THE COLLAPSE OF PRIVATE PRACTICE: EXAMINING THE CHALLENGES FACING INDEPENDENT MEDICINE

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

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United States House Committee on
Ways & Means
CHAIRMAN JASON SMITH

FOR IMMEDIATE RELEASE
May 16, 2024
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Chairman Smith and Health Subcommittee Chairman Buchanan Announce Subcommittee Hearing on The Collapse of Private Practice: Examining the Challenges Facing Independent Medicine.

House Committee on Ways and Means Chairman Jason Smith (MO-08) and Health Subcommittee Chairman Vern Buchanan (FL-16) announced today that the Subcommittee on Health will hold a hearing to identify the financial and regulatory burdens facing independent medical providers and how continued challenges result in consolidated health care systems and barriers to patient care. The hearing will take place on **Thursday, May 23, 2024, at 9:00 AM in 1100 Longworth House Office Building**.

Members of the public may view the hearing via live webcast available at https://waysandmeans.house.gov. The webcast will not be available until the hearing starts.

In view of the limited time available to hear the witnesses, oral testimony at this hearing will be from invited witnesses only. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

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All submissions and supplementary materials must be submitted in a single document via email, provided in Word format and must not exceed a total of 10 pages. Please indicate the title of the hearing as the subject line in your submission. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.
All submissions must include a list of all clients, persons and/or organizations on whose behalf the witness appears. The name, company, address, telephone, and fax numbers of each witness must be included in the body of the email. Please exclude any personal identifiable information in the attached submission.

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THE COLLAPSE OF PRIVATE PRACTICE: EXAMINING THE CHALLENGES FACING INDEPENDENT MEDICINE

THURSDAY, MAY 23, 2024

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON WAYS AND MEANS,
Washington, DC.

The subcommittee met, pursuant to call, at 9:02 a.m. in Room 1100 Longworth House Office Building, Hon. Vern Buchanan [chairman of the subcommittee] presiding.

Chairman BUCHANAN. Good morning. I want to thank our witnesses for being here today to discuss the crucial issues before us, the collapse of the private practice and the impact it is having on patients, as well.

Americans across the country are hurt by skyrocketing inflation from the past four years. I am a former business owner, and I know firsthand how inflation harms small businesses trying to benefit their communities. Physicians are no different. Nearly 90 percent of the medical groups reported increased operating costs last year, according to the Medical Group Management Association. Physicians' costs increased by over 63 percent from 2013 to 2022, making it harder to run a business, let alone their own practice.

During the same timeframe, Medicare's formula for calculating physician payments has increased by only 1.7 percent. In fact, the—adjusted for inflation, the practice cost—Medicare physicians' pay rate plummeted 29 percent over the past 2 decades, with large changes year over year. So how can we get doctors to afford to stay in private practice when their costs are skyrocketing, their reimbursement rates continue to get cut?

Many times, physicians are forced to sell their practice or consolidate, and with a larger system stay afloat. Let me be clear. Whether or not to sell a practice should be the choice of the physician based on what works best for them, their family, their practice, and their patients. They should not be forced into a practice consolidation.

And I will just tell you myself, as a businessperson for 30 years before I got here, I started, my wife and I, a small business. It was the American dream. We created 5,000 jobs from nothing as a couple of blue-collar kids. So a lot of times that leads to other opportunities. I am not saying that is good or bad or indifferent, but that is just my story. But there is other stories like that. So when I hear people are getting crunched in terms of whether they can even stay

in practice, I don't like hearing that. But I will talk more about that today.

Further, I am concerned that our—being transformed from entrepreneurs into employees. According to American Medical Association, the AMA, between 2012 and 2022 the share of physicians working in private practice fell by 13 percent compared to 3 decades ago, where there were—there are now 30 percent fewer physicians in private practice. A thriving health care ecosystem should be included in a balance of large health systems and small, local, mom-and-pop practices.

Back in the day, it was much easier and less expensive for young doctors coming out of medical school to start a practice in their hometown. Now, when I talk to young doctors coming out of medical school, many of them tell me it is too expensive of an endeavor, and they would rather work for a larger system, where they can collect a steady paycheck and not worry about the increasing administrative burdens associated with running a practice.

Another issue I continue to hear from our docs is the growing rate of frivolous lawsuits against medical—the medical community. AMA analysts show that in 2019 medical liability premiums increased by 27 percent, almost double the rate from 2018. Between 2020 and roughly 2022, 30 percent of premiums increase year to year. I am extremely worried about the pressure the trial bar is putting on physicians, at least in my state. I can talk about that, and then I hope that we can talk about what it costs, defensive medicine, and many of the doctors that are surgeons, maybe they are 60, they are leaving their practices early because they don't want to take the potential risk.

Chairman BUCHANAN. With that I look forward to the discussion today. Now I recognize the Ranking Member Doggett for his opening remarks. Thank you.

Mr. DOGGETT. Well, thank you very much, Mr. Chairman. This is an important set of issues that affects our health care providers, and it affects the quality of health care.

I come at it from the experience of having a father who was in solo practice as a dentist for about 35 years. I handled the yard work and the cleanup around there, but I still meet a few people who were children when he practiced who valued that personalized care and remind me of it.

Today's health care system is so much different. I don't think in any part of health care that kind of experience could occur. There are so many barriers to entry and getting a practice started and then maintaining it and so, we find today over 70 percent of physicians who are employed by a health care system or a corporate entity. This consolidation is creating greater obstacles for the few remaining independent practitioners who are struggling to compete, and has significant implications for taxpayers and patients.

There are so many challenges. Your testimony, from reviewing it, deals with a number of them that our physicians are facing. And while I agree that physicians are sometimes over-regulated, the regulator that seems to be interfering the most for many comes in the form of private Medicare Advantage plans.

MA plans continue to interfere with the doctor-patient relationship through burdensome prior authorization requirements, step

therapy, and other management tools. Intended to reduce unnecessary health care utilization, these tools often lead to delays and denials of urgent medical care. One study found that 82 percent of denials that were appealed were ultimately overturned and found to be necessary and appropriate care. But a small, independent practice that is struggling to get a prior authorization request approved often can't afford to go forward with the appeal.

For the care that is delivered, many physicians face inadequate payment, and I know you will be discussing that. Medicaid reimbursement in my home state of Texas is pitiful. We all know well that the Medicare physician fee schedule is a source of stress that we hear about each year. We are hearing about it from health care practitioners across the country.

Private MA plans, however, frequently provide lower payments than traditional Medicare, which is difficult to believe. At the same time, in an upside-down system, Medicare Advantage is being dramatically overpaid, $84 billion in wasted taxpayer dollars this year alone. Yet, insurers are not required to reimburse doctors at least the traditional Medicare rates. With Medicare Advantage now providing coverage for over half of Medicare beneficiaries, physicians are being squeezed further.

As recommended by the independent Medicare Payment Advisory Commission, MedPAC—sometimes the source of great concern and criticism by health care practitioners—but on this issue they say that approval of an inflation update is very important. We must find an acceptable way to pay for that update. But I think that an inflation update alone, though that is a priority of physicians now, is not a panacea. That schedule has become largely irrelevant if over half of the people covered by Medicare are being handled through private Medicare Advantage plans that distort the payment system.

We need to strike a balance to protect the long-term solvency of Medicare, and hold these MA plans accountable for appropriately reimbursing providers. Payment tweaks alone will not address what is already a broken market.

Due to a lack of antitrust enforcement, nearly 80 percent of metropolitan areas have highly concentrated physician markets. Independent physicians are struggling to compete, as they not only face a competing practice being taken over by private equity, but the same forces leading to vertical consolidation that use their immense resources to buy a hospital system and physician practices forcing the few remaining independent providers out of network.

For many independent practices, private equity can appear to be a savior. For physicians struggling to compete with a large health care group, it is easy to understand the allure of these PE buyouts and quick cash infusion. Private equity may help some of these practices, but too often any benefit is solely to the senior physicians who may be about to retire. In my hometown of Austin, I have seen the aftermath of these buyouts. Junior associates, nursing staff, administrative support teams are fired. Prices increase and doctors are pressured to prioritize profits over patients. Practices either go bankrupt or are bundled until we have only one physician group covering a particular specialty.

I look forward to your testimony and our discussion on the many anti-competitive behaviors that have gone unrestrained for too long, and how best we can advance a fair, just, and affordable health care system that supports our health care practitioners and their patients.

Mr. DOGGETT. Thank you so much, Mr. Chairman.

Chairman BUCHANAN. Thank you. I am really excited. We have got great witnesses today, you guys that are actually in the trenches. Many of us up here haven't been where you have been, and you are dealing with the reality, especially in the last 10 years or so.

So the witnesses: Dr. Jennifer Gholson out of Mississippi; Dr. Tim Richardson, a private physician out of Wichita, Kansas; Chris Kean, a private—she is a chief operating officer, so that will be interesting, San Antonio, Texas—Dr. Desai from north Dallas; and Dr. Jha from—with Brown University.

So Doctor, why don't we start with you, Dr. Gholson?

We will move this way. Five minutes each.

STATEMENT OF JENNIFER GHOLSON, MD, FAMILY PRACTITIONER, SUMMIT, MISSISSIPPI

Dr. GHOLSON. Chairman Buchanan, Ranking Member Doggett, and distinguished members of the subcommittee, thank you for the opportunity to testify today. My name is Jennifer Gholson, and I am a family physician from Summit, Mississippi. I am honored to be here today representing the more than 130,000 physicians and student members of the American Academy of Family Physicians. My remarks today are made in my capacity as a 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. It was not long ago that the majority of primary care was delivered by physicians in solo or independent practice who were uniquely connected to the community they served. However, over the last few decades, we have propped up a health care system with misaligned incentives that rewards consolidation and under-invest 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.

I have practiced primary care for more than 20 years. In 2011 I opened my own brick-and-mortar family medicine practice in my rural community which had lacked any primary care practices previously. To say running my own practice was hard would be an understatement, but it was also rewarding. Plans provided no transparency on their contracted rates, meaning I didn't know what I would be paid until I had already signed on the dotted line. Many plans also closed their networks completely and would not contract with me initially.

I was an early adopter of value-based payment through participation in an ACO, where we achieved share 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 me keep my practice doors open.

When the pandemic hit, and Mississippi required us to stop seeing patients in person, we were able to pivot to providing care via telehealth the very next day. 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, the tide started to change. Prior authorizations were increasing while payments were shrinking. Physician practices already get paid two to three times less for services than hospitals, who are able to charge facility fees.

Primary care is at its best when it is delivered by a physician-led team. However, it was hard for my practice and others to compete with hospitals for the same staff. They can offer signing bonuses, higher base salaries, an array of technology that practices often can't.

Eventually, the draw of hospital employment became too alluring for my staff. I had the privilege of working with an incredible nurse for my—almost my entire career. 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. Soon after, both MPs on my team decided to leave, as well. One went to a hospital-owned practice closer to her home, and the other to a subcontractor for managed care companies that offer more flexibility.

After they left, 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, instead of allowing me to resubmit claims. Eventually, for myself and for my patients, I had to re-evaluate whether keeping my practice doors open was the right choice. I knew it would take at least six months to try and replace my staff, and the administrative burden I faced further eroded the time I was able to spend on patient care.

In the decades since I opened my practice, a pharmacy, an urgent care, and a physical therapist had also opened in my small town. The presence of my practice has made a positive economic impact on the community and, most importantly, a positive personal impact on my patients.

I decided to close my practice in the summer of 2022. While this is my story, it is not unique. It is the story of many other family physicians who have been forced into a false choice of either selling their practice, often for pennies, or closing their doors entirely.

Thankfully, Congress can advance policies that will better support the success of practices of all sizes and ownership types. These include improving payment for primary care, addressing misaligned incentives such as facility fees that encourage consolidation, and minimizing the administrative burden that independent practices face.

Thank you again for the opportunity to testify and share my story. I look forward to answering your questions.

[The statement of Dr. Gholson follows:]

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

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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.

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Chairman BUCHANAN. Thanks, Doctor.
Dr. Richardson.

STATEMENT OF TIMOTHY RICHARDSON, MD, INDEPENDENT PHYSICIAN, WICHITA UROLOGY

Dr. RICHARDSON. Chairman Buchanan and Ranking Member Doggett, I am Dr. Timothy Richardson, a urologist and partner in Wichita Urology, an independent physician practice in Wichita, Kansas. I also serve as a board member of the Large Urology Group Practice Association.

My practice is a single specialty group of 12 doctors that serve over 1.1 million lives in a geographic area covering two-thirds of the State of Kansas. We have 13 clinic locations throughout the state that makes it possible for the rural patients to receive critical cancer care and advanced urological treatments where they live.

We greatly appreciate the Ways and Means Committee interest in examining the challenges facing independent physician practices.

While Wichita Urology is no stranger to the mounting pressures independent practices face, we are fortunate to have remained independent. Unfortunately, this is not the case for many of the other practices across the country, despite a commitment to their patients and their communities.

In response to the double whammy of increasing regulatory and administrative burdens alongside declining reimbursement, independent physicians have responded by working harder and more, leading to burnout and early retirement, thereby compounding the shortages and the onus on those who remain in the practice. In fact, yesterday I personally performed 10 surgical procedures and saw 24 clinic patients before racing to catch a 3:00 p.m. flight to be with you here today.

I am reminded of what occurred to a colleague's practice in Shreveport, Louisiana, which peaked at 20 urologists but over time dwindled down to 8 as hospitals recruited their doctors, who could be relieved essentially of 100 percent of their administrative, practice management, and regulatory burdens overnight, alongside an RVU pay schedule that substantially reduced their patient care burdens.

In the face of seemingly endless, expanding workload in private practice, hospitals can offer higher starting salaries on the promise of a work-life balance that limits working hours. Pay differentials, subsidized by site-of-service disparities, made it impossible for them to compete for the nursing staff. That practice eventually collapsed, and the patient access plummeted as more physicians left the practice and the hospital system that acquired the group closed all of the outlying offices northern—in the northern part of the state, where there had formerly been 11 clinic sites.

Just as important, patients lost a one-stop-shop of coordinated and personalized care with physician-patient relationships that had been built over the decades with patients and their families.

This is not an isolated incident, but a nationwide trend. Hospital-employed physicians increased by more than 70 percent between 2012 and 2018, and another 5.1 percent between 2022 and 2023. More than half of the physicians are now employed by hospitals.

It is not hard to understand why. Hospitals have focused on acquiring physician practices because that strategy simultaneously quashes competition in the local market and captures downstream revenue from ancillary services such as radiation therapy, imaging, and physician-administered drugs, often times purchased at 340B prices.

The revenue a physician generates for a hospital employer far surpasses the cost of the employed physician's salary. For example, a recent Merritt survey found that urologists generate $2.1 million while receiving an average salary of 386,000. Similar returns on investments exist for other specialists.

A major factor contributing to provider consolidation is the inability of private practices to remain financially viable. Medicare reimbursement payment updates do not come close to matching the rising practice costs. More recently, physicians have taken payment cuts. Physicians only received a nominal 10 percent increase over the last two decades, while the practice cost inflation rose 47 percent. That is simply not sustainable.

Meanwhile, hospitals have received compounding payment updates based on their input cost, amounting to 70 percent over the last two decades, and enjoy a substantial site-of-service payment advantage for the identical services. As an example, Medicare pays hospitals more than twice the amount a physician receives for a cystoscopy with lithotripsy stent procedure at an ambulatory surgery center, even though this requires essentially the same staff, infrastructure, time, and technical training to perform. Similarly, hospitals receive more than two-and-a-half times more than physicians to infuse identical part B drugs.

Studies have shown that Medicare could save over $150 billion by equalizing these payment disparities. Yet simply cutting the hospitals does not assist physician practices. We would suggest an approach that modestly reduces the HOPD payments and modestly increases physician payments to protect the patient access.

Just as troubling as the reimbursement challenges is the regulatory burden physicians confront, and the lack of alternative payment models available to most doctors. Only 17 percent of participating providers received an APM incentive payment in 2023. CMS failed to implement or even test any of the 17 physician-focused payment models that were recommended by PTAC.

MIPS has been an even bigger disappointment, and only served to burden physicians with onerous, expensive, and largely meaningless reporting requirements. The MIPS reporting program costs nearly $13,000 and takes more than 200 hours per physician per year. That is time that could be spent with patients.

Just as troubling, high performers were not properly compensated because the MIPS's zero-sum game provides bonuses only to the degree other physicians are penalized, and less than 0.3 percent were penalized. We agree with MedPAC's statement: MIPS is, 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. MIPS should be terminated.

The Stark Law also remains an impediment to value-based care delivery. It must be modernized to reflect how care is delivered

today, not three decades ago, when it was first conceived. The physician entrepreneur should be encouraged, not vilified.

I would like to thank the committee for focusing on promoting and protecting independent practices and patients we serve. We look forward to working with you to reform these programs to make them more efficient and improve patient outcomes.

[The statement of Dr. Richardson follows:]

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May 22, 2024

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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.

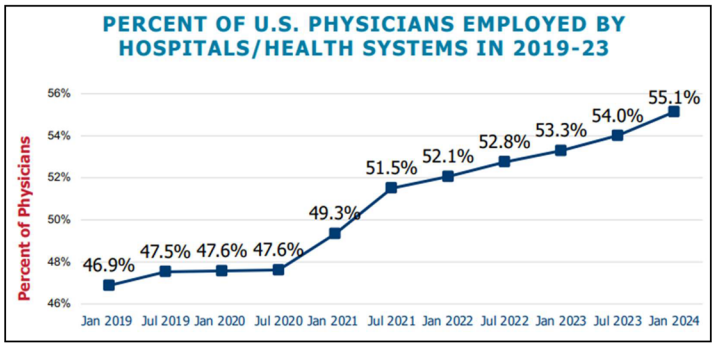
Eventually, unable to sustain the pace, many physicians make the rational choice to become employed by a local hospital system which can relieve essentially 100 percent of administrative, practice management and regulatory burdens overnight alongside RVU pay schedules that substantially reduce their 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.

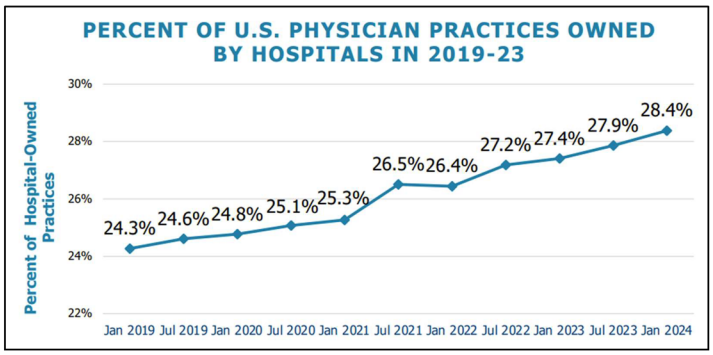
Recent trends of hospitals acquiring and employing more physicians should be troubling to policymakers. A study by Avalere for the Physician Advocacy Institute found that the percentage of hospital-employed physicians increased by more than 70 percent from July 2012 through January 2018 and another 5.1% 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.

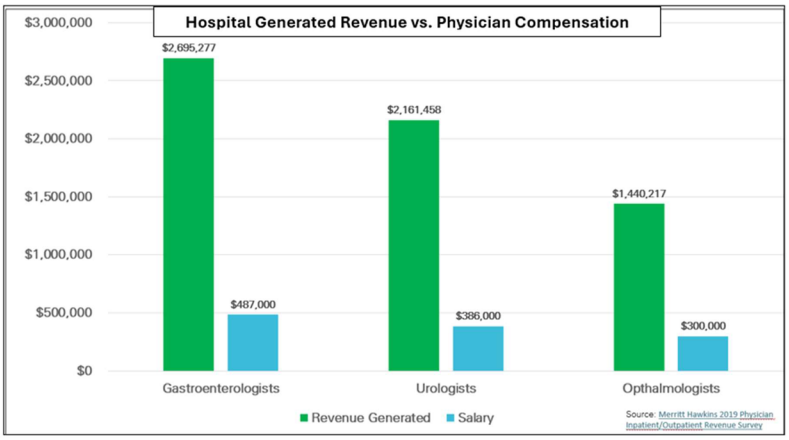


During the 2012-2018 timeframe, hospital acquisitions of physician practices more than doubled, and the acquisition rate has steadily increased from 2019 through this year. In 2022 and 2023 alone, an additional 16,000 physician practices became employees of hospitals.



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.

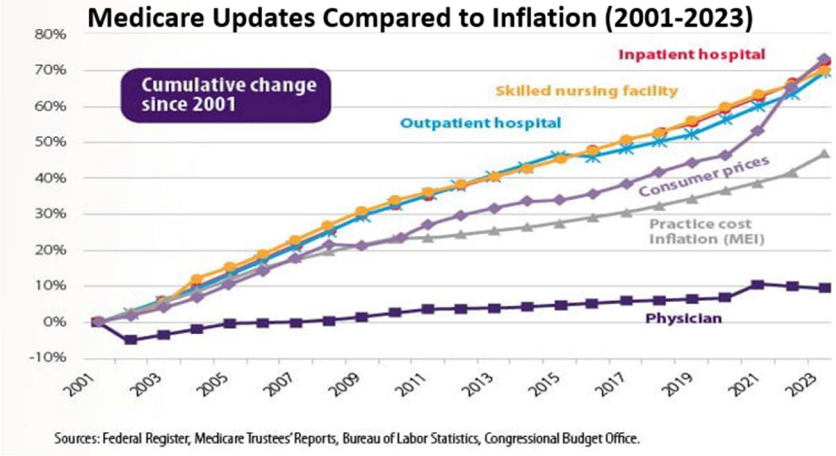
Sadly, patients are unaware that hospitals can mandate that their employed doctors use hospital-owned services that are vastly more expensive yet may be less convenient.

