

OFFICERS

President

Evan R. Goldfischer, MD, MBA,
MPH CPE
Poughkeepsie, NY

President-Elect

Scott B. Sellinger, MD
Tallahassee, FL

Secretary

Jeffrey M. Spier, MD
El Paso, TX

Treasurer

Dave Carpenter
St. Paul, MN

Past President

Jonathan Henderson, MD

BOARD OF DIRECTORS

Kirsten Anderson, CMPE, CPC,
CASC, Springfield, OR

David J. Ellis, MD, FACS
Rosemont, PA

Jason Hafron, MD
Troy, MI

Mara R. Holton, MD
Annapolis, MD

Benjamin H. Lowentritt, MD
Baltimore, MD

David Morris, MD
Nashville, TN

Timothy A. Richardson, MD
Wichita, KS

Chief Executive Officer

Celeste G. Kirschner, CAE

875 N. Michigan
Avenue, Suite 3100
Chicago, IL 60611
www.lugpa.org



Dr. Timothy Richardson Testimony before the Ways & Means Health Subcommittee Hearing: “The Collapse of Private Practice: Examining the Challenges Facing Independent Medicine”

Chairman Buchanan and Ranking Member Doggett,

I am Dr. Timothy Richardson, a urologist and partner in Wichita Urology, an independent physician practice providing comprehensive urological care for patients in the Wichita metro area as well as rural Kansas and Oklahoma. Our 12 physicians, 8 advanced practice providers and 150 employees care for roughly 1.1 million lives over a geographical area covering two-thirds of the state of Kansas. To better serve remote patients in extremely rural areas, our doctors and staff travel many miles to 13 clinic locations throughout the state to provide critical cancer care and urological treatments in those far-flung communities.

In addition to my duties in Kansas, I serve as a board member of the Large Urology Group Practice Association (LUGPA), which represents 150 urology group practices in the United States, with more than 2,100 physicians who, collectively, provide more than one-third of the nation’s urology services. I am here today, however, to advocate on behalf of all physicians in independent practices, regardless of their specialty, clinical focus or the types of patients to whom they provide care.

We greatly appreciate the Ways and Means Committee’s interest in examining the challenges facing independent physician practices and exploring potential solutions to address and reverse trends which have contributed to accelerating rates of hospital acquisition of private practices and consolidation of giant hospital and health care systems. Those trends are worrisome because they have contributed to rising health care cost borne both by the taxpayers and the individual, as well as widening gaps in patient access to care, especially associated with socioeconomic and geographic factors, including rurality.

The Promise of Independent Practice of Medicine

Independent specialty practices like mine deliver integrated services for patients with complex needs, providing a form of one-stop shopping that is not found in a large hospital system where care can be quite fragmented. Independent specialty practices enable physicians to subspecialize in aspects of treatment for different diseases. This promotes efficiency as well as a level of care coordination and personalized care, which is challenging in larger systems with less opportunity for adaptation and flexibility, as they often have so many other competing demands for tending to a sundry of various health care maladies. For example, many of our advanced prostate cancer programs where we manage patients’ prostate issues for decades from medical treatment to surgical treatment to oral chemotherapeutics. For many of these patients, the urologist is the provider they see more than any other, even their General Practitioner, and the ability to receive longitudinal care in a single setting over the course of a lifetime with a provider and practice who know a patient and his family and understand his health care priorities, is very difficult to reproduce outside of the independent practice setting. Finally, because independent practices are small businesses, physicians have the incentive to work more efficiently and longer hours to care for more patients, which will become increasingly relevant as the nation’s population continues to age and the physician specialist shortage reduces the number of doctors to serve that growing aged population.

Pressures on Independent Practices Often Lead to Hospital Acquisition of Physicians

Wichita Urology has remained independent, in part, because there is a shortage of urologists in Kansas, and we serve a large, rural geographic area devoid of huge hospital systems. Unfortunately, this is not the case for many of my peers and colleagues across the country who, despite a commitment to their patients and their communities, their practices and to their role as business owners and employers, have simply not been able to remain viable.

It often starts with hospitals offering higher starting salaries to newly minted urologists who can work fewer hours as employed physicians, which threatens a practice that is trying to replace a retiring physician. (This may be particularly attractive to the increasing number of women who are graduating from medical school and looking for a work-life balance and starting a family.) Recruiting of a physician practice's nurses with large signing bonuses from hospital endowments and cash reserves may be next. In this way a practice may be slowly toppled as they simply do not have the resources to compete.

