

Ways and Means Subcommittee on Health  
The Collapse of Private Practice: Examining the Challenges Facing  
Independent Medicine  
May 23, 2024

Thank you, Chairman Buchanan and Ranking Member Doggett, for allowing me the opportunity to provide boots on-the-ground testimony regarding the financial and regulatory burdens facing independent medical providers and how continued challenges result in consolidated health care systems and barriers to patient care. My name is Christine Kean, testifying on behalf of myself as Chief Operating Officer of TSAOG Orthopaedics & Spine (The San Antonio Orthopaedic Group), and all 41 physicians of our Group.

TSAOG Orthopaedics & Spine, is a fiercely independent physician-owned group, taking care of patients in the greater San Antonio region for over 75 years. I have been fortunate to have worked alongside the dedicated physicians and healthcare professionals of TSAOG for the past 23 years. The Group is a fully integrated, private health care entity consisting of orthopaedic surgeons, pain management, primary care sports medicine, anesthesiologists, podiatrists, and chiropractors. Our physicians own and manage all orthopaedic services to include, advanced imaging (MRI/CT), physical and hand therapy, and two large outpatient ambulatory care centers. Think of us as a small ecosystem for Orthopaedic Care. I have witnessed the direct impact the increasingly difficult healthcare environment has made on physicians, staff and most importantly, patients.

For decades, control of the decisions and delivery of healthcare to patients resided in the hands of physicians, but over the past ten years, and more rapidly, post covid, this control has shifted into the hands of insurance carriers and shareholders of corporations. According to an April 2024 report from the Physicians Advocacy Institute, over 75% of physicians are now employees of hospitals/health systems and other corporate entities.<sup>1</sup>

How did this happen, and more importantly, why does this matter to patients? I will explain and summarize the answers to these two questions in my first-hand testimony today.

How did this happen? Financially, the source of revenue for providers of medical care is fixed, decreasing, and largely not in their control. Congress not dealing with the annual issue of Medicare pay cuts to physicians and lack of permanent payment reform has exhausted an already burned-out population of physicians. This should not come as a surprise to any of you.

In 2021, a typical Medicare patient follow up visit (CPT Code 99213) in our region would pay \$89.05. Today, it pays \$86.46, a \$2.59 decrease from three years ago. For 15 minutes of manual physical therapy (CPT Code 97140), in 2021, we would be reimbursed \$27.07, today it pays \$25.74, a decrease of five percent. These are just two examples, there are many more. These decreases in payments are unsustainable, especially when the inflation rate during that same period was 16%.<sup>2</sup>

An additional challenge facing independent medicine is the rising costs of running a healthcare business. Three years ago, an entry-level medical assistant hourly rate was \$13.50/hour, today it is \$16.50, an annual increase of \$200,000 to our organization. This represents just ONE position needed to care for patients. While this is important and good for our team members, increasing expenses without the ability to increase our fee for services puts us at a disadvantage to other employers in the market. We can't compete against Buc-cees gas station wages that start at \$18.00/hour, they simply increase the costs of the products they sell to cover their higher overhead. We obviously cannot.

The overwhelming number of insurance carrier policy changes, denials and delay tactics for payment of services rendered, and most recently the Change Healthcare breach, has left financially and emotionally drained physician practices nowhere to turn.<sup>3,4,5</sup>

The denial and delay tactics begin with a permission request (prior authorization) to perform a medically necessary service for the patient, not only for surgeries, but also for conservative care such as physical therapy. Through our non-profit research arm, The Burkhart Research Institute for Orthopaedics (BRIO), we uncovered the truth about prior authorizations. After analyzing over 30,000 prior authorization orders for care in 2020, less than 1% were fully denied.<sup>6</sup> Our Group spends over \$500,000 per year to staff this department and yet nearly every request is authorized. Why would the insurance carriers have us go through all this effort? They do this with the expectation that the patient or physician gives up during the process, or worse for the medical practice, the patient receives the care, we bill for it, and then later learn it is denied for no prior-authorization. Cue the billing games!

In this game, the medical record that was originally intended to communicate and document the status of the patient for medical providers use is now processed through automated systems<sup>7</sup> by the insurance carriers to see if the non-computer – the physician – missed any coding information in the documentation. It is then further reviewed by their coding “experts” to later be denied for the inability to determine if the service was rendered because the physician did not use all the words in the billing description of the code for the procedure being performed. This focused claims review, courtesy of Optum, is called “an innovative payment integrity approach”.<sup>8</sup>

Providers are seeing it as just another way to be denied payment for services they have provided in good faith to the patient. The provider staff, at least those that are savvy enough, must then continue fighting through layers of phone calls and appeals to later learn the automated systems, or coding expert determination, is flawed and the claim is in fact payable with the exact same medical records submitted the first time.