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



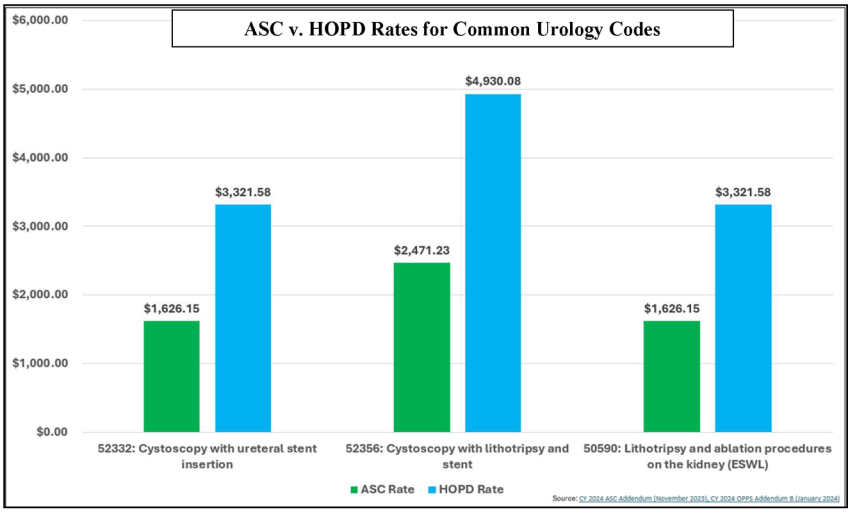
Addressing Site-of-Service Payment Disparities

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.

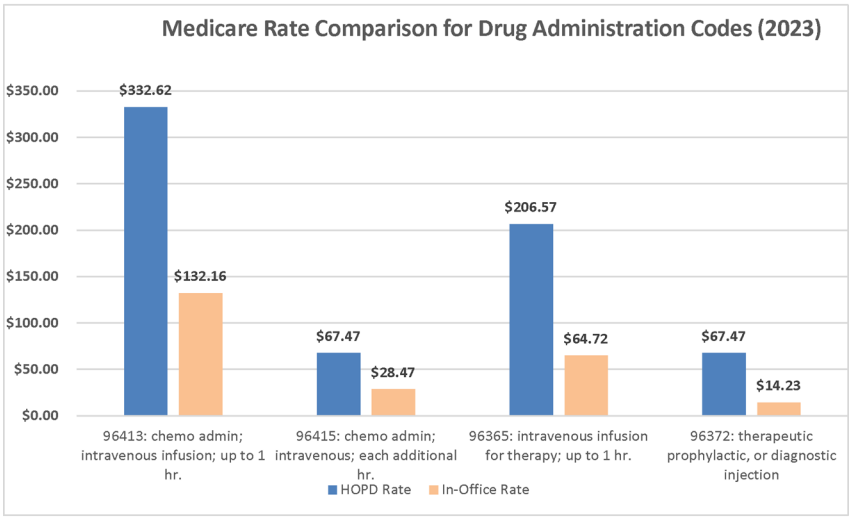
[5] Committee for Responsible Budget "Equalizing Payments Regardless of Site of Care" February 2021., MedPAC, "Report to Congress: Medicare Payment Policy," March 2019, Chapter 4. In 2018 HOPDs were paid $166 for the most common E&M visit for established patients compared with $74 for the same visit 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 OPPS Addendum B (January 2024)



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 change[9], 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, Trogdon 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
[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.

Chairman BUCHANAN. Thank you. I do want to note our next witness. She is the chief operating officer of a practice.

So you are responsible for paying the bills, so you have got probably a unique insight. You know, everybody else is a doctor, but you are actually up there having to pay the bills and deal with that reality. Go ahead. Five minutes.

STATEMENT OF CHRISTINE KEAN, COO, THE SAN ANTONIO ORTHOPAEDIC GROUP

Ms. KEAN. Thank you, Chairman Buchanan and Ranking Member Doggett, for allowing me the opportunity to provide boots-on-the-ground testimony about what it is like to be an independent medical practice in health care today. My name is Christine Kean. I am testifying on behalf of myself, as chief operating officer of TSAOG Orthopedics and Spine, and all 41 physicians of our group.

We are a fiercely independent, 100 percent 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 health care professionals of TSAOG for the past 23 years. The group is a fully integrated, private health care entity consisting of non-operative physicians, orthopedic surgeons, and anesthesiologists. Our physicians and the ones that came before them built this group to help patients navigate an often confusing health care environment by providing as much physician-directed care as possible under a seamless umbrella.

Our patients are able to obtain X-rays or more advanced imaging such as MRI or CT; receive their physical or hand therapy in person, or even virtually; see us after hours, during the week, and on Saturdays in our urgent care solution, OrthoNow; be seen for preventive bone health care. And if they require surgical intervention, we have two outpatient ambulatory surgery centers that provide basic and complex orthopedic surgeries to include spine and joint replacements. If inpatient hospital care is required, this will also be directed and led by our physicians at one of three community-based hospitals in the region. Think of us as a small ecosystem for orthopedic care in San Antonio.

Creating an entity like this is rare. It is extremely challenging to do, and even more difficult to maintain. It requires our physicians to be fully focused on all aspects of the patient treatment plan, to include their own, as the physician, not me, as an administrator, is solely responsible for the liability of every patient they care for.

Meanwhile, they, alongside our administrative team, are also responsible for the nearly 600 professional team members they employ to make right business decisions taking into consideration the complex health care regulatory environment we live in today, as doing so ensures a future will exist for them and our patients for generations to come under this model.

I am here today to help you understand the challenges of maintaining this environment, and why so many private practices across the country are collapsing. There are three main challenges facing independent medicine in our market across the country.

Number one—and I think you know what I am going to say—the source of revenue to maintain this environment is fixed, decreas-

ing, and largely not in our control. A typical Medicare patient 3 years ago reimbursed the practice $89.05. Today it reimburses $2.59 less, and we face more cuts next year. This must change. No entity can stay in business with reductions like this, especially when the inflation rate over those 3 years was 16 percent. Physicians can no longer subsidize the cost of care for the Federal Government, nor should they be required to do so.

Number two, expenses have increased dramatically. And I will give you one example, but there are many more: 3 years ago an entry-level certified medical assistant hourly rate was $13.50 an hour; today it is 16.50. This represents an annual increase of over $200,000 to our organization for just one position needed to care for patients. While giving pay increases is something we are very proud to do and good for our team members, increasing expenses without the ability to increase our fee for services puts us at a disadvantage to other non-health care employers in the market.

And number three, relationship with insurance carriers and others has become at times hostile and not conducive to maintaining a healthy balance required for the delivery of health care today. Simply put, if any health care relationship remains unbalanced, as it is in many of our communities, it will severely limit patient choices, drive up costs, and undermine the integrity of patient care. Patients may even lose their ability to see their doctor.

I noted earlier that we have been in practice for over 75 years, longer than most insurance carriers have been in existence. Believe it or not, we didn't always have health insurance, but we did have doctors. As an independent physician group we have taken pride in caring for 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 offering innovative, cost-effective solutions while being recognized for the best care in the region, and we have the patient outcomes to prove this.

Thank you for providing this forum to learn, and for inviting me to speak to you directly. I am very happy to take your questions. Thank you.

[The statement of Ms. Kean follows:]

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.[1]

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%.[2]

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. [3,4,5]

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 conservate 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.[6] 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[7] 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".[8]

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![9] 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.[10,11,12]

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.[13] 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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Chairman BUCHANAN. Thank you.
Dr. Desai.

STATEMENT OF SEEMAL DESAI, MD, FOUNDER, INNOVATIVE DERMATOLOGY

Dr. DESAI. Chairman Buchanan, Ranking Member Doggett, and members of the subcommittee, my name is Dr. Seemal R. Desai. I am the president of the American Academy of Dermatology Association that represents more than 17,000 physicians nationwide, and I am the founder of Innovative Dermatology, a private practice with 2 locations in Dallas.

I see firsthand the lifesaving work that dermatologists provide for patients, which is especially timely today, during National Skin Cancer Awareness Month, when we are raising awareness of statistics such as the fact that one person dies every hour from melanoma.

I have seen how skin disease can devastate a family. At a young age my brother was diagnosed with vitiligo, a devastating skin disease that causes one to lose their own skin color, resulting in large white patches all over the body, a disease which can feel like a death sentence, especially for patients with skin of color, often leaving patients feeling anxious, depressed, and withdrawn. At the time of my brother's diagnosis, my family would make a 450-mile journey from our home in Atlanta to see the only vitiligo specialist in this country. I saw how critical it was to be able to have access to a high-quality specialist, particularly for a disease which such profound psychological impact. And witnessing my family's patient experience, along with watching my recently-departed late father, a dentist, inspired me to go into medicine.

Now, I am proud that I achieved my dream of opening my own private practice in 2011. The threats facing small practices have grown immensely over the last decade, and the end is nowhere in sight. I started my career with great optimism, but the continual state of medicine in this country has continually directly affected my practice. As president of the Academy, this makes me incredibly concerned about the physicians I represent and, most importantly, the patients we treat.

The greatest challenge facing practices and patients is the failure of the Medicare physician fee schedule to keep up with inflation, especially when physicians are the only Medicare providers that do not receive any inflationary updates. Since 2001 the cost of operating a medical practice has increased almost 50 percent—to be precise, 47 percent. And when adjusted for inflation, Medicare physician reimbursement rates declined by 30 percent from 2001 to 2024. What business can survive under these circumstances?

This payment structure disproportionately threatens the viability of all medical practices, as well as those serving rural, low-income, and underserved communities. This issue is further exacerbated by rising costs and inflation, ultimately leading to less health care options for patients.

Congress must adopt a permanent Medicare payment update that fully acknowledges the inflationary growth of health care costs while working towards long-term reform. The Academy urges Congress to establish a positive annual inflation adjustment, and to in-

crease the budget neutrality threshold by passing H.R. 2474 and 6371.

Since I began practicing, I have increasingly had to grow my patient volume to keep up with demand while simultaneously juggling skyrocketing overhead costs. In 2014 I brought on another board-certified dermatologist to reduce wait times and increase critical access for patients suffering from deadly skin cancers like melanoma and a whole host of other skin conditions. Keeping up with those increasing overhead expenses and paying salaries of another physician, a part-time physician assistant, and multiple medical assistants was costly and became unsustainable.

To continue serving my patients in the best way, I made a decision to combine part of my practice with a larger group to help manage human resource burdens, the vicious cycle of billing and insurance issues, and to help make sure my clinic would continue to function, and frankly, because, as a solo doctor, I was burning out. Fortunately, I maintain full clinical autonomy in a patient-centric model, providing timely and essential access to care.

Another challenge that I encounter multiple times every day when I see patients is the incredible amount of resources we spend on prior authorizations, on medications that will keep patients out of the hospital. This includes staffing a dedicated, full-time employee simply to handle prior authorizations.

In closing, on behalf of our members and the patients I represent as the president of the American Academy of Dermatology Association, thank you for giving me the honor to testify in front of you today. We stand ready to help the committee as you confront the challenges facing practices and health care in this country, and I look forward to your questions.

[The statement of Dr. Desai follows:]

Written Testimony of Seemal R. Desai, MD, FAAD
President, American Academy of Dermatology Association
Founder & Medical Director, Innovative Dermatology

United States House Committee on Ways & Means Health Subcommittee Hearing:
"The Collapse of Private Practice: Examining the Challenges Facing Independent Medicine"

May 23, 2024

Chairman Buchanan, Ranking Member Doggett, and members of the subcommittee:

Thank you for holding today's hearing and the opportunity to testify. This hearing is timely as physicians in the United States face critical challenges that inhibit their ability to continue serving patients.

My name is Dr. Seemal Desai, and I am the founder and medical director of Innovative Dermatology, a private practice with two locations in Plano, Texas. I currently serve as the president of the American Academy of Dermatology Association (the Academy), the leading society in dermatology, representing more than 17,000 members nationwide. The Academy is committed to advancing the diagnosis and medical, surgical, and cosmetic treatment of the skin, hair, and nails; advocating high standards in clinical practice, education and research in dermatology; and supporting and enhancing patient care because skin, hair, and nail conditions can have a serious impact on patients' health and well-being.

Dermatologists diagnose and treat more than 3,000 diseases, including skin cancer, psoriasis, immunologic diseases, and many genetic disorders. We are committed to delivering high value, cost-effective, and innovative care to patients. As dermatologists are at the forefront in the fight against skin cancer and treating numerous skin diseases, the Academy appreciates the Committee's attention to the issues that private practices face. Nearly one fifth of Academy members are in solo practices, and 46% are part of dermatology groups.

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As president of the Academy, it is my goal to keep dermatologists united as we address challenges facing dermatology and frankly all of medicine head-on. This hearing is an important step towards addressing the problems our physicians and patients face every single day.

I have spent a lifetime watching the daily hurdles that physicians and patients face. I am a first generation American born in Birmingham, Alabama. My father was a dentist who immigrated here in the 1970s. He believed in a fundamental American value of giving back to his community. He quickly became involved in his community while also making sure my brother had access to dermatologic treatment for vitiligo, a disease that causes areas of skin to lose color, resulting in spots and patches of lighter skin. For many Americans, including those of color like me, a vitiligo diagnosis can have a devastating effect on how your community perceives you. Children and adults suffering from vitiligo frequently report feeling stigmatized, anxious, depressed, or withdrawn.

The experience of my family coping with my brother's condition was my first introduction to dermatology and the impact a physician can have on a patient's life. Seeing how profoundly treatment helped my brother is why I am where I am now. I went on to earn my medical degree from Morehouse School of Medicine and complete my dermatology residency at the University of Alabama at Birmingham.

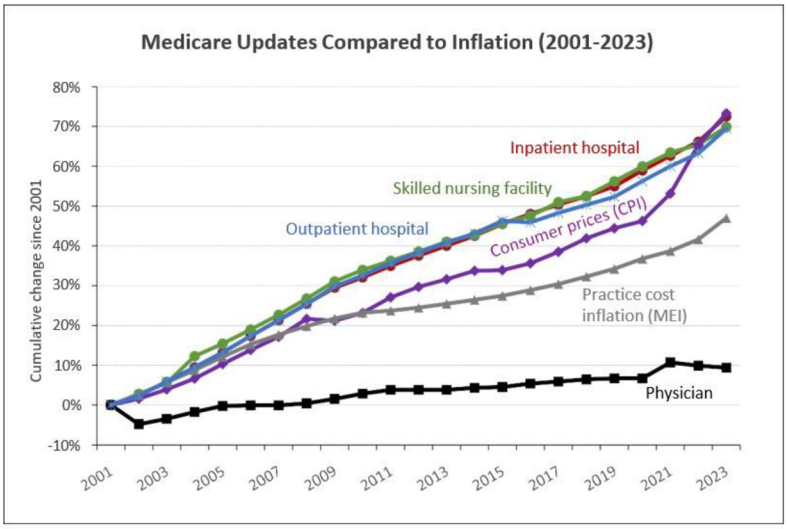
As someone who started his own solo private practice, and now having two offices that make up a group of private clinics, I can speak firsthand about the challenges facing independent medicine. I hear it daily when I travel the country speaking to other dermatologists as practices are being crushed by declining Medicare payments and increasing administrative burdens.

As you explore ways to reform the financial and regulatory burdens facing independent medical providers and how these burdens contribute to health industry consolidation and barriers to patient care, one critical aspect that needs immediate attention is the instability of the Medicare physician payment system. To stabilize Medicare and fortify practices nationwide, the Academy supports establishing a positive annual inflation adjustment and increasing the budget neutrality threshold, supporting a lookback period to correct errors associated with utilization assumptions, and allowing specific services to be excluded from budget neutrality requirements.

Inflation and the Siloed Medicare Program Structure

The failure of the Medicare Physician Fee Schedule (MPFS) to keep up with inflation is the greatest threat to access to care in physician offices. Physicians are the only Medicare providers who do not receive an inflationary increase to cover the cost of doing business. Hospitals and other healthcare facilities receive annual inflation-adjusted Medicare payment updates, but physicians receiving payments under the MPFS are excluded from this type of adjustment. In fact, CMS finalized a 3.4% cut in the Calendar Year (CY) 2024 MPFS final rule. While the Academy appreciates the partial relief Congress provided to the MPFS in the Consolidated Appropriations Act, 2024, physician payments still ultimately received a cut from 2023.

Since 2001, the cost of operating a medical practice has increased 47%. During this time, Medicare hospital and nursing facility updates resulted in a roughly 70% increase in payments to these entities, significantly outpacing physician reimbursement. *Adjusted for inflation in practice costs, Medicare physician reimbursement declined 30% from 2001 to 2024.* This out-of-balance payment structure disproportionately threatens the viability of medical practices, especially smaller, independent, physician-owned practices, as well as those serving low-income or historically marginalized patients. This issue is further exacerbated by rising costs and inflation, leading to increased consolidation and hospital ownership of physician practices, resulting in higher expenses and reduced competition.



Sources: Federal Register, Medicare Trustees' Reports, Bureau of Labor Statistics, Congressional Budget Office

Congress and CMS need to re-examine the siloed approach to reimbursement tied to the Medicare program. According to the 2020 and 2021 Medicare Trustees' report, MPFS spending per enrollee was $2,107 in 2011 and $2,389 in 2021, growing at an average annual rate of 1.3%. However, in contrast, Medicare spending per enrollee in Part A fee-for-service (FFS) was $5,178 in 2011 and $5,576 in 2021 – a 7.7% increase and more than double the cost per patient treated under the MPFS.

In considering the failure of the MPFS to keep up with the rising costs of delivering medical care, it is important to remember that physicians rely on reimbursement to cover a multitude of practice expenses. These expenses include staff salaries, benefits, federal and state regulatory compliance costs, and expenses associated with insurance mandates, such as step therapy and prior authorization. Moreover, technology requirements associated with compliance of the Medicare's Quality Payment Program (QPP) are costly and contribute to the financial strain placed on physician offices.

Physician practices are often small businesses that contribute to the economy of their communities. Other industries can adjust their products' pricing to reflect rising costs and increased staff salaries. However, physicians do not have the ability to do this. In fact, in the face of crippling inflation, the MPFS serves to destabilize practices with year-after-year cuts. Such a structure is unsustainable, and we must not expect physicians delivering essential medical care to Medicare beneficiaries and their communities to endure it. Many physicians have already had to close their doors, leave their communities, retire early, or leave the practice of medicine. There are a staggering number of physicians leaving the workforce, and this trend will continue as nearly 45% of physicians are older than age 55. The loss of experienced physicians is detrimental to patient outcomes and the young physicians who rely on them as a learning resource.[1]

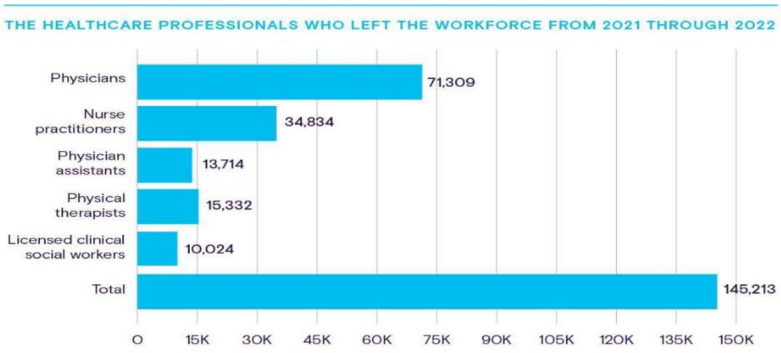


Fig. 1 Analysis of data from Definitive Healthcare's Atlas All-Payor Claims and PhysicianView products. Data sourced from a stable panel of billing organizations from Q1 2021 through Q1 2023. Physicians deemed as dropped out practiced in 2021 and ceased activity by Q4 of 2022. Some providers may still be practicing, but not filing claims. Data accessed September 2023.

The inability to provide inflationary pay raises to practice employees is contributing to the current health care workforce crisis in which we are seeing increasing burnout rates and a mass exodus of our clinical, administrative, and clerical staff into other industries. With reduced staff

[1] https://www.definitivehc.com/sites/default/files/resources/pdfs/Addressing-the-healthcare-staffing-shortage-2023.pdf

comes a diminished capacity to provide quality health care and maintain patient access. Reduced staffing leads to barriers in communicating and coordinating care, such as scheduling appointments and discussing laboratory reports, which can impact patient satisfaction and outcomes.