I've watched the reluctant transition to 'employed' doctor occur repeatedly as remaining physicians struggle to manage increasing regulatory and administrative burdens in the face of steadily declining reimbursement. Absent size, and magnified in scenarios where scope is more limited, physicians respond by working harder and longer hours. In many cases, increasing patient loads to 25 or more patients a day, with surgeries and emergency care and procedures 'in between'. In fact, I personally performed 10 surgical procedures and saw 20 office patients yesterday, prior to getting on a plane to DC. While many physicians are energized by this frenetic activity, others often experience burnout and retire early, exacerbating the practice's prospects.

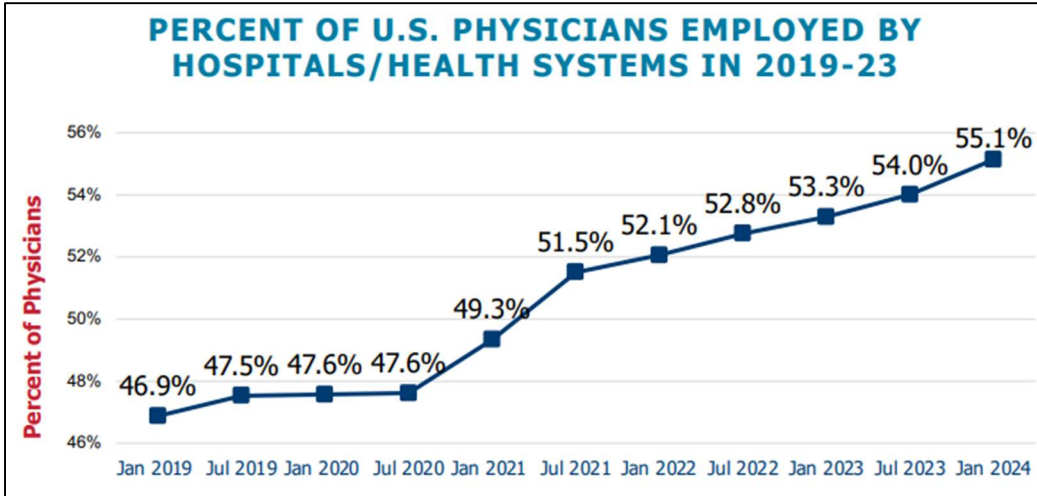
Eventually, unable to sustain the pace, many physicians make the rational choice to become employed by a local hospital system which can relieve essentially 100 percent of administrative, practice management and regulatory burdens overnight alongside RVU pay schedules that substantially reduce their patient care obligations. In some cases, the partners of a practice may decide to sell the entire practice to a hospital system and become incorporated into that hospital. However, while it stabilizes the provider experience somewhat, the acquisition can magnify patient access limitations within a community where a private practice has been acquired because the employed physicians no longer have the economic incentive to care for additional patients passed their assigned working hours.

Burdensome regulation and unbalanced reimbursement schemes heavily favor and incentivize the delivery of care in the often vastly more expensive hospital setting. This uneven playing field threatens the survival of independent physician practices like mine from continuing our many crucial roles, direct patient care, community outreach and care coordination, enhanced access, as well as a competitive counterbalance to large hospital systems. We compete with hospital systems to hire and retain the same doctors, PAs, NPs, nurses, and back-office staff at similar expense but at significantly lower reimbursement for similar services.

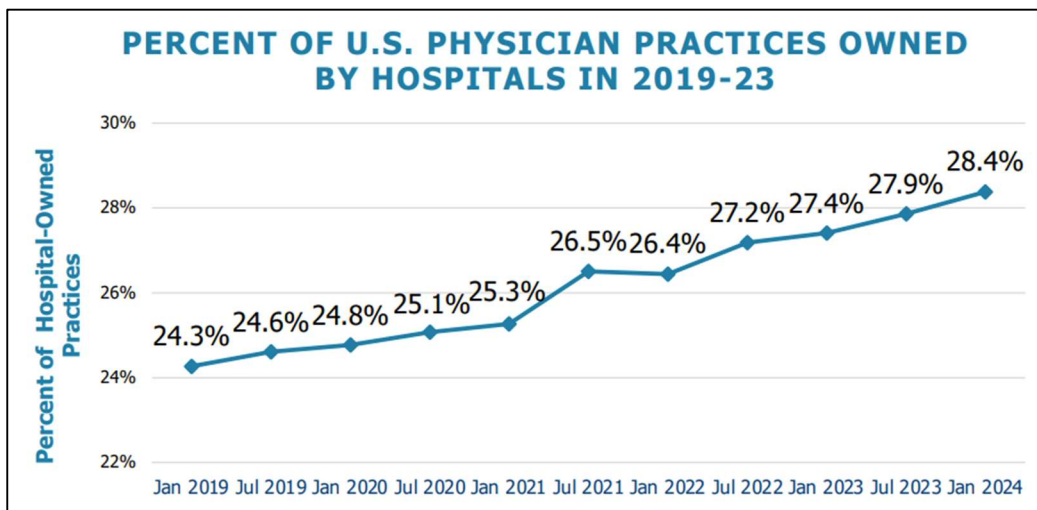
Recent trends of hospitals acquiring and employing more physicians should be troubling to policymakers. A study by Avalere for the Physician Advocacy Institute found that the percentage of hospital-employed physicians increased by more than 70 percent from July 2012 through January 2018 and another 5.1% between 2022 and 2023^{1,2}. More than half of physicians are now employed by hospitals!