What does the medical provider get for all that effort? Continued pains of knockdown, drag out fights for the same, not more, payment we should have received the first time the carrier received our bill. Even when we

“win” this game, we lose on each and every claim submitted because it costs us significantly more to appeal and track the claim over the months it takes to get these claims resolved.

To add insult to injury, some of the carriers unilaterally decided to use a “virtual credit card (VCC)” or Electronic Funds Transfer (EFT) process to pay the provider faster, only to charge a 2% - 5% processing fee that goes largely unnoticed by the medical practice!<sup>9</sup> The No Fees for EFTs Act introduced by Congressman Murphy, will work to fix this problem and that legislation needs to be passed. For our practice, the cost per year for these types of transactions is upwards of \$60,000.

When the healthcare ecosystem becomes unbalanced, doctors, patients and businesses are directly impacted. As an example, our health care plan for our employees is partially self-funded. Meaning, our physician business owners take on the direct expense of our employees and families health care costs up to a certain dollar amount and for catastrophic claims, we purchase re-insurance to cover the remaining cost of care. Because we are partially self-funded, we can clearly see our direct cost for medical services provided in the community in almost real time. A CT scan performed at our own facility will be paid around \$160. A CT scan performed at a hospital emergency room for one of our employees is billed at the contract rate set with that hospital and our health plan. That rate happens to be \$7,000. An unbalanced healthcare ecosystem causes an avalanche of increased cost to employer sponsored health care plans (like ours) and patients directly.

In our market, recent shifts have caused salary rates to become significantly higher than the market, driving up costs. We gave over \$300,000 in pay increases in one year to just six of our anesthesia team members and it was still not enough to retain them. Our ambulatory surgery centers are still understaffed, paying more for the same services and at times have needed to delay patient surgeries until we have enough anesthesia coverage to continue. None of this occurred before the consolidation of anesthesia

services and we have seen this same scenario played out across the country.<sup>10,11,12</sup>

It's even more disheartening when you consider the efforts we take are for the benefit of the patient to provide a safe, high quality experience at a lower cost that also benefits the insurance carriers. Last week, our Ambulatory Surgery Centers were recognized by US News and World Report when they announced their inaugural ratings for the best ASC's in the country. Our center, The Orthopaedic Surgery Center of San Antonio, was one of the top 200 (out of 5,000 evaluated) in the country for patient outcomes.<sup>13</sup> Only 15% of ASC's were awarded the highest rating and we are proud to be included with them. Independent recognition like this helps keep us focused on our mission to continue to fight, even with both hands tied behind our back.

Simply put, if any healthcare market is unbalanced, it will severely limit patient choices, drive up costs, and undermine the integrity of patient care.

I noted earlier that we have been in practice for over 75 years, longer than even health insurance carriers have been in existence. San Antonio is one of the fastest growing cities in the country and has been for the past two decades. As an independent physician group, we have taken pride in taking care of our neighbors and friends, not allowing for shortcuts in care and making sure that a return on investment is not the determining factor in physicians' decision-making. And the results bear this out, as we are consistently recognized for the best care in the region and have the best patient outcomes.

We have survived. We have been large enough in our market to matter and have been willing partners that have brought physician-led innovation and solutions directly to insurance carriers, employers and other medical providers in our community. We have geographically placed our offices across three counties in the San Antonio area making us attractive for insurance companies who need to prove their network is adequate to

service their membership. But even with this, when inflation started to soar over three years ago and we asked for raises in our contract rates, we were met with resistance and the almost word for word responses from the different carriers – “we are disadvantaged to the other carriers in the market, we can’t give an increase, we must insist on decreases in your reimbursement”. In the end, this was simply a negotiation tactic that was met with facts, termination letters and then agreement on a path to move forward so that we could continue to carry out our vision of serving our community for generations to come.

Additionally, and more importantly, we are diversified by long-term strategic design to own and offer all orthopaedic services allowed by law. But none of this has been without a significant expense and real risk to the physicians in a complicated regulatory environment that is not easy to navigate and understand. To be successful, we must continue to invest in a robust infrastructure to support our business so that we are able to maintain the standard of care for our patients, shoulder the liability of the patient, manage the expense to render care, and navigate the compliance and regulatory concerns for the practice.

Strategically building this ecosystem for our community that includes all orthopaedic services to include the ASCs has allowed us to offer a “value proposition” to those seeking our services at a lower cost setting with better quality outcomes. In fact, the largest area of growth in contracting for our Group is working with employers directly.

Lastly, we have a culture of being fiercely independent with strong physician leadership and a professional management team that work together in the best interest of the patient. We have cultivated and empowered physician leadership in managing the practice to include succession planning and training with our young physicians to continue the mission and values of our Group.

Thank you.

Christine Kean

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