The threat of additional cuts to Medicare physician reimbursement compounded by continued inflationary pressures jeopardizes physicians' ability to keep the doors open and care for patients in our communities. Fewer physicians in our communities means longer wait times for patients to receive care. When those patients do receive care, their only option may be non-physician providers of care with less training, or more expensive care in suboptimal settings including emergency departments and hospital-based practices. This is real, not theoretical, and is already occurring in our communities. Medicare patients will suffer in the end with delayed and second-rate care at a higher cost.

The Medicare Payment Advisory Commission (MedPAC) recommended that Congress tie physician payment updates to the MEI or practice cost inflation rates for 2025.[2] Specifically, MedPAC recommended that Congress update the 2024 Medicare base payment rate for physician and other health professional services by the amount specified in current law plus 50% of the projected increase in the MEI. Based on CMS's MEI projections at the time of the publication of the March 2024 MedPAC Report to Congress, the recommended update for 2025 would be equivalent to 1.3% above current law. The Academy appreciates MedPAC's acknowledgment that the current Medicare physician payment system has not kept up with the cost of practicing medicine. This step is crucial for ensuring financial stability in the Medicare physician payment system to maintain continued access to high-quality patient care.

Budget Neutrality

Downward pressure on Medicare reimbursement is due to budget neutrality requirements. This has resulted in a decline of 30% since 2001. The Medicare statute requires that changes made to fee schedule payments be implemented in a budget-neutral manner.

Furthermore, by law, CMS must also create utilization assumptions for newly introduced services. When an overestimation occurs, it remains uncorrectable, leading to irreversible reductions in the funding allocated to the Medicare physician payment pool. For example, in 2013, transitional care management services were added to the MPFS. While CMS estimated 5.6 million new claims annually, actual utilization was under 300,000 for the first year and less than a million claims after three years. This overestimation led to a $5.2 billion reduction in Medicare physician payments from 2013 to 2021. This example highlights the unintended consequences of the current budget policies within the flawed system. We firmly believe that CMS should have the authority to rectify utilization assumption errors that impact budget neutrality and to update

[2] https://www.medpac.gov/document/march-2024-report-to-the-congress-medicare-payment-poly/

the projected expenditure threshold triggering the budget neutrality adjustment, which has remained unchanged since 1992.

Reform Quality Payment Program

Traditional Medicare-based Incentive Payment System
Current value-based programs are extremely burdensome, have not demonstrated improved patient care, and are not clinically relevant to the physician or the patient. Therefore, the Academy has serious concerns with the viability and effectiveness of the Merit-based Incentive Payment System (MIPS) program.

Numerous studies have highlighted persistent challenges associated with MIPS, including practices serving high-risk patients and those that are small or in rural areas. A study titled "Evaluation of the Merit-Based Incentive Payment System and Surgeons Caring for Patients at High Social Risk," examined whether MIPS disproportionately penalized surgeons who care for patients at high social risk. This study found a connection between caring for high social risk patients, lower MIPS scores, and a higher likelihood of facing negative payment adjustments.[3]

Additionally, the Government Accountability Office (GAO) was tasked with reviewing several aspects concerning small and rural practices in relation to Medicare payment incentive programs, including MIPS. The GAO's findings indicated that physician practices with 15 or fewer providers, whether located in rural or non-rural areas, had a higher likelihood of receiving negative payment adjustments in Medicare incentive programs compared to larger practices.[4]

These studies highlight flaws in traditional MIPS, particularly in terms of potential disparities in care and the financial burdens placed on physicians when caring for high-risk patient populations and physicians in small practices.

MIPS Value Pathways
Since the passage of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), CMS routinely introduces new changes to MIPS, requiring physicians to adjust continuously. Physicians are increasingly frustrated by the frequent modifications to the QPP, including the associated administrative burdens of adhering to new program requirements and the lack of incentive payments to adequately compensate for participation efforts. While the Academy acknowledges CMS' attempt to address some of these concerns by introducing MIPS Value Pathways (MVPs) aimed at creating more meaningful groups of measures and activities to offer a more comprehensive assessment of quality of care, this new reporting option is falling short of achieving CMS' goal.

[3] Byrd JN, Chung KC. Evaluation of the Merit-Based Incentive Payment System and Surgeons Caring for Patients at High Social Risk. JAMA Surg. 2021;156(11):1018-1024. doi:10.1001/jamasurg.2021.3746.
[4] Medicare Small and Rural Practices' Experiences in Previous Programs and Expected Performance in the Merit-Based Incentive Payment System Report to Congressional Requesters United States Government Accountability Office.; 2018. https://www.gao.gov/assets/gao-18-428.pdf.

The Academy has significant concerns with the Agency's approach to constructing MVPs, as it is using excessively broad measure sets that lack alignment and provide no added benefit in terms of enhancing patient care or helping patients determine the value of the clinician managing their care. CMS' approach fails to account for the realities of clinical practice and adds yet another layer of complexity to an already confusing program. Take for example, CMS' candidate MVP for Dermatological Care. Despite over two years of discussions and meetings between CMS and the Academy, CMS continues to express interest in the use of a single MVP for dermatology. This decision ignores the critical problem of a one-size-fits-all approach, as it cannot effectively compare costs and quality of care. We have shared with CMS that each subspecialty within dermatology provides unique services to distinct patient populations with varying practice patterns. This diversity in the practice of dermatology makes a one-size-fits-all model ineffective for comparing the cost and quality of care. For instance, dermatologists who treat psoriasis, which is currently considered in the candidate MVP's quality measures may not treat melanoma, the deadliest form of cancer, which is currently the only measure related to cost available in the candidate MVP. Regardless of how CMS ultimately scores MVP participants, if CMS finalizes an MVP that includes a cost measure for a cancer-related disease and quality measures for an inflammatory skin disease, patients and clinicians will question its purpose and become skeptical of efforts to drive value-based care.

The Academy welcomes the opportunity to continue working with CMS and the Congress to identify opportunities to improve quality, patient outcomes, and efficiencies.

Burden on Physician Practices

Furthermore, the QPP must keep a keen focus on preventing physician and staff burnout based on the Department of Health and Human Services[5] own priorities. This includes providing relief from systems-level factors that contribute to health care worker burnout by instituting measures that:

- Implement systems changes that reduce administrative requirements overall.
- Facilitate coordination at the systems level without adding administrative burden to health care practices and health care workers.
- Provide funds to purchase human-centered technology that facilitates providing value-based care.
- Ensure engagement in value-based care does not lead to additional workload, overhead, and work hours for specialists.

Independent practices are a significant component of the health care of our nation. As a private practice physician, I have the flexibility to see a patient without the red tape of a larger institution. Dermatologists treat serious diseases to save people's lives, but we can only save

[5] https://www.hhs.gov/sites/default/files/health-worker-wellbeing-advisory.pdf

them if we are able to see patients rather than be overburdened with paperwork and reporting requirements.

Reducing Barriers to Treatment and Care

Dermatologists are committed to providing the most effective and cost-efficient care and treatments to their patients. Prior authorization policies that require obtaining advance approval before performing a service to qualify for coverage can negatively impact patient outcomes and quality of life. It fundamentally interferes with the patient-physician relationship and is counter to the practice of personalized medicine. The prior authorization process typically requires physicians or their staff to spend the equivalent of two or more days negotiating with insurance companies to approve a medical procedure.

In dermatology, drugs and other therapies are frequently delayed or denied due to unnecessary prior authorization and step therapy policies. While we recognize there has been bipartisan support for prior authorization and step therapy reforms and appreciate recent action by CMS to address these burdens, further steps are needed to ensure patients' access to medically necessary and innovative treatments.

The Academy encourages CMS to remove barriers to care and strengthen private practices by:

- Providing increased oversight of Medicare Advantage (MA) plans to ensure that they are not unnecessarily delaying or denying patients access to innovative therapies.
- Extending its recent prior authorization policies as outlined in its final rule, "Advancing Interoperability and Improving Prior Authorization Processes," to include drugs to safeguard timely access to innovative treatments.

Conclusion

As president of the Academy, the most pressing challenge I hear about from my dermatology colleagues is the need for Medicare physician payment reform, and they are absolutely correct. While I enjoyed starting my own solo private practice and growing my patient centric model, I can attest firsthand to the often-insurmountable challenges that are faced by physicians around this country on a weekly, daily and even hourly basis. I am very concerned about the future of private practices and of healthcare in our nation as administrative burdens continue to grow and Medicare physician payment continues to decline. The last thing I want to see is our patients, the public and our families faced with such limited options of seeing a doctor that they can only see someone in a large hospital-based system or mega healthcare conglomerate.

On behalf of the Academy and our member dermatologists, I sincerely thank you for holding this hearing and for your commitment to ensuring patient access to life-changing dermatologic care. The Academy greatly appreciates your leadership and looks forward to working with the Committee as it considers the challenges facing physician private practices, and we look forward to being a reference for this issue and others in the future.

Chairman BUCHANAN. Thank you.
Dr. Jha.

STATEMENT OF ASHISH JHA, MD, DEAN, BROWN SCHOOL OF PUBLIC HEALTH

Dr. JHA. Good morning, Chairman Buchanan, Ranking Member Doggett, and members of the subcommittee. It really is an honor to be here.

I have practiced medicine for over 20 years, and in that time I have seen American medicine change. I have also seen so many colleagues and friends leave private independent practice.

Now, when I was a kid growing up in India, I would follow my uncle, who was a physician, who made house calls. He mostly made house calls. He got paid whatever the patient gave him. Sometimes he didn't get paid at all. But he made an enormous difference in people's lives, and inspired me to become a doctor. During those years a doctor could keep in his or her head everything they needed to know to care for people. Today a primary care physician caring for a complex, sick population must coordinate care across dozens of specialists, manage a dizzying array of medicines, tests, and procedures.

Providing care in an independent, small practice has gotten harder, to be sure. But on top of that, there is an array of forces driving the demise of independent practices.

Let's start with hospitals and health systems. They have been on a buying spree. Some of these purchases likely have been helpful, maybe closely aligning hospitals and physicians to provide high-quality care, but many have not. We have all seen stories about how a hospital buys a practice. Nothing changes, but because it is now billed as delivered in a hospital-based location, the cost to the patient goes up due to facility fees. The access isn't any better, the quality isn't any better, but these fees make private practices an acquisition target, and cost Medicare and consumers real money.

Large corporations have gotten into this game, the most well-known of which is Optum, a part of the UnitedHealth Group. Optum now owns or manages 1 in 10 practicing physicians in America.

And then there is Medicare Advantage. The commercial takeover of Medicare has made life much more complicated for that independent physician. While payments that doctors receive under MA usually don't match what they receive under regular commercial contracts, they face all the same hurdles and then some. The most obvious example you have heard about today is prior authorization. Most MA plans require prior authorization. Every MA plan has its own set of rules, and prior authorization makes doctors' lives harder and hampers their ability to provide the care they think their patients need.

Further, initial denials of care authorization have grown substantially in recent years.

And finally, last but certainly not least, there is private equity. Recently a colleague of mine in Florida sold his small cardiology practice to a private equity firm. Although he was initially reluctant to sell that practice he had run for over 20 years, he was persuaded by what seemed like a great price. Over time he got pres-

sured to change his documentation so they could bill more aggressively, and eventually he found himself changing the way he practiced medicine. And last, but not least, he heard from some of his longstanding patients that his practice had stopped taking their insurance, meaning he could no longer take care of them.

My colleague is not alone. PE firms are spending hundreds of billions of dollars buying up physicians, practices, hospitals, and nursing homes across America. These acquisitions usually increase costs. They can reduce access. They can even harm patient safety.

So thankfully, there is action, action we can take, and you have heard about many of these today.

First, I think congressional action on site-neutral payments is essential. It just makes no sense to pay more for the same care in the same location, just because the ownership of that practice has changed.

I believe transparency around ownership is essential, so we know who is buying up practices and what they are doing with those practices.

And vigorous enforcement of our existing antitrust laws is critical to ensure that we reduce market consolidation.

And finally—and you have heard this from my colleagues today—it really is time to address the fact that there is no inflation adjustment with the physician fee schedule. That just makes no sense. Physician pay should absolutely keep up with inflation, and we have got to make that a real priority.

My belief is, if we do all of these things, we can have a dynamic health care system where independent practices can thrive and flourish, and patients can have more choices, lower costs, and better care.

Thank you very much, and I look forward to your questions.

[The statement of Dr. Jha follows:]

Written Testimony of Ashish K. Jha, MD, MPH

Professor of Health Services, Policy, and Practice,

Dean of the School

Brown University School of Public Health

Testimony to the House Committee on Ways and Means, Subcommittee on Health

May 23, 2024

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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Chairman BUCHANAN. I thank all of you. We are going to move into the questioning session part of it.

But if you can be somewhat concise, I know there is—these are not simple, but Dr. Gholson, let me ask you. You are talking about your practice, 20 years. You had to unfortunately close the business. If you look back, what—could you have done anything different?

Or a lot of the rural communities that you are in, that you service, the numbers don't add up, especially with—you know, whether—you are getting cut many times every year over the years. What are your thoughts on that?

Dr. GHOLSON. In my community one of the biggest barriers I believe I had was that the local hospital considered me as competition, instead of a community partner, and so they continued to expand around me.

And so there were often times where, say, my patients would go to their emergency room, and be admitted, and they would not list me as the primary care physician because I wasn't employed by the hospital. And then, when the hospital would discharge that patient, instead of sending them back to me as their primary care physician, they would send them back to one of their hospital-employed physicians, which was disrupting the care. That was a major issue for me, because managing a transition from a hospital to your practice helps keep people out of the hospital.

It was also very difficult to contract with insurers because I am—it is just me. I am the CEO, the CFO, the COO. I mean, I do all of that. And so, you know, often they would say, "We don't know if we need you in our network," and I am like, I am the only doctor in this town. How could you not need me? [Laughter.]

Dr. GHOLSON. So I think that was—those were probably the two biggest challenges, is not being able to be competitive with contracting.

I mean, what we get paid for primary care, it is just—it is prices, the price of goods increases.

Chairman BUCHANAN. Thank you. I have got to move along——

Dr. GHOLSON. Sure.

Chairman BUCHANAN [continuing]. Because I want every—Dr. Richardson, you talked about administrative burden has gotten a lot worse. Can you better—a little bit more—articulate that aspect?

Dr. RICHARDSON. Sure. Most of it—well, I shouldn't say most of it. A lot of it revolves around MIPS. I have three staff that are constantly reporting following up—towards the end of the year I had a conversation with our director of operations and said, "How much time do you spend reporting and dealing with MIPS?"

She said, "Towards the last two months of the year, it is at least half of my day. Our head IT, it is at least half of his day. Our head nurse managers, at least half of her day, and throughout the year it is a never-ending game."

Sure, the costs of practice are going up every year, so you have to keep adding in administration for that, decreasing reimbursement. So we are constantly pressured to try to add new service lines of treatment for the patients to try to maintain revenue. But at the end of the day, it is just the increased cost, the increased

need to try to employ more staff, and the competition to try to employ those staff with competing hospitals in town that can pay those staff more.

But MIPS, especially towards the end of the year, is a huge burden for my office staff.

Chairman BUCHANAN. Ms. Kean, what is your—you got a unique perspective. You know, like she said, everybody is the CEO, and the CEO of their own practice. But what is your sense that is the biggest challenge, the top one or two challenges that you face every day or every week in your practice or your business?

Ms. KEAN. Yes. I think, you know, aside from the payment issues, it—certainly, prior authorization has been just an absolute disaster. And it really isn't—it doesn't do anything to improve care. It does absolutely nothing to improve care. But it does allow insurance carriers to deny care. And if they don't deny it on the first prior auth attempt, you know, doctors will get on the phone, spend all kinds of time with the insurance carriers getting it approved.

We examined over 30,000 orders in our practice in 1 year. We have a research entity that helps us do that. And more than—less than one percent of the authorizations that we requested ever fully got denied, and I think that that is just because the patient abandoned the care. So if they are approving it 100 percent of the time, why are they doing it? It is because it is a billing game. Because if you don't have the prior auth on the bill, which you will, then they can deny the care later that you already performed.

And so I think prior authorization is a really big thing that we have tried to address in Texas. We do have a gold card bill there, which we are very proud to support. It is a good start, but we need help with that. It only protects the fully-funded plans.

Chairman BUCHANAN. Okay. Let me ask both of you about private equity. You touched on it. Here is the thing—I see it. Everybody is getting paid less, but yet private equities—I have been in, you know, through the 1980s, with the junk bond deals, and leverage, and all the other stuff, they are usually looking to make 20 to 25 percent.

So one side you have got, you know, where people aren't getting paid enough, but yet they are buying these practices, and it is working for them. And I am sure in five to seven years they are looking to get that kind of return. And I have heard a lot of horror stories on some of it, where doctors thought it was one thing and it ends up being another, they got out of it.

But both of you, I would just like to have you quickly weigh in on that issue of private equity.

Dr. DESAI. Thank you very much, Mr. Chairman, for the question.

I think one of the things that I use as a litmus test when looking at patient care models, be that solo private practice, be that a group, be that a hospital system, multi-specialty, private equity, invested, I think the important north star that we have to consider is where patient care lands between the sanctity of the physician and the patient. And my philosophy and the Academy's position is that we want to ensure the highest level of patient care when a patient sees a board-certified dermatologist for their melanoma, to

save their life from skin cancer, or a horrible inflammatory skin disease.

I think we have to be very careful when evaluating models because it is not a one-size-fits-all approach, as you alluded to in your comments, Mr. Chairman. So I think the important message here is that we have to make sure we understand what is happening between the doctor and the patient in that exam room, and how is that patient accessing the treatment in the best way.

Chairman BUCHANAN. Private equity, Doctor?

Dr. JHA. Chairman Buchanan, so this is a really important issue. And it is, first of all, even hard to know how much private equity is in health care, because there is no real transparency. But they have figured out how to make a buck in the system.

Their general strategies tend to be they buy up a lot of practices in a market, gain a lot of market power, and then go to the insurers and say, "We now own all of these practices. What are you going to do? How do you run a network without us?" And they jack up prices. Ultimately, guess who pays that? Consumers, employers. Guess who doesn't get to see any of that? The physician who is in those practices. So that is their number-one strategy for how they are doing it.

They are doing a whole bunch of other things, changing the way they do billing. This colleague of mine I mentioned who sold his practice initially thinking, well, I can just practice medicine and not worry about the business, he found himself practicing medicine differently because of the pressure he was getting.

So private equity is a real problem. I think we need to begin with transparency. We need to know what these guys—who they are, what is—what the investments are. We need to have vigorous antitrust enforcement so that you don't gain monopoly market power. And I think there is a series of other things we can do, but we have got to get on this.

Chairman BUCHANAN. And let me just say, you know, kind of close to home for me, my nephew graduated as a doctor, a radiologist, wanted to take a job in Florida, interviewed, all that. And then he found out that they were selling out to a, you know, a private equity firm. So he decided to look other ways, and he went out of state to find another opportunity. He joins that firm, is with it now, and then within six months that equity firm bought that one out. So I know there is a lot of discussion about that, but I am just concerned about where all that is going, and the impact that has.

And with that I will turn it over to Mr. Doggett.

Mr. DOGGETT. Well, thank you very much. I would just continue on that subject.

One study I have seen found that private equity-owned medical practices charge 20 percent more, on average, per insurance claim than independent practices, and that an estimated 80 percent of private equity-owned physician practices significantly increased prices just after the takeover. I think the estimates I have seen are that, over the last decade, private equity has invested more than $1 trillion in health care.

You have given the example there in Florida, but overall—similar studies have also shown a number of physicians exiting from the practice after the private equity takeover. Overall, is it fair to

say that private equity's role, with reference to physician practices, is to increase prices to both insurers and to the Medicare system, and to decrease the quality of care?

Dr. JHA. Yes, Ranking Member Doggett, that is a—it is a really important question. And here is where I think the evidence is.

I think, first of all, you have cited the key studies on this. There is a way that private equity firms do this. They first make sure that people are billing kind of as aggressively as possible. Second, as I said, they start getting market power. And, you know, we all—I think all of us agree physicians need to be reimbursed more. That is not what private equity is doing. They are getting higher reimbursements, but they are pocketing that difference. Physicians are not better off.

And so what we are seeing is, as you said, a lot of physicians who are just deciding they don't want to practice in that kind of environment anymore, and leaving those practices.

And then there are studies like one that came out about six months ago that showed that, when private equity took over hospitals, over the next two years medical errors, adverse events went up. And if you say, well, what happened there? My best guess is, you know, that they probably cut back on staffing in that hospital. That is another way to save money. But we know staffing can make a real difference in terms of patient safety.

So ultimately, what we need to do is we need to look at behavior. When there is bad behavior, we need to have clear policies and approaches to dealing with that bad behavior. I don't want to paint too broad a brush stroke. I am sure there are private equity acquisitions that have probably been fine. But overall, when you look at the overall system and see where people are going, it is causing increased costs for consumers and the taxpayer. Doctors are worse off. Patients are worse off.

Mr. DOGGETT. Thank you very much.

Now, Dr. Gholson, you really seem to be exhibit A for what is wrong with the system now. You heard Dr. Jha also reference the need for vigorous antitrust enforcement.

I know one of the things that the FTC has recently done that sparked some controversy relates to these non-compete clauses that seem to have a big impact within the health care system. How with the FTC's recent action on that and other enforcement, which has been lax for years, what impact do you think that will have?