¹ Avalere, "[Avalere White Paper: Hospital Acquisitions of Physician Practices and the 340B Program.](#)" June 8, 2015

² Avalere/Physician Advocacy Institute, "[Updated Report: Hospital and Corporate Acquisition of Physician Practices and Physician Employment 2019-2023.](#)" April 2024.

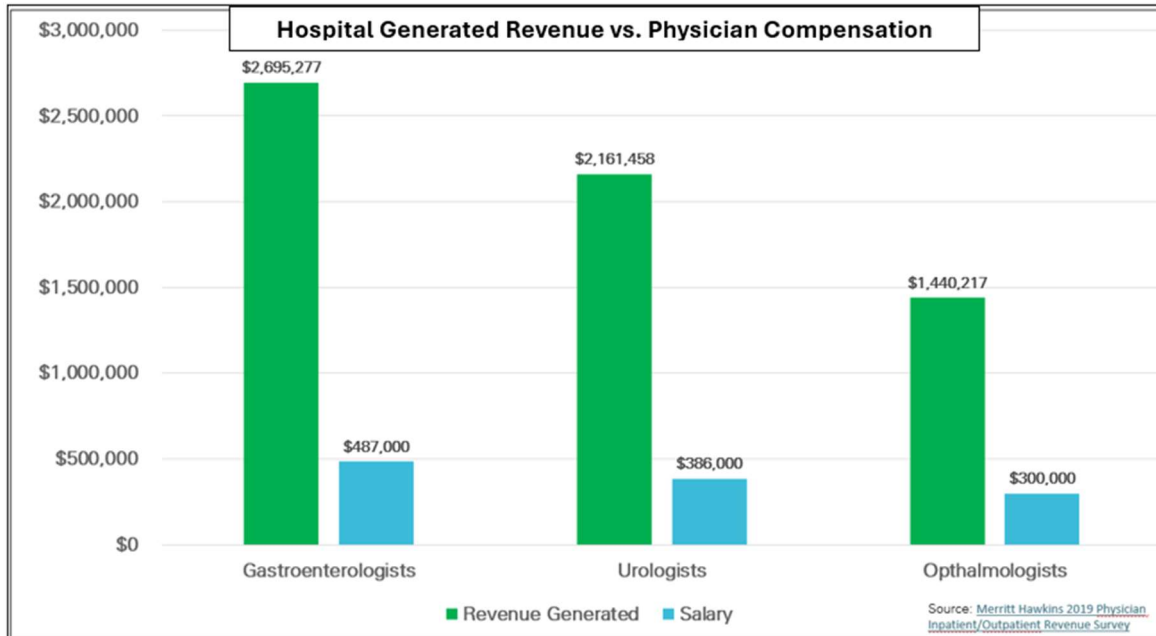


During the 2012-2018 timeframe, hospital acquisitions of physician practices more than doubled, and the acquisition rate has steadily increased from 2019 through this year. In 2022 and 2023 alone, an additional 16,000 physician practices became employees of hospitals.



When hospitals acquire an independent physician practice, services are often delivered by the same providers with essentially the same staff and even in the same location but will cost substantially more. Hospitals have focused on acquiring physician practices because that strategy simultaneously quashes competition in the local market for services such as outpatient surgery and drug administration, increases their 340B revenue as prescribed drugs will become eligible for 340B discounts, and captures downstream revenue from ancillary services such as radiation therapy, imaging, surgery, and lab work that will be referred to the hospital. This downstream revenue a physician generates for a hospital employer far surpasses the cost of the employed physician's salary. A few examples, as presented in the Merritt Hawkins 2019 Physician Inpatient/Outpatient Revenue Survey, include urologists generating \$2,161,458 while receiving an average salary of \$386,000, gastroenterologists generating \$2,695,277 while receiving an average salary of \$487,000, and ophthalmologists generating \$1,440,217 while receiving an average salary of \$300,000.³

