policymakers can do. First, we need to reduce overpayments to MA plans which have helped to drive their takeover of the Medicare program. MA plans take advantage of Medicare's risk adjustment system to balloon the payments they receive in excess of the payments they make to providers.⁵³ MedPAC and others have a long list of suggestions to improve risk adjustment ranging from changing the codes that are collected to removing tools like chart reviews which may lead to overcoding. Beyond risk adjustment, other solutions have been proposed by experts that also require careful consideration including adding MA spending into benchmark calculations or setting benchmarks at a point in time and updating them using administratively set rates. Ultimately, recommended solutions all involve relying less on fee-for-service (FFS) spending for setting MA benchmarks.⁵¹ Additionally, experts recommend replacing the flawed Quality Bonus Program which provides additional payments to higher-rated plans and increases costs but does not effectively judge quality.⁵³ By reducing overpayments to plans it may slow the growth of MA, providing more relief to independent providers. While our goal should not necessarily be to eliminate the MA program which has its purposes, ensuring that payments to plans are appropriate and that plans are not placing an unnecessary administrative and clinical burden on the physician is an important first step.

The prior authorization burden on providers can also be reduced. Important policy options that could make a difference include transitioning to a fully electronic prior authorization process.^{46,54} Not only would implementing such technology drastically reduce the administrative workload for providers, but would also likely reduce financial burden (up to \$417 million annually) and overall health system strain.⁵⁴ However, this solution doesn't address the root of the problem – the rise in initial denials. Standardizing the prior authorization process, making transparent the kinds, types, and rates of denials, and allowing providers to ultimately be able to speak to a comparably trained provider to appeal denial decisions would all work to reduce the burdens and frustrations that so many physicians feel.

Finally, there is a broad consensus that we must address the issue of physician compensation. Physician pay has not been adjusted for inflation, a problem that drives many small practice providers to seek out better pay in large corporate structures.⁵⁵ MedPAC recently recommended inflation-based Medicare physician payments, tied to the Medicare Economic Index.⁵⁶ If we want to maintain a vibrant physician workforce, inflation-adjusted payments, which keep up with the costs of practicing medicine, is an essential policy task, and one that Congress should support the Administration to do.

Conclusion

While there is no silver bullet solution to protecting the sustainability of private practices, these small changes will all contribute to the creation of a health system where providers do not feel as immense of a push into larger, corporate employment opportunities. These policy solutions are not only comprehensive and simple but can be accomplished with action from Congress for the benefit of patients and, importantly, providers.

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