Dr. GHOLSON. I think it will have a positive impact. At the heart of the issue is the relationship between a physician and their patient, and there should be nothing that comes in between that. And currently, with non-compete clauses, it does.

For instance, when I was considering selling my practice, I considered going to work for the hospital, but I would have been under a non-compete. And due to the expanse of where they had practices and outlying hospitals, if I were to break that non-compete, I think I would be 80 miles away from where I live, and I would have had to uproot my family. So it just was not an option.

One of the things that does concern me with the FTC ruling is that it doesn't include non-profits, and we do have hospitals that are—that would fall under that purview as a non-profit. So I would

urge that that be considered, that non-profits should come under that ruling, as well.

Mr. DOGGETT. Thank you very much, and for your testimony, generally.

Dr. Jha, let me also ask you about Medicare Advantage. I have seen estimates that we are paying about $1,500 per Medicare recipient more, per year out of the Medicare trust fund to MA plans, than on traditional Medicare. And yet these plans, some of them, won't pay the health care provider as much as traditional Medicare. Could you just comment about any recommendations you might have for what we can do about it?

Dr. JHA. Yes. So Congressman Doggett, as you alluded to, Medicare Advantage has just taken off. It is now a majority of Medicare patients are in Medicare Advantage. This is really a phenomena of the last 10 years. If you ask the question why, it is because we are overpaying for Medicare and—Medicare Advantage. And that is not, again, translating into better care for patients or better reimbursement for physicians.

There is a series of policy things—risk adjustment, how you do regional, benchmarking—a series of policy options that we have, but we have got to implement them. Just paying more to insurance companies when they are not generating more value for consumers, patients, or taxpayers doesn't make a lot of sense.

Mr. DOGGETT. Thanks to all of you.

Thank you, Mr. Chairman.

Chairman BUCHANAN. Mr. Smith.

Mr. SMITH of Nebraska. Thank you, Mr. Chairman.

Thank you to our panel, as well, sharing your perspective. Thank you for being on the front lines of health care, where I know it is challenging and it hasn't been getting any easier for various reasons.

I am concerned that, instead of finding true reforms, we have just seen over the last few years we just shift around who gets paid, how much, and then there are more regulations, and then there are responses to that. And ultimately, patients aren't any better off with more government intrusion and involvement.

But it is very interesting to hear, Dr. Gholson, your experience, your perspective, that you found the competition to be the local hospital, who wouldn't refer to you. Would that be accurate?

Dr. GHOLSON. [Nonverbal response.]

Mr. SMITH of Nebraska. And that perhaps the full choices to patients were not disclosed to the patient. That is—I am troubled by that, and especially in the broader picture of how we oftentimes hear about how referral, the referral process, should or should not be in other respects.

But, you know, when we have these changes in ownership of practices, it is disruptive, obviously, as was touched on, that insurance plans may not be accepted anymore, and how disruptive that is, ultimately, to patients, and especially those in more rural areas. When I represent one of the most rural districts in America, this can be very disruptive. There aren't that many choices. Mere access is our goal sometimes, when in more urban areas it is—you know, there might be more choices among providers. But to take away even some of that very basic access, I think, is troubling.

I will also point to the regulations and requirements that oftentimes originate here in Washington being a huge problem, and I think the latest is the new staffing mandate for nursing homes. So just in Nebraska—we are a pretty rural state—just in Nebraska, the Biden Administration expects us to come up with 450 new nursing FTEs. Where will they come from? Will they come from the hospitals and the practices that you mention—which, I am guessing, you might already face a shortage in their support staff or, you know, nursing providers. I find this unconscionable, that they would even think of this. And we have nursing homes in rural America already struggling without the new mandates. And I think we all know what the mandates are really about, but it is very unfortunate that these poorly thought-out policies tend to be happening so much these days.

Dr. Gholson, though, could you perhaps elaborate more on, you know, the recommendations or insights that you think we should pursue to address the workforce shortages, whether it is MDs, whether it is other providers that—you know, that full spectrum there, what can we do to bring some relief to the shortages?

Dr. GHOLSON. So in Mississippi one of the things we have done is increased the number of residencies, family medicine residencies in Mississippi, with the belief that where people train they will stay. And so I would encourage—more GME funding would be one thing that you could do to help increase rural physicians.

Mr. SMITH of Nebraska. What did they do in Mississippi to increase those slots?

Dr. GHOLSON. So we established the Office of Mississippi Physician Workforce, and our state legislature appropriates funding every year to assist with the start-up cost for residency, because that seems to be the biggest issue for starting new residencies, is that initial start-up cost.

Mr. SMITH of Nebraska. Do you ever find that there could be some stakeholders who want to participate in creating more slots, rather than just waiting for the Federal Government to put more money into those?

Dr. GHOLSON. Yes. A lot of the hospitals, when they are looking at supporting the Graduate Medical Education, they will often put up some of their own funds because they see the economic impact down the line.

Mr. SMITH of Nebraska. But there would not be something at the Federal level that would stand in the way of their wishing to do that. Would that be accurate?

Dr. GHOLSON. The only thing I see is that sometimes there is a cap on payments at the Federal level that should probably be looked at for GME funding.

Mr. SMITH of Nebraska. Okay, all right.

Thank you, I yield back.

Chairman BUCHANAN. Ms. Sewell.

Ms. SEWELL. Thank you, Mr. Chairman, and I want to thank our witnesses.

Supporting our nation's physicians is pivotal to reducing negative health outcomes. Dr. Gholson, I represent Alabama, next door to Mississippi. And I think one of the reasons why I am so passionate about making sure we increase the number of slots, the GME

slots—and I want to thank our colleague, Representative Fitzpatrick, and I for working so hard to try to increase the number of slots. We promote a bill, the Resident Physician Shortage Reduction Act, and we have tried to increase as many as we can in order to increase the workforce. The belief is that, as you said, if they do a residency in these smaller rural communities, hopefully they will stay.

My district, Alabama's 7th congressional district, is both urban and rural. And like you, I have many independent physicians that are struggling. In fact, one is Dr. Steve Furr. Dr. Furr is a practicing rural family physician in my district from Clarke County, Alabama. Not only does Dr. Furr practice at the Family Medical Clinic of Jackson, Alabama, but he also serves as the national president for the American Academy of Family Physicians. Dr. Furr, like many family physicians, has served in his community as an independent physician for 25 years without an inflationary update in 10 years. Yet, of course, all of his medical equipment has—costs have increased. And after COVID, obviously, the price of having good nursing support staff has increased, as well.

We should be doing everything we can to ensure that independent physicians have enough capital to sustain their practices without having to resort to consolidation with large health systems, which is why I am also a very proud cosponsor of H.R. 2474, which is the Strengthening Medicare for Patients and Providers Act. It has strong bipartisan support. I think it is the right thing to do for our nation's physicians. This bill would provide physicians with the inflationary increase that they need by changing the Medicare payment rate to reflect the Medical economic index for inflation. This would help providers like Dr. Furr and other independent physicians.

I think it is really important that we do whatever we can to level the playing field so that independent physicians have just as much of a chance as these big, private equity firms. And I am committed to trying to do everything I can to see that through. I know our whole committee is.

Dr. Jha, thank you for sharing your expertise in today's hearing. How can we best support independent physicians in rural and underserved communities that do not desire to be consolidated with larger systems and larger practices?

Dr. JHA. Yes, thank you, Congresswoman, and you actually laid out a lot of the issues. And I think our—my colleagues have here, as well.

I mean, first of all, I do think we really do need to look at reimbursements for primary care more broadly. Nothing against our specialist friends who are on the panel, but primary care reimbursement continues to be a serious problem for family practitioners, general internists, pediatricians. I think that is an area that requires more attention. I think that would be helpful to all primary care physicians, certainly in rural areas.

There is no question about it in my mind that—you know, if you think it is hard practicing in a world where a majority of your Medicare patients are MA in an urban setting, it is incredibly hard in a rural setting. You don't have the ability to have a full-time person just managing prior authorization.

Ms. SEWELL. Yes.

Dr. JHA. That is untenable. So some of the policy issues that I have talked about with MA, you know, with site-neutral payments, those are all going to be helpful everywhere, but particularly for the rural provider who is just much more vulnerable to these kinds of things.

Ms. SEWELL. Absolutely. Dr. Gholson, can you talk a little bit about your experience, and what recommendations you would give this committee in order to help support independent physicians?

Dr. GHOLSON. Well, I agree with my colleague. Paying primary care is vital to the—being able to sustain primary care independent practices in rural America.

And the budget neutrality issue is also something I think that needs to be looked at. I love my colleagues. I don't want them undervalued because I feel like I need to be valued more.

We have talked about prior authorizations, the administrative burden. That is key.

It is just really paying us for the work that we do, and the value that we bring not only to our patients, but we bring value to our communities.

Ms. SEWELL. Absolutely. And often times you are in communities where there is a medical desert. And so you also provide economic opportunity.

Thank you so much, Mr. Chairman. I yield back the balance.

Chairman BUCHANAN. Mr. Kelly.

Mr. KELLY. Thank you, Mr. Chairman, and thank you all for taking a day out of your life to be here today to try to explain your business model. You guys have so much non-productive labor, but everybody in business has that today.

I am just going to take a couple of seconds to push a bill that we are going to be dropping on the 5th of June. It is the Improving Seniors' Timely Access to Care Act. Ms. DelBene is on this, Dr. Bucshon is on this, Dr. Bera is on this.

And at this point I want to take the time that I have remaining and give it to my friend, Dr. Wenstrup, who is actually in this business, and goes through what you go through every day.

But I got to tell you, I wish I could say that there is help on the way. I don't know how anybody runs a profitable business anymore, especially anytime the government gets involved in it.

So at this point, Dr. Wenstrup, take it away.

Mr. WENSTRUP. Thank you, Mr. Kelly, I appreciate you obliging me and giving me more time, and I will use my time when it comes about, too.

Before I get started, without objection, I would like to enter a statement for the record on behalf of my friend, colleague, and fellow co-chair of the GOP Doctors Caucus, Dr. Murphy. He is away. He is going to be undergoing surgery. I want you all to keep him in your prayers. And without objection, I would like to submit his statement for the record.

Chairman BUCHANAN. So ordered.

[The statement of Mr. Murphy follows:]

Congress of the United States
Washington, DC 20515

Statement prepared for:
U.S. House Committee on Ways and Means
Health Subcommittee

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

Thank you, Chairman Buchanan and Ranking Member Doggett, for holding this hearing. Please pardon my absence at this extremely important meeting to deal with a personal medical issue. I would like to say that as a practicing physician of more than 30 years, I have witnessed firsthand the financial pressures, administrative burdens, and bureaucratic hurdles that have consumed independent physicians, their businesses, and ultimately the patients which they serve. What was once a rather simple business model intended to uniquely serve patients' individual needs has now become a corporatized machine fit to survive inadequate reimbursement levels, insurance denials and delays, and an obsessive regulatory environment.

Financial Pressures

Since 2001, Medicare reimbursement for physicians' services has declined 26% when adjusted for inflation. No other government payee has been cut so drastically. Over the past 3 years alone, CMS has proposed to reduce Medicare reimbursement by a combined 24.4%. This fiscal year, CMS estimates medical practice costs to increase 4.6%. As staffing, supplies, and equipment costs are rising, reimbursement for these services is not being updated adequately.

Furthermore, budget neutrality provisions of the Medicare physician fee schedule have not been updated since the fee schedule was implemented in 1992. Insurers and third-party entities charge physician practices 2.5-5% to receive payment for their services electronically. Additionally, insurance companies are not complying with the 30-day statutory payment timeline post No Surprises Act IDR process – with some physician practices waiting 2 years to be paid – and the Department of Health and Human Services has been negligent in enforcing their own rules.

The current Medicare physician fee schedule is completely unsustainable. It does not reflect the true cost of practice expenses. CMS's policies and congressional dereliction are driving provider consolidation, which leads to beneficiaries receiving care in a higher-cost settings. We must immediately develop short-term and long-term solutions to provide stability and certainty for physicians so that we maintain access for Medicare patients.

Administrative Burdens

Prior authorization, step therapy, and other utilization management tools imposed by predatory and greedy insurers upon physicians lead to delays in cancer diagnoses and treatment. Lives are affected and lives are lost. These obstructive measures also levy additional staffing costs on physician practices and reduce physicians' time with their patients. These unnecessary

hindrances have added to the mountainous administrative burden and are a primary reason for physician burnout. AI holds the ability to augment certain administrative functions, while saving the Medicare program, physicians, and insurance companies money, but it is incumbent that insurers do not malign AI to increase already absurd denial rates.

Additionally, the excessive regulatory environment perpetuated and embraced by CMS has increased the cost of care for seniors and independent practices and provide little to no meaningful improvement to patient care. CMS, insurers, and states all have their own unique set of quality metrics that physicians are required to report on. Standardizing and reducing duplicative measures that are merely process-based would save the government and physicians money while ensuring patient safety.

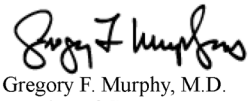
Bureaucratic Barriers

The Affordable Care Act enacted a ban on newly established or expanded physician-owned hospitals. According to a study from UConn Health and Loyola University Chicago, "For the 20 highest cost DRGs treated by POHs in the US, our analysis of 2019 Medicare claims data indicates that total payments were between 8-15% lower than in traditional hospitals within the same market."[1] Such protectionist regulatory barriers to entry imposed by Congress and CMS have limited competition in the market and increased costs on beneficiaries.

Conclusion

The prognosis of the viability of owning and operating an independent physician practice, in my medical opinion, becomes bleaker every year. A majority of residents don't plan on being clinically active. Those that do are now being employed by hospitals or corporate entities at record highs. The higher institutions of medicine have become lost in their plight to help the physician workforce by embracing identity politics rather than future patient needs. In a time of severe physician shortages is the fact that employed physicians do not produce the same FTEs of labor as do private ones. Older physicians are burnt out and retiring in droves. And, ultimately, the math simply doesn't work. The ACA is written to drive private practice into oblivion. Patient care will suffer. If Congress is serious about supporting and reviving independent practice and maintaining access for patients, we must provide the appropriate financial support, eliminate red-tape, and allow physicians do to what they were trained to do – take care of patients.

Sincerely,



Gregory F. Murphy, M.D.
Member of Congress

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[1] Aseltine, Jr., R. H., & Matthews, G. J. (2023, October). *A Study of the Cost of Care Provided in Physician Owned Hospitals Compared to Traditional Hospitals: Analysis of 20 High-Cost Diagnostic Related Groups Using 2019 Medicare Claims Data*. https://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/Advocacy/Cost-Report-10-18-23-final-v5.pdf?ver=JmfWn9Qwkx7TJSOZnPgQoQ%3D%3D

Mr. WENSTRUP. So obviously, everyone—everything you have said is spot on. We have covered all the points. But our country is facing a critical shortage, and access to quality care is definitely a problem.

One thing I do want to say is that I hope that we don't, as the medical professionals, reduce the level of expectations in our education and training, as it will make it even more difficult to defend our value. We have got to do that. You mentioned board certification. That is important in every one of our specialties, because it represents ascertaining the highest level of quality care that you can provide. And I get that.

You know, it is so hard to fathom what has happened to medicine because providers are the product. We are the product and are the key to a healthy nation to begin with. And it just—and we need a strong, uninterrupted doctor-patient relationship to exist.

When I first started in practice, I set up my own practice. I had two employees. And if someone was sick, my mom came in. You like that, don't you, Dr. Gholson? And it was wonderful, it was wonderful. And as time changed, I joined a large orthopedic group, but I still practiced as an independent physician, I felt it. You know, it was the type of practice where at Christmas time people are bringing your gifts, you have developed relationships, and I think that is the key to a successful outcome.

One of the reasons I ran for Congress is I looked at Washington and I said we have people making health care decisions that have never seen a patient, have no idea what it is like being out in the trenches. And the profession has changed a lot since I started that practice which I valued, but it was no problem when I went to a larger group because we were all of the same ilk. We were independent, we were practicing. Our reputation mattered in the community. That is what mattered, not what Washington thought. I have always felt it really didn't matter to me. Yes, you know, if you want us to do this, submit this and that—which, obviously, as you know, and as everyone has commented, got worse and worse and worse, and more and more burdensome.

But I remember starting out in practice. And every day from Washington I was hearing about greedy doctors, greedy doctors. This is the 1980s. And I thought I am $185,000 in debt. That is cheap today, that is cheap today. And I worked during school to keep it down. I am not greedy. And I figured I will make a good living as long as I do a good job and take care of people. That is all it comes down to.

I am against fraud. We want to catch people that are committing fraud and everything else. But other than that, get out of our way. Let us take care of people.

We get on calls for prior authorization, and I am talking to somebody who is not in my specialty telling me what I can and can't do. I ask them for their license and how the patient can make an appointment for them, because if they are going to take over the care they should take over the liability. And I am just sick of it. They take no liability, but they determine the outcome of the patient, they delay the treatment of the patient. All of these things.

We have got to take control, and we have got to start telling Washington, as providers and as Members of Congress, enough is enough.

My time has expired here, but I am just getting warmed up. [Laughter.]

Mr. WENSTRUP. I yield back.

Chairman BUCHANAN. Stay tuned for act two. [Laughter.]

Chairman BUCHANAN. Ms. Chu.

Ms. CHU. Dr. Jha, thank you for your testimony. Every year, especially over the last few years, especially during the last half of the year, physician group after physician group will come in pleading not to just get zero percent increase in their Medicare fees. Current law has the updates at 2.93 percent for 2024, but it will drop to 0 percent for 2025 unless Congress intervenes.

So the physicians say the updates are insufficient, and that there is no means to deal with inflation. And of course, they talk about that, with this insufficient Medicare payment updates, it is really difficult to deal with their practices. We have heard a lot about these challenges today from so many of you who have testified.

What do you recommend we do to upgrade how Medicare pays physicians in a way that will improve value without breaking the bank?

Dr. JHA. Yes, Congresswoman, thank you for that very important question.

I guess I would begin by saying that part of the reason they come in every year is because we have a long tradition of not fixing things for the long run, and then doing this kind of Band†Aid fix every year. We did that for a year. Eventually, MACRA solved one part of that problem, but then now we have this issue.

Look, I think we need a long-term fix on inflation adjustment for our physician fee schedule. I just—I have not encountered someone who does not think that that is the case. Where there is some disagreement is exactly how do we do that. And do we use the Medicare economic index that tracks costs of practice? What proportion of that over what time?

I think MedPAC has laid out a strategy and an approach that I think is pretty reasonable. I suspect other people may be—you know, may not disagree with their—I mean may not fully agree with their approach.

But the bottom line is that, instead of fixing this—you have plenty of other issues you need to be dealing with. Having to do this every single year creates uncertainty, it wastes time, and it creates hardship. And for physician practices planning out next year, if they don't know what they are going to get paid, that makes them more susceptible to being—to saying, fine, I will just take the deal from the hospital or the private equity firm. So a long-term fix is what we need at this moment.

Ms. CHU. Thank you for that. Dr. Jha, you also highlight the issue of frequent wrongful prior authorization denials in Medicare Advantage plans. I am especially concerned that a growing number of these denials are determined by flawed algorithms and unvetted AI tools that fail to account for beneficiaries' individual circumstances.

In 2022 the Department of Health and Human Services inspector general found that AI denials led to amputations, fast-spreading cancers, and other devastating diagnoses for some seniors. In response to these AI denials, I sent a letter to CMS last year detailing specific enforcement actions the agency can take to increase oversight of AI tools in Medicare Advantage coverage decisions. And earlier this year I was pleased that CMS finalized new prior authorization rules instructing plans to make coverage decisions based on individual circumstances, as opposed to AI.

But questions about the enforcement of these instructions remain. So Dr. Jha, can you elaborate on how the rampant use of unvetted AI tools by MA insurers creates unnecessary burdens for physicians, and contributes to harmful outcomes for patients?

And what additional measures should be taken to enforce these rules and ensure that private insurers are not leveraging AI tools to unlawfully deny care for seniors on Medicare Advantage?

Dr. JHA. Yes, and again, I think we have heard almost everybody on this panel talk about prior authorization and its problems. I think there was a report out—I want to say it was ProPublica, but one of these news outlets—that looked at Cigna. Their denial—they spent a second-and-a-half per claim to make their denials. This is not a physician carefully reviewing the circumstances and making a clinical determination.

The way that most of these insurance companies work is, if you can use an algorithm, you deny first a whole set of things. You just have raised the bar for the physician to have to come back, argue for the case. And a lot of physicians in a busy practice will just give up. And that is actually the strategy.

Look, I think there are instances where prior authorization can make sense. If you are doing something somewhat experimental, extraordinarily expensive, extremely unusual, going through an extra burden or an extra hurdle can make sense. But I think, for more routine things, a lot of what CMS laid out—I think it was in your letter, as well, Congresswoman—is really smart. I think we have got to have actual physicians involved in the decision-making, transparency about authorized pre-authorization rates and denial rates. There is a lot of work to be done.

But again, what I would love to see is long-term fixes on these, because Medicare Advantage is here to stay, and we have got to make sure that we solve these problems for the long run.

Ms. CHU. Thank you, I yield back.