³ [Merritt Hawkins 2019 Physician Inpatient/Outpatient Revenue Survey](#)



This harmful trend is being increasingly recognized and acknowledged. Recently, The New York Times reported, “[t]he level of hospital consolidation today – 75 percent of markets are now considered highly consolidated – decreases patient choice, impedes innovation, and erodes quality and raises prices... Some purchases are essentially catch-and-kill operations: Buy a nearby independent cardiac center, for example, to eliminate cheaper competition.”⁴ This consolidation increases costs without any concomitant increase in quality and has been well documented.

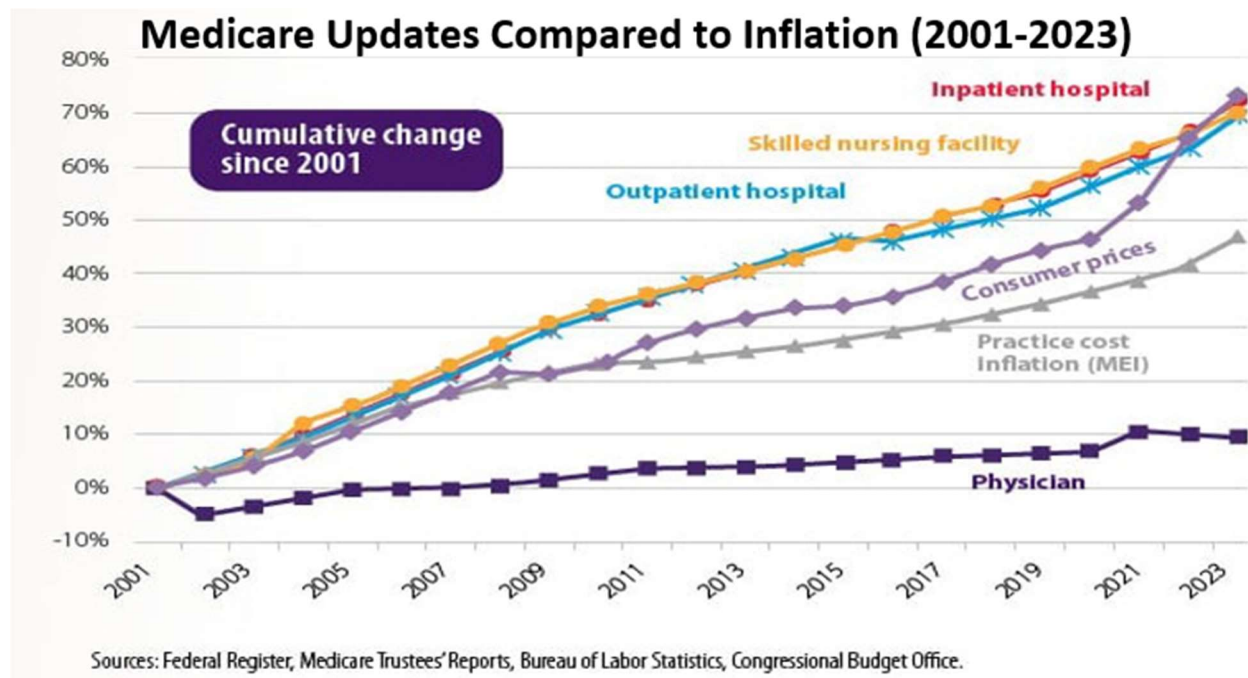
Sadly, patients are unaware that hospitals can mandate that their employed doctors use hospital-owned services that are vastly more expensive yet may be less convenient.

Physician Reimbursement Must be Reformed to Reflect Increasing Practice Costs

A major factor contributing to provider consolidation is the inability of private practices to remain financially viable due to rising practice costs while physician reimbursement declines. In fact, Medicare payment updates were scheduled for all fee schedules in 2024, except the PFS, where, in the face of almost double-digit inflation, physicians were met with a 3.4% reduction. While Congress eventually mitigated half of the cut, it is self-evident that the trend of rising costs and decreased payments is simply unsustainable.

Meanwhile, institutional providers in Medicare (e.g., hospitals, skilled nursing facilities, home health agencies, dialysis facilities, etc.) receive compounding market basket payment updates based on their input costs. In contrast, physicians receive nominal updates or payment freezes that have no relation to their increasing practice costs. The flat reimbursement over the past two decades stands in contrast to the compounding payment updates enjoyed by hospital systems, which has expanded the disparities between the two sites of care and undermined physician practices’ ability to survive, let alone compete.