Chairman BUCHANAN. Thank you.

Dr. Wenstrup. And we are going to move two to one now.

Mr. WENSTRUP. Thank you, Mr. Chairman.

You know, one of the things I want to continue with what I was saying, when I said I didn't care what Washington thought, I didn't want them to have to worry about what I was doing, either, you know, at the same time. I cared about what the patient's results were, what they thought, what my referring doctor thought, what my hospital community thought, what my fellows around me, my society thought, all those types of things. Because when you do that, you are going to be fine.

But if you are doing something out of the extraordinary or something inappropriate—Dr. Jha, you kind of touched on that—I un-

derstand that. You know, let's have some oversight here and there. Our society should have oversight over how people practice. All those things are important.

But I remember in my first term here with the Doctors Caucus, we were meeting with CMS, and they said to us, "All the things we are starting to implement are really starting to work."

I said, "For who? For who?" I said, "You have taken the joy out of taking care of people. You have made it such a burden to actually put your hands on someone's shoulder, and take care of them, and tell them you are going to be there for them, because you spent more of your time trying to appease they who never see the patient."

You know, going forward, okay, what are we going to do going forward? You know, at the GOP Doctors Caucus we talk about our focus on making America the healthiest nation on the planet. What are we doing? Is everything we are doing leading to better health for all of America? And how do we incentivize prevention, and how do we understand here in Washington the return on investment when we actually have a cure for something, and the cost of it pales in comparison to treating someone for 25 years?

Those are the types of things we need to work on here, and move forward as a nation so that we can do more for patients. Because there is a greater value to the healthy human being, and even those with chronic illnesses if we can keep them healthy. Guess what? They can go to work. They can do things and pay taxes, which is more money we can get our grubby little hands on up here. And that is, you know—but the value of the healthy human being is never really considered. We have to keep promoting this.

I do want to spend time talking about something that I know will be near and dear to Dr. Gholson. Xavier University in Cincinnati, Ohio is starting a new DO school. Why are they starting DO? Because DOs tend to gravitate more towards primary care. And look, you know, the practice that I have as a podiatric surgeon, you know, we are doing vascular, we are doing orthopedics, we are doing dermatology, we are doing a little bit of everything—sports medicine. We do a lot of prevention. We do a lot of prevention, try to prevent ulcerations, limb salvage, those types of things. So this is near and dear to my heart, that we focus on preventive care and incentivize it.

You know, the doctor that does the CABG, the open heart surgery, that is great. You save a life, you should be rewarded for that. That is tremendous. But the primary care doctor that works with the patient that prevents them from ever needing that CABG, you really don't get rewarded for that. We need to focus on those types of things. That will be better for us as a nation.

So Xavier started the DO school because they tend to focus more towards primary care, which we need in southern Ohio tremendously. At the end of the Trump Administration we did pass 1,000 new residencies with—a large focus should be going to rural. So I am trying to coordinate residency programs in our rural areas because, as you said, people stay. These are some of the solutions, though. These are the things we have to focus on.

But I want to go back to the problem, and I really want my colleagues to focus on this. We need to take control.

We passed the No Surprises Act in a bipartisan fashion to take anxiety away from patients who worry about—so they don't have to worry about their bill, it will be taken care of between the insurance provider and the doctor. We did it in a way that we hoped would be fair to everyone, and where doctors would want to be in network, and insurance companies would want you in network. And HHS went and changed the bill to exactly what we said we didn't want. These are problems we have here. But we need your voice to keep talking about these things so that we can make the changes.

And so, I don't really have a question, but I want to go back to that with Dr. Gholson and get your comments on that, because I hope this is going to be a successful thing. And you have somewhat mimicked that with—I think it sounds like what you did at the state level by helping to get the residencies underway. Can you comment on that a little more?

Dr. GHOLSON. On the work that the OMPW has done?

Mr. WENSTRUP. Yes.

Dr. GHOLSON. Yes. So we started that about 11 years ago with the idea that we needed to increase physicians in rural areas. Specifically, we needed to increase well-trained family medicine physicians in rural areas because we felt like that family physicians could take care of maternity needs, they could take care of pediatric needs, they could take care of preventative visits. It was—seemed like the best solution to help with our lack of medical care in rural areas.

We too recently started a DO school in Mississippi. It is relatively young. I think they have graduated their second or third class, and it has been good to see their commitment to primary care in the state. But it is a pipeline. It doesn't happen overnight.

One of the things we also did is we started the Rural Medical Scholarship Program. So we encouraged our medical students at both the MD university and the DO university to choose to go into primary care, and so they were able to graduate medical school with no debt.

Mr. WENSTRUP. Thank you. My time is expired, but thank you very much.

Chairman BUCHANAN. Mr. Hern.

Mr. WENSTRUP. I greatly appreciate it.

Mr. HERN. Thank you, Mr. Chairman. I would like to thank the witnesses for being here today and, as my colleague from Pennsylvania said, taking some time out of your life to come talk to us about something that you do every single day.

I will—as my colleagues up here have described, I want to describe a health care system that I grew up in many years ago in the Ozark Mountains of Arkansas. I remember seeing the same doctor for every ailment I had, from the time my brother accidentally shot me with a bow and arrow to the scar on my face from a barbed wire fence to broken bones and even the common cold. This was a time before there were third-party billers, electronic health records. If my mom couldn't pay the bill that day, which she usually couldn't, she put it on the ledger. And when she got paid, she paid the doctor. And guess what? That system worked. I am

here today, and getting to talk about the very thing that I grew up in.

It seems so simple, you know, a patient and a doctor together were the heart of the health care system. But sadly, we are a long way from those days. Now we have third-party billers, huge health systems, and no one knows how much anything actually costs.

One thing that really concerns me that I am glad this hearing highlights is the fact that the health care system will buy up a physician practice, jack up the prices—and sometimes overnight—and get paid much higher rates than private, physician-owned practices for the same exact services. A lot of times this is because these hospital systems tack on a so-called facility fee. Study after study after study shows that patients are being charged exponentially more for the same services.

According to an analysis of six outpatient procedures released last fall, hospital common procedure prices were substantially higher, in some cases five times higher than when performed at a physician's office. There is no evidence that outpatient care in hospital-owned facilities for the same services results in better outcomes. So patients are left with no added benefits, just higher prices and less choices. This is why I introduced H.R. 3417, the FAIR Act, which would require all off-campus outpatient departments to have separate NPIs so they cannot change—charge onsite hospital prices.

Dr. Richardson, you touched on this a bit in your testimony. Would you agree that requiring unique identifiers for on and off-campus facilities and other site-neutral policies would lead to lower out-of-pocket costs for patients?

Dr. RICHARDSON. Thank you for the question.

Absolutely. We have a very comprehensive one-stop-shop practice, where we offer radiation therapy, diagnostic therapy, surgical therapy, medication therapy, clinical trials—basically, treatments and diagnosis throughout the gamut. If we sold to a hospital system overnight, by changing nothing, not changing the sign on the door, not changing the physicians, not changing location, overnight it would cost two to three times more for any of the insurance companies or Medicare, and the patient's out-of-pocket, as well.

So it absolutely makes a big difference, when all of a sudden you are billing under a hospital code instead of an outpatient procedure code or an outpatient clinic code, that the price just skyrockets. And it has nothing to do with quality of care. It has nothing to do with access of care. In fact, most of the time it would actually decrease access, because all of a sudden we are not motivated to work as much because we are getting paid substantial rates on RVUs, because the hospital can't afford to do it due to their site of service disparity and benefits and advantages in that realm.

Mr. HERN. Thank you. Another issue that I am gravely concerned about and interested in is this idea of physician-owned hospitals.

I know we all have our opinions on the Affordable Care Act, and my opinion is there was a lot wrong with it, but today I focus on the ban on opening new, physician-owned hospitals. I found it a bit foolish that we have sat back and watched hospitals and health care systems take over and buy physician practices now employing

upwards of 75 percent of our physicians, but do not let physicians, the ones providing the care, invest and run their own hospitals.

Physician-owned hospitals have shown to provide equivalent or higher quality care more efficiently and at a lower cost, compared to community hospitals, resulting in significantly better patient experiences and outcomes. Ms. Kean, you noted the benefit patients see from going to an independently owned hospital group. Do you think allowing physicians to own hospitals would create more competition?

And also, what type of benefits have you seen regarding patient care when physicians own their own place of work?

Ms. KEAN. Yes, I know a lot about that. You know, as I said, we are 100 percent physician-owned, as a practice here in San Antonio. We own two outpatient ambulatory surgery centers 100 percent, and we also manage them, and that is physician-led.

We do not own a hospital. We were not able to do that, unfortunately. But we did partner with a hospital in San Antonio to help us, you know, get control over the care that they are receiving in the hospital system.

But yes, I don't see a reason why a physician can't own a hospital. I understand that there is regulatory, you know, requirements as far as a referral relationship and where that patient is going to go. But the physician actually knows where the best place is for the patient to receive care. And I think we just need to let them do that.

Mr. HERN. Thank you.

Mr. Chairman, I do want to note that when I said I got shot with—by a bow and arrow from my brother, that they all kind of smiled like they have worked on people who had been shot by bow and arrows before. [Laughter]

Mr. HERN. So Mr. Chairman, I yield back. Thank you.

Chairman BUCHANAN. By the way, I have got two brothers, so I know——

[Laughter.]

Chairman BUCHANAN. And three sisters. So I got—Mr. Davis, you are recognized.

Mr. DAVIS. Thank you, Mr. Chairman, and I want to thank all of the witnesses for very interesting insights and this discussion.

I have been thinking I have been around health care now, I guess, for a pretty good period of time. I have worked in clinics, I have sat on the board of hospitals. I have taught at medical schools. I hope that I can leave today with a feeling that, yes, we are all concerned about conserving the private practice of medicine, the independent, private practice.

I remember when I used to teach a course at the University of Illinois School of Medicine, and we taught a course called The Realities of Medicine. As young medical students would come in, they would talk about their goals and what they wanted to do. Of course, many of them would indicate that they wanted to do family medicine, family practice. They wanted to be internists. By the time they graduated, many of them would have changed their positions and changed their minds, and would decide that they needed to go into something that compensated them a little differently, that the reality was they may have wanted to do one thing, but

when it got down to deciding, they would find it necessary to decide that they want to do something else.

And I guess there is always this business of economy, the business of our economic system, and the business of where do we and how do we equalize or try and equalize systems so that the systems work together.

I am a sociologist. I am a big fan of a fellow called Frederick Douglass, who used to say that he knew one thing if he didn't know anything else, and that is that in this world you may not get everything that you pay for, but you will certainly pay for everything that you get, and that you pay one way or you would pay the other.

I wonder if each one of us could give one thing you think we can really do that would help conserve and preserve the independent, private practice of medicine.

I have been reading the papers, and I have read several stories in the last weeks or two.

So Dr. Gholson, why don't you just start and go?

Dr. GHOLSON. It is tough to give you just one thing, so I am kind of torn between get rid of prior authorizations absolutely, completely, and for—as primary care, paying us for what we are worth.

Dr. RICHARDSON. Thank you. I think maybe one of the biggest indicators or the biggest thing to keep us in business is just updating the physician fee schedule so we can actually keep pace with the cost of running a practice. Our overhead, employee overhead, has gone up 30 percent in the last 2 years. Our medical insurance goes up 10 to 20 percent every year. We literally just can't keep pace with it, and we can't keep hiring. So updating that fee schedule that keeps pace with that cost would be beneficial.

Ms. KEAN. I would like to get the medical record back in the hands of the physicians, instead of these AI tools and insurance carriers. It has become a billing weapon, and not the medical record that it used to be. I would like to see us get that back.

Dr. DESAI. Congressman Davis, thank you for the question.

We have got to fix the Medicare physician reimbursement schedule. And H.R. 2474 and 6371 need to be passed to allow physicians to maintain practices to preserve that sanctity, which you so appropriately referenced, between the patient and the physician. We have got to fix that, and we need your help.

Dr. JHA. Congressman, my—if you—number one for me is site-neutral payments. I think it is a major reason why we are having—we are seeing physician practices get bought out.

Second, dealing with Medicare Advantage prior authorization that we have talked about.

I also think physician fee schedule is important. But if I had to order it, site-neutral; going after MA; dealing with private equity. Those are major forces in the health system that we have to deal with.

Mr. DAVIS. Thank you all very much.

Thank you, Mr. Chairman. I yield back.

Chairman BUCHANAN. Yes, Mrs. Miller, you are recognized.

Mrs. MILLER. Thank you, Chairman Buchanan and Ranking Member Doggett, and thank you all for being here today.

I cannot agree more with the physicians on our committee and the life that they have led, the lives you all have led, and how important you are. You are so important.

I live in West Virginia, a very, very rural state. You know, sometimes it can take from an hour to almost five hours, really, to get to your doctor or to your hospital because our terrain is just very challenging. But we need care. And, you know, just for a routine checkup sometimes, it is critical that our local, rural physician practices exist so that they aren't always burdened, you know, with the far drive and the expensive visits to a hospital for something very minor. That has worried me for years, having to go to a hospital for something very minor when you could go to your family physician.

Today's economic environment, with inflation through the roof, and thanks to the reckless spending that continues to go on with this Administration, many independent physician practices cannot afford to keep their doors open. Frankly, I think the Federal Government doesn't reimburse well enough to make it feasible for you to do it at all. So this is a huge issue for physicians, as well as patients.

Dr. Gholson, I was really disheartened to hear about your struggles and your practice that you endured because of bad policy. And I know firsthand how devastating it is to rural communities to lose their local doctor. So to help paint the picture for my colleagues that may not be from rural areas—and there are a lot of them that aren't here that really ought to hear this—can you go into detail about the different physician-patient relationships that happen in independent practices, particularly in rural areas, compared to physicians in these huge practices?

Dr. GHOLSON. So to paint the picture of how rural my community is, we are a one-stoplight town.

Mrs. MILLER. Yes.

Dr. GHOLSON. My patients would be able—they could walk to my practice to see me, because we were right downtown. I was able to do home visits with my patients, which gave you incredible insight to what was going on in their life. I would see them at Walmart, and they would talk to me about their care. I would see them in church, and they would ask me questions about which specialists they felt like they needed to go to. And even though I closed my practice in 2022, I still get those questions from my former patients, even today.

So you really are part of the community. You are part of the fabric. You sponsor the local baseball teams. You are at the team events for—as team physicians. The whole community becomes like family.

Mrs. MILLER. You are almost the elder of the family, so to speak. I mean, you are that—you are just that important.

As much as I would love to see every independent practice thrive, I know that there are tons of challenges out there that you all face that can drive you to close or sell your practices and move into a larger health system. Prior to having to make the impossible choice to close your practice, can you tell us some of the pressures that come with competing for your workforce with the larger health systems, or if there is any pressure to consolidate your practices?

Dr. GHOLSON. So for me, competing with the local hospital is probably the biggest thing with my workforce. I could not compete with what they were able to pay my nursing staff. We already had a nursing shortage going into COVID, and COVID exacerbated the nursing shortage. A lot of nurses started doing travel nursing.

Mrs. MILLER. Oh, yes.

Dr. GHOLSON. And so it was just very difficult to compete, and physicians—and the hospitals had an advantage because of the facility fees they were able to garner from the care that they were receiving. So that made it very difficult to compete.

Mrs. MILLER. You are right.

Dr. Richardson, in order for people to understand more the business side of Medicare reimbursement simply not being enough to even cover the costs of operating in a rural area, are there examples where Medicare regulations or reimbursement requirements have limited your practice's ability to provide high-quality services to your rural patients?

Dr. RICHARDSON. I think it is just more of everything is more difficult when you are treating patients in rural areas. Unless you actually have a provider in that area, from a specialist standpoint, you are traveling. I mentioned earlier we have 13 clinics throughout the state. Those are clinics where we actually get in our car, grab our staff, and grab our equipment, our scopes, our drugs, put them in our trunk, drive to that community to run a clinic, and sometimes do some simple outpatient surgeries at that local, rural hospital, and then drive back. So it is just an increased burden. It is a burden to your quality of life. It is a burden to your practice at home.

We have had the discussion of consolidating care and making patients drive to the Wichita metro area because we are so overburdened there, and we just haven't had the heart to do it because many of these patients simply cannot or would not make the travel. They don't have the social support or the resources to drive three to four hours.

Mrs. MILLER. That is right.

Dr. RICHARDSON. And honestly, I think one of the biggest improvements we have had over the last couple of years, one of the good things that came out of the pandemic, was actually telemedicine.

Mrs. MILLER. Right.

Dr. RICHARDSON. There are so many of these patients in rural Kansas that need a five-minute appointment with me that can easily be done over telemedicine. And so we have tried to take advantage of that when possible.

Mrs. MILLER. Thank you for that answer.

And I yield back.

Chairman BUCHANAN. Thank you.

Mr. Fitzpatrick, you are recognized.

Mr. FITZPATRICK. Thank you, Mr. Chairman. Thank you all for being here today.

Medicare physician pay and its impacts on patient access to care remains a major issue in my community in Bucks and Montgomery Counties in Pennsylvania, as it has been and continues to be across the country. While I was pleased that Congress acted in the March

8 government funding package to address the Medicare physician pay cuts, predictable, sustainable reforms are still needed to prevent this in the future.

As you all are well aware, adjusted for inflation and practice costs, Medicare physician pay plummeted a total of 29 percent from 2001 to 2024, and physicians now face another steep 3 percent payment cut at the end of this year.

My first question to you, Ms. Kean: Can you discuss some of the impacts that this pressing financial instability is having on physician practices, including things like difficulty in retaining staff, trouble keeping their doors open, rising costs, administrative burdens, and the like?

Ms. KEAN. Thank you for the question. Yes. I mean, trying to retain our staff has been very, very difficult, and it is not just the hospitals that we are competing against. I am competing against retail entities that can just simply raise their prices. We can't do that. And so that is probably the biggest thing that is the impact there.

And yes, Congress, you know, must act. You know, Congress must act to avoid these cuts. And we all cheer that, you know, it wasn't as bad as it could have been. It is as bad as it has ever been, and it needs to be addressed immediately. If this panel is trying to figure out how to protect private practices, that is the number-one thing. There is nothing else after that.

Mr. FITZPATRICK. And have you seen a disparate impact in rural communities, underserved communities?

Ms. KEAN. Yes, absolutely. I mean, the rural communities are impacted in a greater way. They are losing their doctors.

And, you know, just listening to the physicians here—I am not a physician, but I am an advocate for them, and when I hear these stories, it just breaks my heart. It shouldn't be like that. And it is because of these things that, you know, we are talking about today that are getting in the way of taking care of patients, and for patients—or for doctors to even want to be doctors. We need help.

Mr. FITZPATRICK. Dr. Desai, you had stated in your testimony that since 2001 the cost of operating a medical practice has increased by 47 percent. Could you explain how these operating costs have impacted your practice and others like yours?

And how do you think Congress can address this?

Dr. DESAI. Congressman Fitzpatrick, thank you for the question.

You are absolutely right. The cost of seeing patients and providing the care that these patients deserve and need is astronomically different from when I started in practice. When you look at the inflationary updates that Medicare hospitals and skilled nursing facilities get that physicians simply haven't been a part of and have been excluded from, it makes it incredibly difficult to see patients on a day-to-day basis.

I can just give you an example. In my practice alone we have to increase the volume of patients that we have to see on a day-to-day basis to justify the increasing overhead costs that I have to pay for these medical assistants to be able to be in the exam room typing on an iPad, when I should be spending time with you, checking you for skin cancer and melanoma and creating that relationship,

which I do on a clinical basis, but I am challenged at the same time to make sure I have assistance there to help me that I can afford to keep to be able to see those patients that I need to see because the overhead is high.

So it is an incredibly vicious cycle. And what concerns me the most is that my job is to save lives from skin cancer, make people's skin disease better, keep people out of the hospital. It becomes incredibly challenging to do that when the day-to-day practice of medicine keeps it very hard to simply keep the lights on and to pay the bills to run the practice.

Mr. FITZPATRICK. Thank you, Dr. Desai.

I just want to associate myself with the comments of Dr. Wenstrup. The world needs the United States of America, and the only way we can be there for America and the world is if we are healthy. And the only way we can be healthy is if the doctor-patient relationship is healthy, as well. And the more—the criticism that I have always shared with my colleagues about the CFR, it is a cumulative registry. We always add to it, we never address what is redundant, what is duplicative, and what is actually outcome-determinative in the opposite effect, the opposite direction of what the intended purpose of that regulation was.

So I am hopeful that we are going to continue to work together on this committee to address the redundancies. We talked about several of them here. Prior authorization is probably—I mean, in addition to physician cuts, Medicare payment reimbursement, the amount of time you have to spend dealing with bureaucrats rather than serving your patients could lead to the death of health care in America. And we have to address it with urgency.

I yield back, sir.

Chairman BUCHANAN. Mr. Beyer.

Mr. BEYER. Mr. Chairman, Ranking Member, thank you for holding this and thank you for being here today.

My sister, my father-in-law, and my uncle all had full careers as independent physicians, and I very much appreciate that this is one of those wonderful pieces of Ways and Means where almost everybody on the committee agrees that we really need to make sure that we preserve the independent physician practices.