⁴ Rosenthal, Elisabeth, “[Your Exorbitant Medical Bill, Brought to You by the Latest Hospital Merger.](#)” New York Times. July 25, 2023



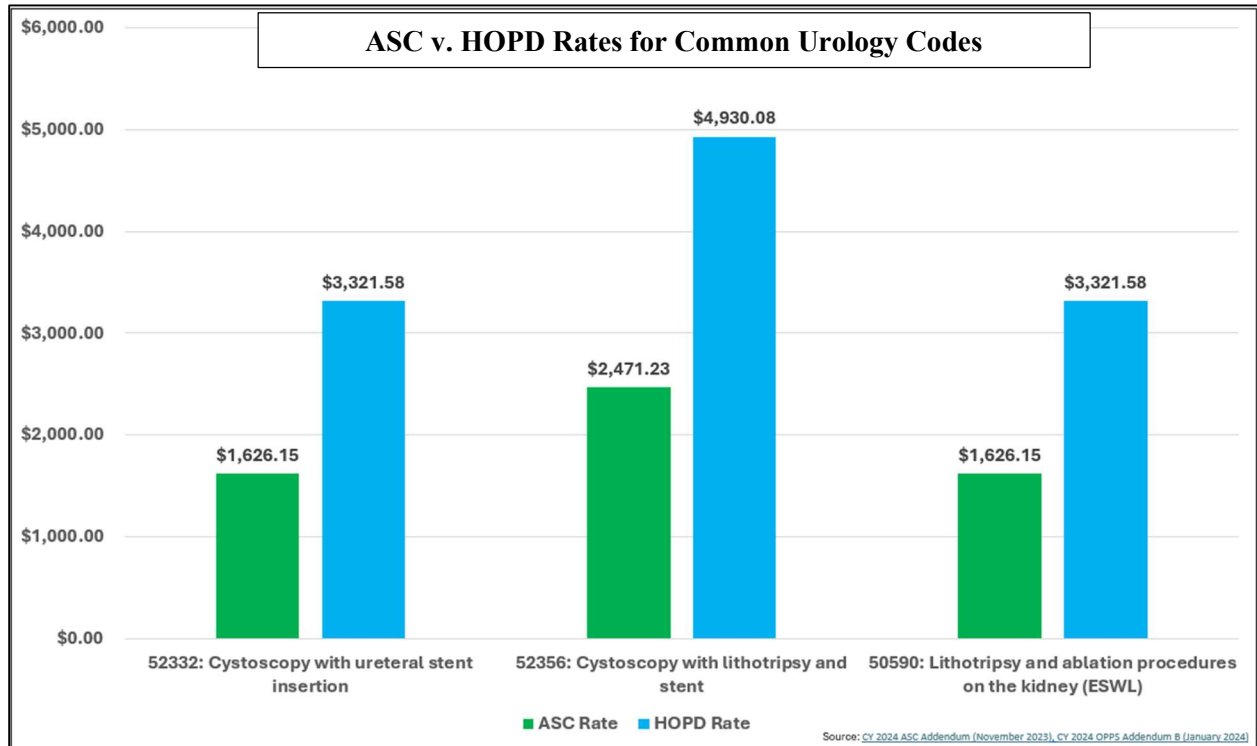
Addressing Site-of-Service Payment Disparities

Independent physician practices provide high-quality, accessible care in the community yet are forced to compete with hospitals under payment models that favor these larger, more expensive sites of care. Site-of-service payment differentials are an artifact of historical views that did not anticipate the tremendous technological and clinical innovations that have advanced the complexity and types of care available in outpatient settings and, concomitantly, reduced costs associated with the delivery of that care. Yet, the policy of paying hospitals substantially more (often more than twice as much) for the identical services provided in a physician’s office or ambulatory surgery center (ASC) paradoxically acts as a disincentive to pursuing innovations that could shift care out of the higher cost hospital setting, thereby perpetuating inflationary cost trends and inhibiting patient access. These payment differentials waste taxpayer and beneficiary dollars and provide mega-hospital systems with additional resources and incentives to acquire physician practices, promote consolidation, limit competition, and restrict patient treatment options.

In 2015’s Balanced Budget Act, Congress endorsed the principle of preference for care delivery in the lowest cost equivalent site of service. Implementation of these site-neutral recommendations has the potential for massive savings, both to taxpayers and directly to beneficiaries in premiums and copays. A study from the Committee for a Responsible Budget demonstrated \$153 billion of net savings to the Medicare program over a decade if site-of-service payment differentials were eliminated. Medicare beneficiaries would save an additional \$137 billion, including \$51 billion in lower premiums and \$43 billion in lower cost-sharing, plus an additional savings of \$43 billion for those with Medigap coverage.⁵ Medicare’s overall spending on affected services would fall by roughly half once the policy is fully implemented.

⁵ Committee for Responsible Budget “Equalizing Payments Regardless of Site of Care” February 2021., [MedPAC, “Report to Congress: Medicare Payment Policy,” March 2019, Chapter 4.](#) In 2018 HOPDs were paid \$166 for the most common E&M visit for established patients compared with \$74 for the same visit provided in a physician’s office. MedPAC and CMS use E&M or “clinic visit” at different times to describe similar interactions so in this brief we use both terms, [MedPAC, “Report to Congress: Medicare Payment Policy,” March 2019, Chapter 5.](#) e

As an example, Medicare pays hospitals more than twice the amount as physician offices for a cystoscopy with lithotripsy stent (CPT code 52356), even though this requires essentially the same staff, infrastructure, time, and technical training to perform. Hospitals are paid \$4,390, while physician-owned ambulatory surgery centers are paid \$2,471.23 for an identical procedure.

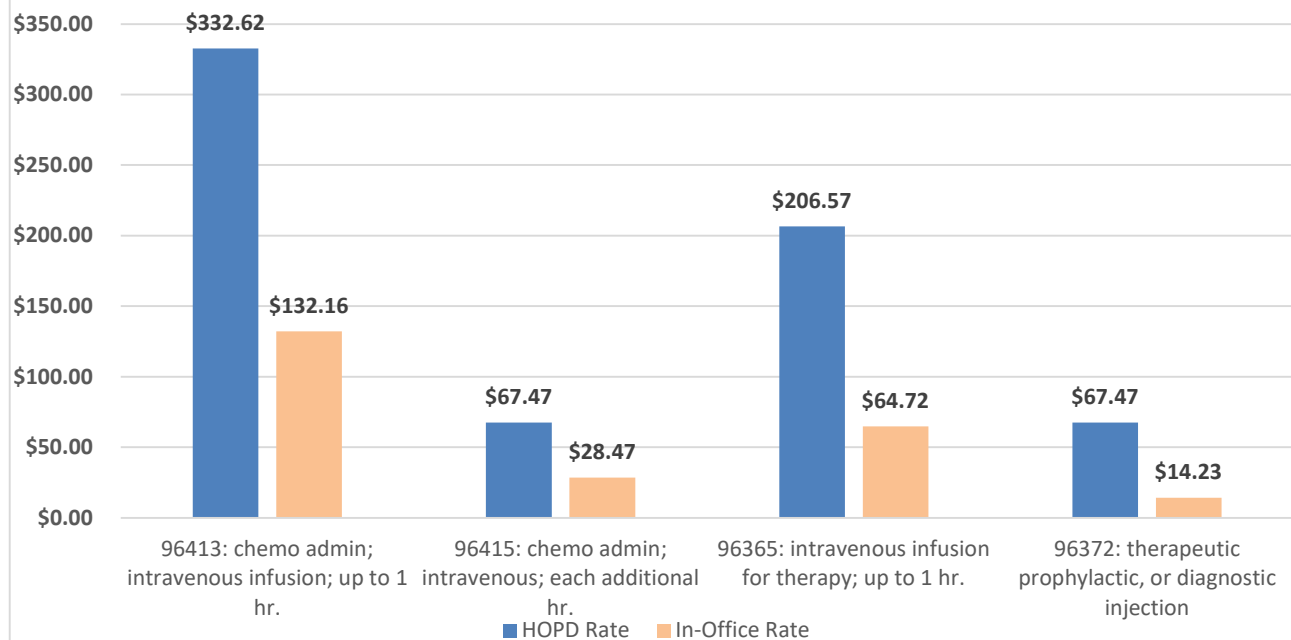


Similarly, Medicare pays more than twice as much to hospitals to infuse the same drugs that require the same nurse staff time and technical training compared to what Medicare pays in a physician office (\$325.64 in the HOPD setting vs. \$140.16 in the physician office).^{6 7} Even more concerning is that the patients are penalized for receiving their physician-administered Part B drug in the physician office because the law caps Medicare beneficiaries' out-of-pocket liability in the HOPD setting at \$1,600, yet Medicare beneficiaries who receive their infused drugs in their own doctor's medical office face unlimited liability based on 20% of the total cost. (The IRA capped beneficiary liability for Part D drugs but did not enact a similar cap for Part B drugs, which are typically much more expensive.)