To that end, Dr. Jha, I am the father of two Brunonians, so I am glad to have you here. But you championed site neutrality. And 10 years ago Mike Pompeo, when he was a humble member of the House, and I sponsored a site neutrality bill, and I have done that every year since, which means I get a lot of visits from hospitals who tell me why this is such a bad thing, that they deserve to get more because they are taking care of the indigents. They have to be there 24 hours a day. They have all these arguments.

From your perspective, why is site neutrality still so important?

Dr. JHA. Yes, Congressman thank you.

Site neutrality is just critical for all of the reasons you have heard today. Look, if the issue for hospitals is they have to take care of a sicker, a more indigent population, we should figure out how to pay for that directly. But what site neutrality does is it totally perverts the health care marketplace, where there is now this very large incentive for hospitals to buy up physician practices. And that doesn't increase access, it doesn't increase quality. All it

does is it just allows Medicare to pay a lot more. Consumers pay a lot more through private insurance.

And there has been progress on site neutrality. I don't want to say we have made no progress, but there are really large sets of issues that are still not addressed.

I think I have heard from my friends and colleagues in the hospital industry who worry about this. You know, we have a long history in American health policy of doing X to solve Y. If the problem is that hospitals are not getting paid enough for certain things, let's pay them more to do those certain things. Let's not have a policy that totally perverts the marketplace. I think that is not the solution.

And it is creating—I mean, if you think about where private physicians have been largely getting bought out, it has largely been hospitals. Yes, private equity more recently. Yes, MA is a huge part of the problem. But it is hospitals that have been buying out practices because of a government policy that we can reverse.

Mr. BEYER. By the way, that was exactly my family's experience. My father-in-law retired, turned the practice over to his younger colleague who, two years later, sold it to the hospital because he had to.

So Dr. Gholson, we really appreciate all the challenges that you and your practice have faced. You talked about—let me quote—50 percent of your time on cumbersome administrative tasks. We spent a lot of time up here on AI, and one of the things that seems to be exciting is ambient clinical documentation. Can you use that? Is it affordable for a practice in Mississippi? Would that change your life much?

Dr. GHOLSON. So yes, I use AI now to help create patient education materials. It saves time. I do have to review them.

I am really looking forward to seeing what AI does in the documentation arena, because we spend a lot of our time documenting. So I think there is some promise with AI.

I also am concerned on the flip side of what insurers are going to do with AI that may be detrimental. So I think it needs to have some guardrails.

Mr. BEYER. Yes, yes, yes. Every doctor I know is terrified of a machine algorithm making the decision of what patient care is.

Ms. Kean, you are not a big fan of the way we do EHRs. How would you fix the electronic health record system?

Ms. KEAN. Oh, boy. That is a big question.

You know, I think that interoperability is probably the biggest thing, and that is, you know, every single one of us, when you come to our practice, we are going to ask you the same questions. Why do we have to keep asking those questions over and over again? Isn't there a way that we can communicate so that, you know, if the first physician asks those questions, it can be passed through to all of us?

We need help with that. It doesn't seem like it is happening. We do get medical records from other providers, and it does come in automatically. But in order to actually figure out what the care happened, you have to go through all of the MIPS checkboxes of everything that somebody has asked the questions about that does not provide any real information to the doctor that needs to treat

the patient. We need to know what that other doctor had to say, and what they are sending to us for——

Mr. BEYER. Yes.

Ms. KEAN [continuing]. And how we are going to be able to evaluate that, and then get that information back to them. The rest of the information that we are being asked is really for the record, from a billing perspective, and that is it.

Mr. BEYER. Great, thank you. I know the Veterans Affairs Department and the Department of Defense are trying to work hard just to make veterans and active duty military EHRs work together, and it has been a huge and problematic problem.

All right. Thank you, Mr. Chairman, I yield back.

Chairman BUCHANAN. Ms. Tenney, you are recognized.

Ms. TENNEY. Thank you, Mr. Chairman, and thank you to the witnesses and for your expert testimony.

I also really appreciate the insight that we receive on this committee from some of our doctors: Dr. Wenstrup, also Dr. Murphy, and also Dr. Ferguson, who serves on the main committee.

And I have also served on numerous hospital boards, nursing home boards, and we have seen this shift away from the doctor-patient relationship that we were all concerned about happening if we tried to centralize and federalize our system, our health care system.

I am a practicing attorney. We see this, a similar thing, happening in our legal field, where the bureaucrats decide what legal questions are answered. The bureaucrats decide what decisions judge make—judges make. My dad was also a judge.

But I want to just touch on a couple of things, but I first want to ask all of you, because we have talked about these issues in getting more doctors, better doctors, getting—more interested in getting into the health care system. Could I ask you, do you agree—and I am going to ask each one on the panel—that we need to have and protect a merit-based system in our health care field, that we have the very best people going into this field?

And I just want to start with Dr. Gholson and go all the way across the board. Do you think that that—we should continue—or continue to protect a merit-based system in terms of who gets to be a physician?

Dr. GHOLSON. I do think we need to protect the merit-based system, but I also think that the merits need to be transparent. We need to know the playing field by which we are being judged. And right now that is not happening.

Ms. TENNEY. Okay. Can you just go on and give us, like, a one-sentence answer? Thank you.

Dr. RICHARDSON. Yes, definitely merit-based. You can't walk into an ER and have someone treating you that was there because of other factors besides their merit.

Ms. TENNEY. All right, thank you.

Ms. Kean.

Ms. KEAN. Yes, I absolutely agree.

Ms. TENNEY. Dr. Desai?

Dr. DESAI. Thank you, Congresswoman. Absolutely. I think we need to cultivate the best and brightest minds in this country to go into medicine. We need that for the future of the health care

system. We have those people in our country. We need to promote them to become doctors.

Ms. TENNEY. So transparently, we want to make sure that everyone is qualified based on a neutral standard, not we don't know who they are, we just know they are excellent when they take their boards.

Dr. DESAI. And if they want to be a doctor, they can become a doctor.

Ms. TENNEY. That is great. Thank you.

Doctor Jha.

Dr. JHA. Yes, I think I agree with my colleagues. Transparent standards, merit-based. Very clear that we want a workforce that can take care of the American people at the highest quality possible.

Ms. TENNEY. Thank you so much.

I just—I want to jump into a couple of questions. So Medicare reimbursement to these providers, various providers, doctors who are failing to keep up with the increasing costs of operating a physician practice, I hear—almost every doctor I have had in the last 20 years has retired or been—ended up as a hospitalist. You know, the cost of operating a practice, we have outlined this all day today.

Medicare beneficiaries in my underserved area—Dr. Gholson, I have towns in my district that have a stop sign, not even a stoplight, so—and we have a dire physician need in upstate New York, way up in the rural areas. So these are huge problems.

And the 2023 Medicare Trustees report identified ongoing reimbursement gaps as a threat to long-term access to physicians for Medicare beneficiaries. I wanted to ask you to what extent has the growing gap between the operational costs of independent physician practices and Medicare's actual payment affected the viability of practices, and how has it impacted patient access in rural areas?

And I want to ask Dr. Gholson that, and also Dr. Richardson. If you could, just comment. We are struggling to get any kind of MD in federally-funded health care spaces in my—in entire counties in my district. If you could just say——

Dr. GHOLSON. Yes, I would—it impacts it tremendously. Every January I hold my breath, waiting for the fix. In the meantime, I am having discussions with my office manager of what staff I am going to reduce hours or let go, which is going to impact the access that my patients have to me.

Ms. TENNEY. And Dr. Richardson.

Dr. RICHARDSON. Yes, I think I mentioned earlier that our employee overhead has gone up 30 percent in the last year, and that is not the only sector within our business that we are paying more for. So I would venture to say Medicare Advantage plans actually decrease access because, at least where I am, most of the specialists try not to participate in them. The patients are always coming in saying, "Well, I am trying to find an insurance plan that my doctor accepts," and those Medicare Advantage—or disadvantage plans, whatever you want to call them—are actually decreasing access in my area.

Ms. TENNEY. Well, let me ask you, outside of congressional intervention, you know, to update the physician fee schedule, what else can we do? What kind of targeted reforms can we do generally

to the practice of medicine to create a stable, predictable fee schedule that you can rely on, not knowing, you know, year end to the changes?

What can we do? And I only have a few seconds left, but if you could, jump in.

Dr. RICHARDSON. It has got to be tied to just the cost of taking care of patients. As long as we are taking care of—and we are able to keep a business open to take care of the patients, whatever that fee schedule is——

Ms. TENNEY. Well, what can we do in Congress?

I mean, we would love to be able to give you better access to that care, and better access to a reliable, stable, predictable fee schedule.

Dr. RICHARDSON. Well, mark the index to the MEI, you know, the updates need to be, I think, indexed to the MEI to adjust for the cost of business.

Ms. TENNEY. Great. Thank you so much. I thank you all for your great testimony.

And I yield back.

Chairman BUCHANAN. Mr. Moore, you are recognized.

Mr. MOORE of Utah. Thank you, Chairman Buchanan. Thanks for holding this important Health Subcommittee hearing today on the challenges facing independent physician practices.

And your expertise is very much appreciated today. Thank you, witnesses.

A contributing factor to the collapse of private practice are maybe well-meaning but overly burdensome reporting and administrative requirements placed on physicians such as the Merit-based Incentive Payment System, or MIPS. Quality measurement in MIPS can be costly, time-consuming, and, at times, bear little relation to physicians' actual performance in providing quality care to beneficiaries.

One estimate found physicians spend an average of $12,800 annually to comply with MIPS's quality measure reporting, devoting approximately 53 hours per physician.

A 2022 study in the Journal of the American Medical Association found that MIPS scores are inconsistently related to performance, and physicians caring for more medically and socially vulnerable patients were more likely to receive low scores, despite providing high-quality care. Kind of counterintuitive, if you will.

And among a survey of small, rural providers, few participants felt that MIPS would improve quality care or—sorry, improve care quality, or provide administrative relief.

I had a group—as soon as I came, one of my first meetings I came on when I came on the Ways and Means, even—came and laid all this out for us on the issues that exist within the quality care standards within this program. And this is not a big attention-getting issue. This isn't going to cause a lot of bickering back and forth between parties. This is a fundamental problem, the way that CMS operates and it has existed for years. It should be low-hanging fruit.

And I would love to just get a little perspective to find ways to accurately reflect patients' outcomes and the value a physician is providing to the Medicare program. Dr. Desai, do you feel that

quality reporting metrics and MIPS, more broadly, do a good job of accurately assessing the level of care you provide to patients?

What recommendations do you have to reform these quality measures?

Dr. DESAI. Congressman Moore, thank you very much for that very pertinent and valuable question, and I appreciate you bringing up the challenges of reporting burdens, because reporting is burdensome.

MIPS has not shown to help make care better as a well-rounded outcome for patients. I can tell you, from my experience, the art of that office visit, the 20 minutes that I want to spend with you talking about your skin disease, some of that goes into clicking buttons on an iPad that have nothing to do with what you are there to see me for. For example, if you are coming in to see me to take care of a melanoma, which is a deadly skin cancer, half of the things that I have to report in your chart that day have nothing to do with your medical history related to your skin cancer.

We know that MIPS has caused challenges, and I will give you one example. There was a study that actually showed doctors who took care of patients from a higher social risk perspective ended up with lower MIPS scores, and actually got decreased reimbursement, even though they were taking care of patients who are much more at risk, and have much more complex medical illnesses. So we have got to fix MIPS. It hasn't improved anything.

And what is challenging is CMS is now going into the next phase of MIPS value pathways and other systems which are seemingly supposed to improve that process, and have already, prior to implementation, posed major challenges.

Mr. MOORE of Utah. So again, counter-intuitive.

Dr. Richardson and Dr. Jha, I saw you nodding, as well. Anything to quickly add to that?

Dr. RICHARDSON. No, the reporting is largely meaningless. He is spot on. Most of what we are reporting and spending office time and personnel time to do has nothing to do with the care that the patient is there for, especially when you are dealing with specialists.

I take care of a lot of advanced prostate cancer patients, and we are spending time charting, documenting, following up, finding out if they had their colonoscopy or if they want to stop smoking. And granted, those things are great from a general practitioner standpoint, but many of these reporting details, from a specialist's standpoint, are completely meaningless.

Mr. MOORE of Utah. Thank you.

Dr. RICHARDSON. And there is no tie to quality or value.

Dr. JHA. Yes, and I will say this. This is a very classic problem of policy. I think it was a well-intended program when it was first created. It had bipartisan support. Some of us were hopeful that it would actually work. It really hasn't. Like, the evidence here is MIPS doesn't improve quality, it just burdens physicians. And at this moment we have just got to find a path forward.

And I will say quality reporting is important, as a concept. The measure should be we should have a smaller number of measures, it should be automatically collected, and they should focus on

things that patients care about, patient outcomes. We can do that. We have the technology. That is not what MIPS is achieving today.

Mr. MOORE of Utah. Even in my remarks that talked about being well-meaning, well-meaning at first and it just hasn't—it hasn't hit the mark.

We are working on a lot of things to enhance transparency and incorporate provider, patient, and other stakeholders' perspectives. Right from your initial responses, like, you give me more motivation to continue on with that initial conversation I have. Our team is all in on this, and would love to engage with any of you and continue to any of my colleagues.

So again, thank you, Chairman, I yield back.

Chairman BUCHANAN. Mrs. Steel, you are recognized.

Mrs. STEEL. Thank you, Mr. Chairman.

Apart from Hawaii, California ranks first among the states with the highest cost of living, between 35 to 45 percent above the national average. California consumers have been—I mean, have seen—prices grow about 20 percent overall in 2020, and many are experiencing continued rising prices, especially in services such as medical care, housing, and electricity, and others.

At the same time, California seniors are facing a physician shortage heightened from the pandemic, physician burnout, rising overhead costs, and declining reimbursement. And the physician shortage is impacting patients across—access to necessary care. And it is much worse in California.

And I am just so glad that all the witnesses are coming here that, you know, we can discuss about independent physicians. And thank you for all coming.

And I just want to ask all the witnesses. California's physician practice landscape is rapidly changing toward an increase in market consolidation and vertical integration. That is what I see in California. What do these trends mean for patients I represent and to the doctors, for especially independent doctors?

You can just—anybody who wants to answer it is going to be great.

Dr. JHA. Well, maybe, Congresswoman, I will just start by saying very quickly the evidence on consolidation is actually quite clear when—whether it is vertical consolidation, it is horizontal consolidation, consolidation that is really not focused on integration and improving care tends to cost more, patients have worse experience, physicians who practice in them are—worse experience. It is sort of one of those rare things where everybody is worse off, except maybe the provider organization that can make more money.

So there is a series of things that we can do to deal with that consolidation. We have talked about a lot about some of those policies: site neutrality, dealing with MA, vigorous enforcement of antitrust. But this is an issue that is really prominent in California, but it is prominent across the country.

Dr. DESAI. Congresswoman Steel, thank you very much for bringing that up, and I appreciate you asking about seniors, because I think it is incredibly important that we realize that, when we talk about Medicare payment system, we are talking about seniors being able to see a doctor for the health care they deserve, that they have dedicated their lives for, and that they need.

And I think that all of my panelists agree that, once we get the appropriate level of inflation-adjusted reimbursement tied to the MEI with bills like H.R. 2474 and 6371, we can at least start to preserve and ensure that seniors have the access that they need.

I will also mention that when we talk about access to care, we need to make sure that the health care system still attracts young students and young, bright minds to go into medicine who want to become doctors and serve patients. Otherwise, when we all become seniors, who is going to take care of us?

I give you an example of my daughter, an 11-year-old. She wants to be a dermatologist and take care of patients with skin disease when she gets older. I hope there is a practice of medicine and dermatology for her to become one. I honestly don't know what the future holds, and I really appreciate you bringing up the aspect of seniors' care, because it represents a phase of life that we will all be in at some point. Thank you.

Mrs. STEEL. Ms. Kean, before you go, you know, you were talking about the redundancy that, you know, you were asking these questions that every patient is coming in, and AI is a really big part of it. And I am glad that I am not on the—just the Ways and Means Committee and our Health Subcommittee, but I am on the AI task force, too.

So we have been talking a lot about health care issues because we want to prevent that redundancy and time wasting with the patients, and you can see—actually give more to, you know, patients' attention instead of that, you know, asking same questions over and over and then try to get the records, you know, from the other doctors. So I just want to talk about just a little bit more that, you know what—we have a policy, and you cannot really share much about these patients and other stuff. How are we going to help, and how are we going to store these, you know, data?

Because I am on the Select Committee on China, too. So, you know what? We see a lot of these data that has been stolen. So, you know, how are we going to really, you know, store all these data, and how are we going to share only with our physicians?

Ms. KEAN. Yes, I think that, you know, putting the care back in the hands of the patients, and the medical records back in the hands of the patients, I think, is probably the primary thing that could happen. If you allow them to contain that, to have access to the medical records, we are huge proponents of that. We want patients to be 100 percent involved in their care, and that means knowing what is in their charts.

I think that that is probably a way to go, and to find some way to protect that would be, you know, critical.

Mrs. STEEL. Mr. Chairman, my time is up. I have a lot of questions here, so I am going to just submit in writing.

Chairman BUCHANAN. Okay.

Mrs. STEEL. Thank you.

Chairman BUCHANAN. Ms. Van Duyne, you are recognized.

Ms. VAN DUYNE. Thank you very much, Mr. Chairman.

Two weeks ago the House Committee on Small Business held a hearing on examining the impacts of the regulatory burden on small practices. I am glad to see us holding this hearing in this

committee, and it is clear that over-regulating is killing private practices.

In Texas's 24th district I have hosted a number of roundtables with doctors, who have—many of—are attendees here today as a witness.

Dr. Desai, thank you so much. It is great to see you here today. I appreciate you making the trip up. I always make it a point to ask our physicians how much time that they spend in a screening. You were talking about this earlier, doing administrative work versus face to face with their patients. And it is shocking to hear the time that our medical providers have to spend on compliance. And they would rather, obviously, strongly prefer to spend the time with their patients.

In fact, one local doctor—I am sure you remember this—she even shared a heartbreaking story about how she had finally achieved the American dream. She had opened her own practice, only to be forced to sell it because it got too expensive to keep up with all of the government red tape.

When regulatory costs reach the point that it is no longer feasible for small, private health care practices to keep their doors open, it leads to one thing, and you have been mentioning this all day: consolidation. That decreases quality of care, it limits competition, which increase costs, and it limits the possibility of physicians owning their own businesses, thereby restricting access to care and ultimately hurting patients.

We can't continue to allow over-regulation to shut the doors of small care providers, and I am glad that our committee is focused on finding solutions to provide better and more affordable patient care.

Dr. Desai, it is great to see you again. And I would like to ask you what reforms that you would like to see that would encourage higher quality care in Medicare, while reducing those kind of burdens for physicians.

Dr. DESAI. Congresswoman Van Duyne, it is great to see you, as well. And thank you, in particular, for your leadership and all of the work that you are doing in this space, along with the subcommittee and the committee.

I think you hit the nail on the head. I think the fact that we are here in a meeting talking about physicians not being able to dedicate their time to serving the patients' needs because they are too busy filling out paperwork, clicking buttons, on a phone call, hiring dedicated employees that are full-time equivalents with full salaries simply to do burdensome paperwork like prior authorizations like we have talked about is the problem.

I think we have got to make sure that we, as physicians, get reimbursed for the care that we are providing. And I think the important message here is, with all of your leadership on bills like H.R. 2474 and 6371, we can at least start to make sure that those of us in private practice, those in academic practice, those in large groups—this is all across the entire health care spectrum—can continue to practice, and see those patients, and keep the doors open.

I will give you one quick example. I had a patient with severe eczema, which typically is something that we treat on a very common daily basis, itchy red rash over the body. I can get that better

pretty quickly. This patient, a young law student, an SMU law student, ended up in the ICU in the hospital with total body erythroderma. Just picture a full-body burn. The reason she ended up in the hospital, a 21-year-old law student, highly-functioning, bright young lady ended up in the hospital because of the fact that the insurance company would not prescribe her the biologic medication that would get her clear in two to three doses because they wanted her to—a cream for a rash that covers 80 percent of her body.

Ms. VAN DUYNE. That is crazy.

Dr. DESAI. She was in the hospital in the ICU, almost died, and now is recovering from that. So——

Ms. VAN DUYNE. Thank you for sharing that.

Dr. DESAI. Thank you.

Ms. VAN DUYNE. You know, we have heard many of the Democrats that have labeled private equity as a villain, and I have heard from a significant number of physicians that they are starting to look into private equity as an investment so they don't have to consolidate. What are the positive impacts of private equity investment in medical practices?

Dr. DESAI. I think when we talk about competition, I think competition is a good thing. I think access is a good thing. I think when you have only one or two players in town, if you will, that is a problem.

We, everyone in this room, is a patient at some point in their life. We want to be able to pick the doctor that we like, that we believe in their credentials, that we connect with, that we can have a rapport with. If you have only got two to choose from, that is going to limit your options. And I think, when we encourage competition broadly in the best interests of the highest quality patient care, that is where we need to land.

Ms. VAN DUYNE. And you are saying private equity is something that actually helps increase the competition within those markets, as opposed to decrease?

Dr. DESAI. Well, and I think I would frame it in the way that private—not all private equity is bad. Not every academic medical center is great. Not every hospital system is great. I think we can't label a one-size-fits-all approach. I think we have to be open minded to make sure, hey, if you are a doctor in this practice model and you can deliver exceptional care, then you are doing a great job.

Ms. VAN DUYNE. Excellent.

Thank you, and I yield back.

Chairman BUCHANAN. Mr. Estes, you are recognized.

Mr. ESTES. Well, thank you, Mr. Chairman, and thank you for allowing me to waive on to the Health Subcommittee, which I am not currently a member of.

And thank you to all the witnesses who spent a lot of your time today talking about issues that are important to you, but also important to us. I want to particularly welcome Dr. Richardson to our committee who is from Wichita, and I have been to their facility there, and I appreciate the opportunity to see, you know, the day-to-day activities.

You know, as you noted, Dr. Richardson, your practice doesn't just serve patients in Wichita, but across the State of Kansas and

into Oklahoma. And also, you know, across the country, physicians like you are serving rural Americans, providing quality health care to parts of our country that are too small to support specialists on their own.

Unfortunately, we are seeing the bureaucratic red tape, lower reimbursement rates, rising prices are all weighing heavily on your independent physician practices. And we are seeing those private practices close or consolidate as a result.

Mr. Chairman, I have a letter that Dr. Wenstrup gave me from a primary care physician who talked about being an independent physician versus being a hospital employee, and I would like to submit that for the record.

Chairman BUCHANAN. Without objection.

[The information follows:]

May 22, 2024

I have been asked by Dr Brad Wenstrup for my opinion on the pitfalls of hospital employment for physicians as opposed to private practice.

The largest pitfall of hospital employment is the loss of autonomy. Physicians employed by hospitals often have less control over their schedules and patient load compared to those in private practice. Decisions are often influenced by hospital policies and administrative goals rather than individual physician judgment.

Hospital employed physicians are often faced with increased administrative responsibilities, including extensive documentation which can detract from time spent with patients.

Hospitals frequently used performance metrics and productivity benchmarks to evaluated physicians. This can lead to pressure to see more patients in less and time, compromising the quality of care.

While hospital employment provides a stable salary, there may be fewer opportunities for financial growth compared to private practice, where physicians can directly benefit from their practice's profitability.

Physicians in hospital employment may miss out on developing skills in practice management, business operations, marketing and staff management.

Hospital employed physicians might be subject to institutional goals and priorities that might not always align with optimal patient care.

The structured and high-pressure environment of hospital employment can contribute to physician burnout, particularly if the work/life balance is not adequately managed.

Despite these pitfalls, hospital employment can also offer benefits like financial stability, reduced administrative burdens with access to advanced medical technology making this a viable option.

Douglas A Saunders, MD

Mr. ESTES. Thank you.

You know, as I have spoken with patients and physicians and support staff throughout Kansas, consolidating or closing practices is not helping Kansans receive more or better-quality care. With fewer and fewer doctors and nurses in private practice, patients are seeing increased costs and, in some cases, worse outcomes.

The Kellogg School of Management notes that prices increase 14 percent when a private practice is acquired by a hospital, and a National Opinion Research Center survey found that 45 percent of physicians report deteriorating patient-provider relationships after consolidation. These increased costs and diminished outcomes are not the recipe for a healthy society, and our committee must prioritize solutions that preserve the vital role of private practices.

Dr. Richardson, I am especially intrigued by your practice because you have been able to stay independent while serving more than a million patients throughout rural parts of our state. In your testimony you highlighted the fact that Wichita Urology has managed to remain independent, in part because of the shortage of urologists in Kansas. Unfortunately, urology is far from the only specialty with a physician shortage in Kansas, which, as you know, often impacts, most importantly, the rural parts of our state.

Can you elaborate on how your private practice is still open to serve these rural areas, and how that is not often an option for physician groups that have been acquired?

Dr. RICHARDSON. Yes, thank you. Thank you for being here, and nice to see you.

Yes, we are not unique in the specialty in our area that does these outreach clinics. Gastroenterology, cardiology, rheumatology, a lot of the specialists do the same outreach clinics throughout rural Kansas because they know it is needed, because they know that those patients can't drive three to four hours, and those patients don't often have any specialists in those areas.

Speaking on consolidation, there is a hospital system that does own specialists that do no outreach, right? So that is—that is the picture of consolidation in our area. The independent physicians are reaching out doing telemedicine, driving, having clinics at these rural communities to reach those rural patients while the consolidated hospital system is not. They are allowing those patients to drive.

You also mentioned the increased cost of running a medical practice, the inflation. It is that reason only that we have considered consolidating ourselves back to Wichita, and taking our staff out of those outreach clinics. It is not because we don't enjoy seeing those patients in the rural areas. It is not because those rural patients don't need it. It is because we almost can't afford it with the difficulty in hiring new nurses, new MAs, the increased cost of running health care. We have talked about, just from a financial standpoint, consolidating. And like I said, we haven't had the heart to do it, and I hope we won't, and I don't think we will. But that is the only reason we have even had that conversation.

Mr. ESTES. Yes, I thank you for that. I know we have much more importance around—the folks that live in Wichita or other urban areas don't realize and take—I mean, they take health care for granted because you may have 10 or 20 specialists 10 or 20

minutes away that you can actually interact with. It is not necessarily the case in rural areas.

You also mentioned about site-neutral payments, and they don't necessarily equalize. Can you provide further details on how policies could be managed without necessarily reducing payments to hospitals?

Dr. RICHARDSON. Yes, like I said in my opening statement, I don't think the right thing is to just decrease payments to hospitals. That doesn't necessarily help physician practices stay in business. It doesn't help access, it doesn't help the patients. But I do think that it is an unfair, unlevel playing field. Right now we are competing with those systems for the same providers, the same doctors, the same nurses, the same MAs, which makes it difficult for us to run an independent practice.

So I think site neutrality is, if not the most important, one of the top two important things of keeping independent physicians in practice. We are simply just competing against someone that we can't beat. And so I think a more reasonable solution would be to modestly have a decrease in the HOPD payment and a modest increase in the physician. Knowing that is asking to just decrease payments for hospitals. That doesn't help our practice to stay in business, that doesn't help us serve patients, and it certainly doesn't help increase access.

Mr. ESTES. Well, thank you, and thank you to all the panelists.

Again, I yield back, Mr. Chairman.

Chairman BUCHANAN. Thank you.

I would like to submit a letter in the record from a doctor in my community.

[The information follows:]

Thank you, Chairman Buchanan and Ranking Member Doggett, for the opportunity to submit this statement for the record. I am Dr. Randy Pilgrim. I completed medical school and residency at the University of Minnesota, and have been board-certified for over 30 years. During that time, I have served in numerous leadership roles in the specialty of emergency medicine, and am regularly involved with health policy issues at state and national levels. I am deeply committed to not only the care of emergency patients, but also to the sustainability of the system that cares for them.

As a physician and a leader, I am deeply concerned about the challenges facing independent medicine in our nation. I believe that independent physicians are essential for ensuring access, quality, and innovation in health care. Because of our contributions to patients and to the health care system, we deserve support and protection from the forces that threaten our survival.

Independent physicians face a perfect storm of pressures that make it increasingly difficult to sustain our practices and serve our patients. These pressures include:

- *Administrative Burdens:* Independent physicians spend an excessive amount of time and resources complying with complex and often redundant regulations, including documentation, treatment justification or authorization, and quality reporting requirements. These tasks take away time and resources from patient care, reduce clinician satisfaction and increase burnout and attrition.

- *Medicare Reimbursement Reductions:* Independent physicians have experienced significant and persistent cuts in Medicare reimbursement rates, at the same time that the cost of providing health care consistently rises. These cuts have been driven by antiquated budget neutrality triggers and a lack of inflationary updates for decades (which is unique to physician services). Reimbursement cuts undermine the financial viability of independent practices and may force physicians to leave their practice, find alternative employment, or pursue consolidation into a hospital system or health plan.

- *No Surprises Act (NSA)*: This law does an admirable job of protecting patients from surprise medical bills and keeps patients out of the middle of payment disputes between providers and health plans. However, the implementation of the NSA has had significant consequences for independent physicians and the health care system. In particular, it has driven dramatic reductions in reimbursement for physician services at a time that increases are sorely needed. A recent study by the Emergency Department Practice Management Association (EDPMA) shows a 39% reduction in out-of-network reimbursement for emergency medical care in 2023, with no concurrent relief from administrative burdens, malpractice obligations or quality of care expectations. The combined effect of Medicare and NSA reimbursement reductions is crippling, and once again, particularly threatens small and medium-sized independent practices in rural and underserved communities.

- *Malpractice costs:* Patients deserve appropriate remedies for adverse, avoidable clinical outcomes. Currently, malpractice insurance costs are high and rapidly increasing, especially for high-risk specialties such as emergency medicine, obstetrics, and surgery. This adds to the

concerning realities that independent medical practices have to confront daily, and require more resources (rather than less) in order to sustain high quality medical care.

- *Workforce shortages*: Independent physicians face growing competition for talent and experience constant recruitment challenges, especially in rural and underserved areas. Recent increases in administrative burdens combined with reductions in reimbursement are driving more burnout and attrition. This compounds the effects of the aging of the physician workforce and the limited supply of residency slots.

These challenges are not unique to independent physicians, but they are especially acute and compounded for us, as many practices lack the economies of scale, bargaining power, and support systems that larger organizations can offer. As a result, many independent physicians feel forced to leave their practices, find alternatives, or sell to a hospital or health plan. In other instances, they may partner with other entities that can provide them with capital, infrastructure and stability in order to move forward.

In recent years, private equity has emerged as a source of capital and support for independent physicians. For independent physicians, these relationships can also provide greater access to technology, operational support, innovation and strategic input, while allowing practices to retain clinical autonomy and decision-making authority. These relationships may also help independent physicians achieve efficiencies, optimize performance, and expand access, scope and reach—particularly to rural and underserved communities.

In my experience, the right strategic relationship has empowered a physician-led culture, enhanced clinical quality and outcomes, allowed further investment technology and innovation, and has permitted an expanded footprint in rural and underserved areas. It can also address some of the challenges that independent physicians face, including administrative burdens, reimbursement reductions, malpractice costs, and workforce shortages. All of this can occur in the setting of the highest standards of ethical and professional conduct, in compliance with applicable laws and regulations governing our profession.

I ask the Subcommittee to consider carefully how to reduce administrative burdens and other factors that distract from patient care, while also maintaining a range of structural options for independent practices to effectively provide high quality care in a variety of settings. I also ask the Subcommittee to tackle the fundamental issues that we encounter as described in this statement, and to implement policies that continue to empower and support the practice of independent medicine in our country.

Thank you for your attention and consideration.

Randy Pilgrim MD FACEP

Chairman BUCHANAN. Let me just kind of give you one easy one, but I need to get kind of your thoughts and ideas on this because we are going to wrap up, we are just about done.

Tort reform. I am from Florida. We have a lot of frivolous lawsuits, a lot of lawsuits, and I am curious about how that impacts your business—one, from premiums and two is just from defensive medicine. I don't know how you can measure that, but I think it is something that probably can be measured, where people do procedures or things because they just want to be careful or be sure about that.

The other thing is I can just tell you in our area we have a lot of doctors, in their late 50s, early 60s, that have made good money, surgeons and others, and they want to hang onto it, and they are worried about practicing out there. If something goes wrong, someone is going to take their net worth. And so it is a big, big issue in Florida.

But Doctor, why don't we start with you, and we will just run through here real quick? This is going to be the wrap-up question.

Dr. GHOLSON. Thank you for the question.

In Mississippi we had state-level tort reform in the early 2000s, which made a huge impact on our ability to continue to practice medicine. For family medicine in particular, it did decrease the number of family medicine physicians who did OB, and we are actually seeing the consequences of that now.

But I do know, for family medicine doctors who want to do OB, the price of malpractice is still an issue. It is still overtly high.

Chairman BUCHANAN. Yes.

Dr. Richardson.

Dr. RICHARDSON. So tort reform is never going to be turned down by physicians, and it is a very important thing to discuss, and I think it is a very good thing. It is very specific, or it is very specialty-specific and very state specific. There are some specialties where tort reform is absolutely crucial to allow them to stay in business and continue to work until they are 65. In some specialties, it is not as crucial.

I think it pales in comparison to moving the needle compared to site neutrality and physician fee updates. But it is certainly an important thing to address, especially in some specialties in states.

Chairman BUCHANAN. Yes, and I do know every state is different. I put that—50 states, you all look at this a little bit differently.

Ms. Kean.

Ms. KEAN. Yes. We in Texas passed tort reform a little over 20 years ago. And it—I can tell you, it just, you know, firsthand, it absolutely impacted the malpractice rates our physicians were paying. It decreased it substantially.

Texas is a very friendly state for physicians. We see a lot of physicians that want to come there because of tort reform. They feel like, you know, they won't lose, you know, everything that they have worked so hard for if something terrible happens. And so I would absolutely look to Texas to see how they did that, because it is working very well for us.

Chairman BUCHANAN. Yes, I have heard good things about Texas.

Dr. Desai.

Ms. KEAN. It is working.

Dr. DESAI. Mr. Chairman, thanks for this important question and topic.

I will quote you a statistic. I read a study by the AMA that said in 2022 over 30 percent of physicians reported being sued. That is a staggering number, and that is exactly, to your point, why there is so much concern from physicians to even go into medicine or to continue practicing and doing procedures that are well within their scope of practice, but out of fear that they could be sued, potentially by anyone, depending on their state legislation.

At the American Academy of Dermatology Association, we certainly support broad, Federal medical liability system reform, but we have got to put in common-sense limits into these medical liability regulations. Thank you.

Chairman BUCHANAN. Doctor Jha.

Dr. JHA. Yes, very briefly, I am going to largely echo what Dr. Richardson said. I mean, this is an important issue. I think there is good evidence that the malpractice system in our country leads to over-utilization of certain types of testing. The defensive medicine we talked about, the data on that, I think, is quite clear.

There has been progress at the state level. There are certain specialties that are still at risk. It is one part of the bigger picture we have been talking about today, which is how do we keep independent physicians in check. We have got to deal with all of the other stuff: site-neutrality, Medicare Advantage, physician fee schedule updates. If we do all of that and make this a part of that solution, I do think we can get to a better place.

Chairman BUCHANAN. I think part of the reason that they go after—in our state, again—the doctors is because they have a reputation to protect, and they know that. And I think for some of them, they take advantage of it. But I am glad to see what Texas and some of the other stuff has done. Now, everybody should have their day in court, in a sense. But my point is we need to take a look at stuff that is frivolous.

But I want to thank all of you. I think it has been very productive. I think our members are excited about the input we have gotten. As someone mentioned earlier, you are all busy, all successful people. We really do appreciate you coming up, and you do have a big—you do make a big difference. Thank you, and have a great day.

[Pause.]

Chairman BUCHANAN. Again, let me just add one thing. I would like to thank our witnesses for appearing before us today.

Please be advised that members have two weeks to submit written questions to the witnesses—with answers later in writing. Those questions and your answers will be made part of the formal hearing record.

With that, the subcommittee stands adjourned.

[Whereupon, at 11:21 a.m., the subcommittee was adjourned.]

MEMBER QUESTIONS FOR THE RECORD

VERN BUCHANAN
DISTRICT 16, FLORIDA

FLORIDA DELEGATION
CO-CHAIR

COMMITTEE ON WAYS AND MEANS
TAX-WRITING COMMITTEE
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Congress of the United States
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06/05/24

Dr. Gholson: *How do you think the current structure of the physician fee schedule contributes to consolidation within the health care industry?*

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Questions for the Record for Dr. Jennifer Gholson
U.S. House Ways and Means Committee
Health Subcommittee Hearing on
The Collapse of Private Practice: Examining the Challenges Facing Independent Medicine

Question for the Record from Subcommittee Chair Vern Buchanan

1. Dr. Gholson: How do you think the current structure of the physician fee schedule contributes to consolidation within the health care industry?

   Response: Medicare's underinvestment in primary care is one of the key drivers of financial instability for practices, leading many to the false choice of either consolidating or closing their doors. 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.

   Medicare also currently puts small business physician practices at a disadvantage due to the site of service payment differentials. 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.

   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, which has been 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. For some small, rural practices and hospitals, the effects of consolidation may be different. If consolidation preserves access to healthcare then it is beneficial to the community. If consolidation forces small business physician practices to close limiting access and choice for the community there is little benefit to consolidation. Consolidation

often results in the closure of service lines not deemed highly profitable – including primary care – and may worsen access to care in these communities.

Practice transformation and quality improvement require significant investment in practice capabilities including technology, people, and new workflows. Yet the Medicare Physician Fee Schedule does not include any annual update, unlike other Medicare payment systems, and strict budget neutrality requirements force adjustments any time Medicare tries to make investments or pay for new services. In practice, this physicians face an annual cut to their payment, which is already insufficient and hasn't kept pace with inflation. The current structure quite literally asks physicians to do more – take care of sicker, more complex patients, navigate increasing prior authorization requests, and try to get paid through cumbersome coding processes – with less in our current financial environment.

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Congress of the United States
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6/05/24

Dr. Richardson: *What has been your experience with MIPS and the administrative burden that it entails? What specific recommendations do you have for this committee to help ease some of these administrative burdens you face every day with MIPS quality reporting measures? How can CMS tailor measures to improve care quality?*

Dr. Desai, Ms. Kean & Dr. Richardson: *How can the committee specifically help reduce onerous requirements for reporting more accurate and appropriate quality measures?*

Dr. Richardson: *Why is it important to incentivize participation value based care payment systems, such as both MIPS and advanced alternative payment models (AAPMs)? How can the Centers for Medicare and Medicaid Innovation improve the scope of models to provide more opportunities for providers to participate in AAPMs?*

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Question from Chairman Buchanan: Dr. Richardson: What has been your experience with MIPS and the administrative burden that it entails? What specific recommendations do you have for this committee to help ease some of these administrative burdens you face every day with MIPS quality reporting measures? How can CMS tailor measures to improve care quality?

Answer from Dr. Richardson: As a specialty practice with 12 physicians, we have only been able to identify 13 MIPS metrics that are even remotely related to our patient population but are still largely meaningless to measuring or improving the quality of their urological care. The burden of tracking these metrics required of MIPS is significant, and while it's difficult to quantify the expense to the medical practice of this burden, it's obvious how much it affects nearly every employee department on every patient encounter.

As an example, at front desk check-in, patients are required to answer additional questions related to MIPS metrics followed by additional time spent by our medical assistants to input this data into the chart. Physicians must document and add appropriate codes to validate the data, even if completely unrelated to the patient's visit, followed up by our coding staff to double check and adjust the coding, if necessary. Our nursing manager, IT manager and Director of Operations spend hours each week and days at the end of each year making sure the data is reported appropriately. We estimated that, at a minimum, this adds 3 minutes per patient encounter, which may not sound like a lot but averages 10-20% of the time of a typical patient visit and with over 13,000 Medicare patient encounters per year in my practice, this equates to over 12 additional hours per week that could be used for patient care instead of paperwork. Unfortunately, all the resources spent to collect and disseminate MIPS data are not useful in promoting higher quality care by physicians nor helpful in informing patients which doctors deliver higher quality care than their peers. Furthermore, as currently designed, MIPS offers no realistic way for practices to recoup the cost and burden of participating given the budget neutral status of the program.

As I stated at the hearing, I believe MIPS should be repealed and Congress should start from scratch by working with the physician community to develop a program that actually measures how well physicians are providing care and encouraging them to constantly improve that care and patient outcomes. This could be done by working with physician specialty societies on measures pertinent to each specialty, as well as consensus-building organizations like the National Quality Forum for measures that apply across specialties. The measures should come from the practicing physicians in the trenches caring for patients not disassociated bureaucrats at CMS.

Question from Chairman Buchan: Dr. Desai, Ms. Kean & Dr. Richardson: How can the committee specifically help reduce onerous requirements for reporting more accurate and appropriate quality measures?

Answer from Dr. Richardson: Congress should consider the decade-long experience of MIPS since enactment of MACRA to be a failure and repeal it along its mostly meaningless measures. The sheer volume of reporting requirements is core to the administrative burden of MIPS. Reducing the number of measures to ones found to be valuable by physician specialty groups. For example, the American Urological Association (AUA) and LUGPA have developed or endorsed measures related

to prostate cancer diagnosis, treatment, and follow-up, which are more relevant and meaningful than the generic MIPS measures that apply to all specialties.

Further, the new reporting system must abandon the zero-sum game in MIPS for rewarding high performing physicians and penalizing low performing physicians. Quality improvement cannot be properly incentivized if resources for rewards can only be derived from penalties on poor performing physicians. Congress should provide new resources to reward high performing physicians with measures that actually recognize high quality care and improved patient outcomes.

Question from Chairman Buchanan: Dr. Richardson: Why is it important to incentivize participation value-based care payment systems, such as both MIPS and advanced alternative payment models (AAPMs)? How can the Centers for Medicare and Medicaid Innovation improve the scope of models to provide more opportunities for providers to participate in AAPMs?