⁶ [CY 2024 ASC Addendum \(November 2023\)](#)

⁷ [CY 2024 OPSS Addendum B \(January 2024\)](#)

Medicare Rate Comparison for Drug Administration Codes (2023)



These changes are not theoretical. Data suggests that there has been a marked shift away from the physician’s office towards the HOPD for the administration of outpatient chemotherapy.⁸ In addition to the above trends, it has been demonstrated that the acquisition of physician practices by hospitals is an additional important driver of this change⁹, particularly since 340B hospitals can also then benefit from the vast profit margin on administration of certain medications to the newly incorporated patient population of the acquired practice.

The Ways & Means Committee is to be commended for advancing a provision in the “Lower Costs, More Transparency” bill ([H.R. 5378](#)), which passed the House last year, that addresses this issue with respect to off-campus hospital outpatient departments by requiring parity for Part B drug administration. That provision, as well as the one requiring a separate identification number and an attestation for each HOPD department, saves Medicare \$4.1 billion over ten years.¹⁰ Congress could build on that policy by applying site neutrality to drug infusions provided on hospitals’ campuses, where most occur.

We underscore that payments need not be entirely equalized by simply reducing payments to hospitals. Congress should consider closing payment disparities by modestly reducing hospital payments while modestly increasing payments to physicians for the same services to ensure patient access is protected. We do not support the MedPAC recommendation that would cut ASC payments to the physician office rate if just a plurality of volume is provided in the physician office setting. Rather, we recommend

⁸ Winn AN, Keating NL, Trogon JG, et. al. [Spending by Commercial Insurers on Chemotherapy Based on Site of Care](#), 2004-2014. *JAMA Oncol.* 2018;4(4):580–581.

⁹ Jung J, Feldman R, Kalidindi Y. [The impact of integration on outpatient chemotherapy use and spending in Medicare](#). *Health Econ.* 2019 Apr;28(4):517-528.

¹⁰ [Estimated Direct Spending and Revenue Effects of H.R. 5378, the Lower Costs, More Transparency Act. Congressional Budget Office. December 8, 2023](#)

retaining CMS’s majority rule of physician office volume to trigger lower ASC payments, as is currently the case. The real opportunity for savings is the higher cost procedures that could migrate from HOPD to ASC, where no current site-neutrality payment structure applies. Excessive payment cuts to the ASC setting could well result in many of those procedures reverting to the HOPD setting rather than diverting them to the physician office.

MACRA Has Failed Independent Practices

While many large hospital systems have enrolled in accountable care organizations (ACOs), which qualify as an Alternative Payment Model (APM) under CMS’ Quality Payment Program, and leveraged that participation to acquire physician practices, independent physician practices have largely been left behind. Only 17 percent of participating providers (roughly 227,0000 clinicians) received an APM Incentive Payment in 2023.¹¹

Regrettably, the vision Congress pursued in MACRA of inviting the physician community to develop their own ideas about innovative APM delivery programs and “let a thousand flowers bloom” has not come into fruition. Indeed, while 17 of the 40 submitted Physician-Focused Payment Models were recommended for approval or pilot testing by the Physician-Focused Technical Advisory Committee (PTAC), it is incredible that CMS failed to implement or test any of these.¹² CMMI is clearly focused on broader, system-wide reforms that are time-consuming to develop, cumbersome to launch, and resource-intensive to implement. It is disappointing that we have lost a decade of real-world experience that could have been gleaned from models that were developed by providers “in the trenches” who clearly understand where payment policy may be misaligned with quality and cost concerns. Testing models in discrete geographic areas can be rapidly undertaken by the physician community, put into effect, and evaluated for cost containment and quality improvements.

The Medicare Incentive Payment System (MIPS) has been an even bigger disappointment and only served to burden physicians with onerous, expensive, and largely meaningless reporting requirements. A 2021 study published in JAMA Health Forum found that it costs an estimated \$12,811 and takes more than 200 hours per physician to comply with MIPS.¹³ And even with that investment of resources, there are serious questions about whether these investments result in any meaningful upside for practices—especially for smaller, independent practices where the administrative burden and up-front financing are particularly challenging—and whether the MACRA program actually results in higher quality care. MIPS participants can theoretically receive payment bonuses up to 7% or penalties up to 9% based on their performance score within the four categories of the program: quality, cost, promoting interoperability, and improvement activities.

However, since the program is designed to be budget neutral, these positive adjustments can only increase and improve if other practices do not increase their own MIPS scores and are penalized for poor performance. The design of MIPS discourages collaborative care and efforts to improve quality across the system, as high-performing practices will be reluctant to share best practices and risk receiving smaller, positive payment adjustments as other practices improve their scores. Moreover, because many of the MIPS metrics were so meaningless that almost all practices that reported data were not penalized, the upside potential of being a high-achieving practice was negligible. This is evident in a 2021 Government

¹¹ [Bolstering Chronic Care through Physician Payment: Current Challenges and Policy Options in Medicare Part B. Senate Committee on Finance. May 17, 2024](#)

¹² [Physician Focused Payment Model Technical Advisory Committee. PTAC Proposals and Materials, available at: https://aspe.hhs.gov/collaborations-committees-advisory-groups/ptac/ptac-proposalsmaterials#1061](https://aspe.hhs.gov/collaborations-committees-advisory-groups/ptac/ptac-proposalsmaterials#1061)

¹³ [Shullar, Dhruv et. al., Time and Financial Costs for Physician Practices to Participate in the Medicare Merit-based Incentive Payment System. JAMA Health Forum. May 14, 2021](#)

Accountability Office (GAO) report that found only 0.29% of participants received a negative adjustment.¹⁴

The Medicare Payment Advisory Commission (MedPAC) commented, “MIPS as presently designed is unlikely to succeed in helping beneficiaries choose clinicians, helping clinicians change practice patterns to improve value, or helping the Medicare program reward clinicians based on value.”¹⁵ When the experts advising Congress state the program has been a failure and the facts are equally damning, it is time for Congress to terminate MIPS.

Antiquated Stark Law Inhibits Independent Practice Success

It has been shown that competition in the healthcare market improves outcomes and reduces costs.¹⁶ Regrettably, physicians are barred from owning hospitals and are subject to antiquated laws enacted 35 years ago. The Affordable Care Act permanently barred new physician-owned hospitals and barred growth of current physician-owned.

Dr. Brian Miller of the American Enterprise Institute noted because of ACA’s statutory ban, “more than \$275 million of planned economic activity spread across 45 hospital expansion projects ceased. More than 75 new hospitals, either planned or under development, were prematurely terminated, representing more than \$2.2 billion in economic losses. Intangible losses include the loss of the “physician entrepreneur” and user-driven innovation in the face of increasing corporatization of medical practice, both likely contributing to the increase in physician professional dissatisfaction... Premature foreclosure of the POH marketplace inhibited the development of the US version of the “focused factory” model of specialized hospitals or integrated Reversing Hospital Consolidation: model of specialized hospitals or integrated practice units, a feature seen in other markets.”¹⁷

LUGPA worked closely with aligned stakeholders to encourage updating existing regulations governing the Stark statute and strongly supports the administrative reforms made by both CMS and the HHS Office of the Inspector General (OIG) in December of 2020. The OIG administrative changes created three new safe harbors to encourage value-based care models: (1) care coordination arrangements without requiring the parties to assume risk; (2) value-based arrangements with substantial downside financial risk; and (3) value-based arrangements with full financial risk. Concurrently, CMS adopted revisions to the Medicare self-referral statute, also designed to support value-based payment arrangements in the Medicare program.

Although these regulatory changes were helpful in advancing the adoption of payment arrangements that reward value over volume, they remain constrained by the underlying statutes. Furthermore, these regulations are complex and hard to understand by providers. As a result, practitioners have been reluctant to enter new or innovative payment arrangements for fear of triggering inadvertent violations of the underlying statutes or investigations by overzealous prosecutors.

¹⁴ [Medicare Provider Performance and Experiences under the Merit-based Incentive Payment System. Government Accountability Office. October, 2021.](#)

¹⁵ [Redesigning the Merit-based Incentive Payment System and Strengthening Advanced Alternative Payment Models. Report to the Congress. Medicare Payment Advisory Commission. June 2017.](#)

¹⁶ [Gaynor M, Moreno-Serra R, Propper C. Death by market power: reform, competition, and patient outcomes in the National Health Service. American Economic Journal: Economic Policy. 2013 Nov 1;5\(4\):134-66.](#)

¹⁷ [Brian Miller et al. “Reversing Hospital Consolidation: the Promise of Physician-Owned Hospitals” Health Affairs](#)

Conclusion

We thank the committee for focusing on promoting and protecting independent practices. LUGPA looks forward to working with the Committee to help improve access, enhance quality, and reduce costs for our patients. Please feel free to contact Dr. Mara Holton (mholton@aaurology.com), LUGPA's Health Policy Chair, if we can provide additional information to assist the committee as it considers these issues.