Answer from Dr. Richardson: As I mentioned in my testimony, most physicians, particularly those in independent practice have been unable to participate in alternative payment models because their structure and requirements essentially require sponsorship by a hospital system. They are too complex, risky, costly to implement, and/or insufficiently targeted for specialties. Accountable Care Organizations appear to be the only viable APMs, but they are biased to hospital-employed physicians. Independent practices, particularly in specialty medicine, have been left behind. CMS and CMMI have demonstrated a bias towards developing system-wide payment models that can typically be only undertaken by large hospital systems Leaving behind independent practices such as mine.

When MACRA was enacted, we were hopeful that the PTAC would enable the physician community to develop various alternative payment models that could at least be undertaken on a pilot-tested basis (for example in discrete geographic communities or specific physician specialties). But CMS refused to approve ANY of the 17 models vetted and recommended by PTAC, which means we have lost a decade of valuable experience and data showing which models show results and could be modified or expanded while also informing policymakers of others that should be abandoned. Now these models are mostly theoretical.

As a result, patients have lost out on new and innovative ways to deliver medicine and coordinate care, while mostly independent practices have been shut out of the higher reimbursements that come with APMs and taxpayers have lost out on the potential savings that could accrue from the more efficient delivery of care.

An obvious solution is to resurrect the PTAC and require CMS to pilot test those models approved by the Commission for 3-5 years in select communities to determine whether they should then be modified, expanded or terminated. This would provide valuable experience in a variety of models and encourage the physician community to endeavor to find more ways to bring value and savings to the Medicare program while improving patient outcomes.

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Dr. Desai, Ms. Kean & Dr. Richardson: *How can the committee specifically help reduce onerous requirements for reporting more accurate and appropriate quality measures?*

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SINCE 1947
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ORTHOPAEDICS & SPINE

June 20, 2024

The Honorable Vern Buchanan
502 Cannon House Office Building
Washington, DC 20515

RE: The Collapse of Private Practice: Examining the Challenges Facing Independent Medicine Subcommittee Hearing on May 23, 2024, Follow Up Question

Chairman Buchanan,

Thank you for allowing me to be part of this process and to provide insight from a physician practice point of view, into quality measure reporting.

Per your question –

"How can the committee specifically help reduce onerous requirement for reporting more accurate and appropriate quality measures?"

According to CMS, "MIPS was designed to tie payments to quality and cost-efficient care, drive improvement in care processes and health outcomes, increase the use of healthcare information, and reduce the cost of care." Unfortunately, most people in the industry would agree that it doesn't appear the program is working as originally intended.

A study published in the Journal of the American Medical Association (JAMA) on December 6, 2022, "illustrated that the program's accuracy in identifying high-versus low-performing providers is really no better than chance"[1]. Moreover, if CMS intends for this program to work, providing feedback to clinicians on what they are doing well and what they can improve on is imperative, and that simply does not occur. CMS is effectively holding providers accountable for maintaining the speed limit without giving them a speedometer to determine how fast they are going. Or worse, even if the reporting was effective, it would only tell them how fast they were going almost two years ago.

To answer your question quite frankly, I would ask that Congress sunset the MIPS reporting requirements completely. This change could redirect the resources currently spent on data collection, processing, and interpretation - both at the practice level and within the government – towards supporting Medicare reimbursement increases for physicians. Such a shift would alleviate the administrative burden on healthcare providers and allocate more resources to enhance patient care and access.

While we recognize the importance of reporting measures that can assess quality, it is evident that the current program isn't effectively meeting the needs of patients or healthcare providers. Consumers

prioritize patient choice and access to care, and the existing framework is failing to address these critical aspects. Without a long-term solution to the Medicare physician fee schedule, I fear physicians will prioritize not seeing, or reducing, the number of Medicare patients to a level they can afford to see in their practice. This would lead to a significant reduction in access to healthcare for Medicare patients, in turn, undermining the purpose of the program.

There are several private consumer driven entities that are using publicly available claims data to formulate physician quality such as Embold Health[2]. Perhaps CMS can partner with companies that specialize in providing these data instead of attempting to generate it on their own. This collaboration could offer a cheaper solution and solve for what the MIPS program originally intended to produce. The American Medical Association recently announced that it is working on solutions to replace the MIPS program with its Data-Driven Performance Payment System[3]. I'm looking forward to evaluating those options as well.

I recognize that Congress moves in a slow manner. However, patients and physicians cannot wait for a "fix" to Medicare physician payment cuts. As we discussed at the subcommittee hearing, as each day goes by, more consolidation happens across the United States.

America's seniors do not want to lose access to their preferred physicians, so I urge Congress to consider a sunset of the MIPS program and redirect the dollars associated with running that program for an immediate fix to the Medicare physician payment dilemma.

I'm encouraged there is a desire and energy being devoted to finding ways to maintain private practices in America, but Congress and Medicare have little time to waste in bringing the needed changes to CMS before a complete collapse of the system occurs.

I am happy to remain available to you for any additional questions you may have. Thank you again for your efforts and commitment to this issue.

Sincerely,

Christine Kean

Christine Kean
Chief Operating Officer

[1] https://jamanetwork.com/journals/jama/article-abstract/2799153

[2] https://emboldhealth.com/how-it-works

[3] https://www.ama-assn.org/practice-management/medicare-medicaid/why-medicare-pay-reform-ama-s-top-advocacy-priority

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COMMITTEE ON WAYS AND MEANS
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SUBCOMMITTEE ON WORK AND WELFARE

Congress of the United States
House of Representatives
Washington, DC 20515–2703

June 6, 2024

Ms. Christine Kean
Chief Operating Officer
The San Antonio Orthopaedic Group
19138 U.S. Highway 281 North
San Antonio, TX 78258

Dear Ms. Kean,

Thank you for offering your opinions to the Committee about how to ensure physicians can remain in private practice. While payment, regulations, and relationships with health plans all play a role in discouraging physicians from staying in private practice, so too does the Medicare statute. H.R. 1610 would ensure chiropractors can treat Medicare patients up to the full scope in their state, just like they do when those patients are covered by employer plans. Can you respond on how breaking down that statutory barrier would help those in your orthopedic group, and chiropractors generally? Are there are other similar statutory barriers that you think should be addressed as well?

I appreciate your consideration of this question and look forward to your response.

Sincerely,

Adrian Smith
Member of Congress

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June 20, 2024

The Honorable Adrian Smith
502 Cannon House Office Building
Washington, DC 20515

Re: H.R. 1610

Dear Congressman Smith:

Thank you for the follow-up question related to H.R. 1610. I appreciated the opportunity to testify before your committee about the current challenges of private practice.

Per your question:

> While payment, regulations and relationships with health plans all play a role in discouraging physicians from staying in private practice, so too does the Medicare statute. H.R. 1610 would ensure chiropractors can treat Medicare patients up to the full scope in their state, just like they do when those patients are covered by employer plans. Can you respond on how breaking down that statutory barrier would help those in your orthopedic group, and chiropractors generally? Are there are other similar statutory barriers that you think should be addressed as well?

While I would love to opine on adding covered benefits to Medicare beneficiaries, at this point, I do not believe it is appropriate for Congress to be considering new legislation to expand benefits (to include chiropractic services) when the foundation of the health care delivery system, the physician, has faced unpredictable rates at best for the past twenty years, two straight years of Medicare physician payment cuts with more on the way, AND all this during the highest inflationary period in recent history.

One Hundred Percent of Congress' Medicare Efforts Should Be Focused on Fixing Medicare Physician Payments.

Patients Are Losing Access to Physicians (MDs and DOs)
The headlines are everywhere: Medicare patients are facing massive waits for primary care physicians. An increasing number of specialists are forced to limit or drop Medicare patients

because the Medicare payment cuts and increasing overhead costs are making it impossible to deliver care to Medicare patients.

The Centers for Medicare and Medicaid Services (CMS) indicated that it would like to move all specialty care into value-based programs. However, this will not be possible with a declining participation of physicians in the Medicare program.

Medicare's inability to keep up with overhead costs is leading to a two-tiered system. Many seniors are now being forced to tap into their health savings account (HSA) or cash to see their preferred physicians. And this trend is likely to see a dramatic increase in the near future: more and more physicians will limit their Medicare patient populations.

Medicare Cuts Lead to Consolidation

Both sides of the political aisle in Washington point to consolidation as one of the greatest threats to the health care system. Consolidated markets harms everyone: patients, payers, Medicare and physicians.

It is critical for each region to have a healthy health care ecosystem in which patients have choices in physicians, hospitals and ambulatory surgery centers. Countless studies confirm the higher quality and lower costs that are created by unconsolidated markets.

Medicare physician payment cuts lead to consolidation. Private practices face extraordinary costs to keep the lights on: employees, diagnostic equipment, real estate and many other costly elements are required to offer patient care. The inability of Medicare physician payments to keep up with the costs leads private practice physicians with no choice but to consolidate.

Congress Used to Fix the Medicare Cuts

The annual Medicare physician payment cuts have become a cadence in Congress for over two decades. Whether it was the sustainable growth rate (SGR) or Medicare Access and CHIP Reauthorization Act (MACRA), Congress typically froze the cuts or offered a small payment update.

Congress used to fix the flawed Medicare physician payment funding formula ever year, whether it was the current iteration or the old sustainable growth rate (SGR) formula. However, we have now reached an era in which Congress allows physicians to take annual payment cuts.

Even when Congress freezes Medicare physician payment cuts, the physician payments "have plummeted by about 30 percent from 2001, adjusting for inflation."[1]

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[1] https://fixmedicarenow.org/history

Meanwhile, hospitals and other segments of the health care industry actually receive payment increases from Medicare each year.

I recognize that Congress moves in a slow manner. However, patients and physicians cannot wait for a "fix" to Medicare physician payment cuts. As each day goes by, more consolidation happens across the United States.

Physicians are the foundation of the health care delivery system. Nothing happens without physician participation in health care: the hospitals, ambulatory surgery centers, nursing homes and other service areas are not possible without physicians.

America's seniors do not want to lose access to their preferred physicians. I urge Congress to not be distracted by considering any expansion of Medicare benefits, but instead, make an immediate fix for the Medicare physician payment cut dilemma the top health care priority in Congress.

Sincerely,

Christine Kean

Christine Kean
Chief Operating Officer

VERN BUCHANAN
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Response to Question for the Record
United States House Committee on Ways & Means Health Subcommittee Hearing:
"The Collapse of Private Practice: Examining the Challenges Facing Independent Medicine"

Seemal R. Desai, MD, FAAD

Chairman Buchanan: ***How can the committee specifically help reduce onerous requirements for reporting more accurate and appropriate quality measures?***

The committee can specifically help reduce onerous requirements for reporting more accurate and appropriate quality measures by pursuing policy changes that replace the current Merit-based Incentive Payment System (MIPS) program with a more sustainable approach tied to annual payment updates, while incentivizing CMS to share data with physicians, and improving underlying measures and reducing burdens.

Current value-based programs are extremely burdensome, such as MIPS, have not resulted in improved patient care and are not clinically relevant to the physician or the patient. The American Academy of Dermatology Association (AADA) has serious concerns with the viability and effectiveness of the MIPS program.

Since the passage of the Medicare Access and CHIP Reauthorization Act of 2015, CMS has routinely introduced new changes to MIPS, requiring physicians to adjust continuously. Physicians are increasingly frustrated by the frequent modifications to the Quality Payment Program, including the associated administrative burdens of adhering to new program requirements and the lack of incentive payments to adequately compensate for participation efforts. While the AADA acknowledges CMS' attempt to address some of these concerns by introducing MIPS Value Pathways (MVPs) aimed at creating more meaningful groups of measures and activities to offer a more comprehensive assessment of quality of care, this new reporting option is falling short of achieving CMS' goal.

The AADA has significant concerns with the Agency's approach to constructing MVPs, as it is using excessively broad measure sets that lack alignment and are incapable of offering meaningful feedback to enhance patient care. For example, CMS' candidate MVP for Dermatological Care fails to consider the diversity within dermatology and the distinct diseases treated by different subspecialties. Despite over two years of discussions with the AADA, CMS continues to express support for the use of a single MVP for dermatology. Dermatologists' practices vary greatly, so CMS must compare the same procedures and conditions if it wants to accurately assess quality of care. There are ten subspecialties in dermatology, each providing different care for diverse patient populations (e.g., pediatric dermatology vs. dermatopathology), with significant differences

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in workflow and costs, making comparisons extremely challenging and inappropriate. Dermatologists who treat psoriasis (included in the candidate MVP's quality measures) do not treat melanoma (the only cost measure in the candidate MVP), which decouples the nexus between cost and quality. Failing to address these distinctions could lead to misleading comparisons and potentially compromise patient care. We urge Congress to instruct CMS to work with specialty societies to ensure that MVPs and other value-based models that are clinically relevant and improve patient care.

The AADA is working with the American Medical Association and other physician specialties to craft legislation that transforms the MIPS program into a workable program aimed at improving patient care and reducing avoidable costs. While the legislation is still a work in progress, the proposal would address steep penalties that are distributed unevenly by eliminating the unsustainable MIPS win-lose style payment adjustments and instead link physicians' MIPS performance to their annual payment update, creating more alignment across Medicare payment programs. Penalties would be reinvested in bonuses to high-performers, as well as investments in quality improvement and APM readiness aimed at assisting under-resourced practices with their value-based care transformation with an emphasis on small practices, rural practices, and practices that care for underserved, minoritized, or marginalized patients. The proposal would also reduce burdens by requiring CMS to give automatic credit in each applicable performance category for a measure or activity that inherently satisfies multiple performance category requirements.

The proposal would hold CMS accountable for timely and actionable data. Specifically, it would exempt from penalties any physicians who do not receive at least three quarterly data reports during the relevant performance period. These reports are critical for the program to work as it is intended so physicians can monitor their ongoing performance and identify gaps or variations in care that can be used to improve quality of care, care outcomes, and reduce costs.

PUBLIC SUBMISSIONS FOR THE RECORD

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May 23, 2024

Chairman Vern Buchanan (R-FL)
Ranking Member Lloyd Doggett (D-TX)
House Committee on Ways and Means
Health Subcommittee

Dear Chairman Buchanan and Ranking Member Doggett:

Thank you for holding today's critical hearing on consolidation of corporate hospital systems and their role in the ballooning cost of healthcare in America.

Better Solutions for Healthcare, a national coalition representing a broad range of employers and consumers, has been working to advance legislation to harmonize billing practices in off-campus hospital outpatient facilities, end corporate hospital systems' "dishonest billing" practices, and shine more light on hospital prices. In particular, we are grateful this committee included key honest billing components of the Facilitating Accountability in Reimbursements Act – or the FAIR Act – into the bipartisan Lower Costs, More Transparency Act, which received a strong 320 – 71 House floor vote December 11, 2023.

Our coalition's mission is to educate the public about the leading role corporate hospital systems play in driving up the cost of healthcare and advocate for reforms to lower the prices Americans pay for care. America's job creators and local and state business leaders know all too well how the rapidly increasing cost of care creates barriers to good health. Even more, rural patients benefit from site-neutral payment reform, which one study estimates would save seniors on Medicare undergoing breast cancer treatment $1,500 a year.[1]

Let's be clear – removing the financial incentive for large corporate hospital systems to buy small rural doctors' offices helps folks living in rural areas maintain access to more affordable health care.

As Congress ramps up scrutiny of corporate hospital systems' role in the continued and unsustainable rise of health care prices, the House Committee on Ways and Means is well positioned to harmonize billing practices in off-campus hospital outpatient facilities, ensuring honest billing to make healthcare more affordable for patients.

The need for site-neutral reform is growing. As more corporate hospital systems buy smaller, independent practices, they frequently charge patients for services provided in physicians' offices as if they were delivered in a hospital setting. So, the same service, provided by the same doctor, in the same doctor's office, now costs the patient as much as 300% more simply because a corporate

[1] *Examining the Impact of Site Neutral Payment on Costs for Cancer Care*, American Cancer Society Cancer Action Network, https://www.fightcancer.org/sites/default/files/acs_can_site_neutral_issue_brief_-_final_10-19-23.pdf. Accessed 7 March, 2024.

hospital system owns the doctor's practice.[2] Rural Americans, who often have limited options for where to receive care, are particularly vulnerable to these cost-inflating practices.

We cannot solve the health care affordability crisis in America without addressing the role of corporate hospital systems. Today, one out of every three dollars spent on healthcare goes to hospitals.[3] And hospitals charge $417 for every $100 of their costs.[4]

Corporate hospital systems continue to argue cost shifting across public and private payors is necessary because Medicare and Medicaid underpay their facilities. Yet, in reviewing the hospitals' own data, the nonpartisan Congressional Budget Office (CBO) concluded, "…providers do not raise the prices they negotiate with commercial insurers to offset lower prices paid by government programs."[5]

Indeed, the Medicare Payment Advisory Commission (MedPAC) has repeatedly found that relatively efficient hospitals break even on Medicare.[6]

In the 118th Congress, six House and Senate committees have conducted over a dozen hearings and markups scrutinizing corporate hospital systems' practices, and today's hearing offers another practical step forward in tackling Americans' skyrocketing healthcare costs.

As previously mentioned, the House passed the Lower Costs, More Transparency Act by a 320 – 71 bipartisan vote, with 166 Republican and 154 Democratic lawmakers supporting the bill, which includes site-neutral reforms for physician-administered drugs, saving $3.74 billion, and requires off-campus hospitals to have a unique identifier, saving $2.32 billion.

For patients to realize true affordability, comprehensive site-neutral reforms must be enacted. Americans depend on pragmatic legislators to work together to address the problem of corporate hospital costs. Thankfully, there is now bipartisan consensus to put an end to these alarming price markups.

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[2] Shinkman, Ron. "Study quantifies cost differential between physician offices and hospital outpatient care." *Fierce Healthcare*, Accessed 6 March, 2024. https://www.fiercehealthcare.com/finance/study-quantifies-cost-differential-between-physician-offices-and-hospital-outpatient-care.

[3] Gee, Emily. "The High Price of Hospital Care." *Center for American Progress*. Accessed 13 Oct. 2023, www.americanprogress.org/article/high-price-hospital-care/.

[4] *The Cost of In-Home Care*, MDC Healthcare, 24 Oct. 2022, www.mdchealthcare.org/understanding-the-cost-of-in-home-care-and-the-cost-of-a-hospital-stay/#:~:text=U.S.%20hospitals%20charge%20an%20average,stay%20at%20home%20long%20term.

[5] *The Prices That Commercial Health Insurers and Medicare Pay for Hospitals' and Physicians' Services*, Congressional Budget Office, www.cbo.gov/system/files/2022-01/57422-medical-prices.pdf. Accessed 13 Oct. 2023.

[6] *Hospital Inpatient and Outpatient Services*, Medicare Payment Advisory Commission (MedPAC), www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/mar20_entirereport_sec.pdf. Accessed 13 Oct. 2023.

better solutions
for healthcare™

Better Solutions urges the committee to support policies that promote hospital competition, enforce federal price transparency laws for hospital charges, rein in hospital markups, and ensure honest billing practices by corporate hospital systems.

Sincerely,
Better Solutions for Healthcare

American Society of Anesthesiologists®

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Statement of
Ronald Harter, M.D.
President, American Society of Anesthesiologists
Ways and Means, Health Subcommittee Hearing
"The Collapse of Private Practice: Examining the Challenges Facing Independent Medicine"
May 23, 2024

Chairmen Smith and Buchanan,

The American Society of Anesthesiologists (ASA) commends you for holding this important hearing to explore the collapse of the independent practice of medicine.

The practices of independent anesthesiologists involved in anesthesia, critical care and pain medicine continue to struggle in the current health care environment. Among the most pressing issues facing these practices are the broken Medicare physician payment system and the unrestrained behavior of profit-driven, market-dominant health insurance companies. Medicare and aggressive health insurance companies have effectively sapped independent, community-based practices of the economic resources necessary to remain viable. Without these resources, independent practices have become weakened and vulnerable to sale and acquisition. We urge the Committee to address these significant risks threatening the viability of all independent physician practices, including those owned by anesthesiologists.

Broken Medicare Physician Payment System: Reforms Needed

The Medicare physician payment system has been broken for decades. As a result of fundamental flaws in the payment system and a series of ill-advised policy changes, Medicare payments for physician services are extremely underfunded. Current payment rates are insufficient to sustain the independent practices of anesthesiologists.

As this committee well knows, the Sustainable Growth Rate (SGR) mechanism, implemented as part of the Balanced Budget Act of 1997, resulted in a series of annual payment cuts that required nearly annual Congressional intervention to forestall. The annual Congressional "doc fix" exercises served as temporary patches that pushed pending payment cuts into the future years. At points during the effective dates of the SGR, Congress acted to prevent payment reductions of over 20%. From 2003 through April 2014, Congress passed 17 laws to override the SGR-mandated payment cuts.[1] The SGR system was unsustainable.

[1] Congressional Research Service, "The Sustainable Growth Rate (SGR) and Medicare Physician Payments: Frequently Asked Questions." March 16, 2015. https://crsreports.congress.gov/product/pdf/R/R43430

In an effort to address the flawed SGR formula, Congression overwhelmingly passed and President Barack Obama signed into law The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). Sometimes presented as a "permanent doc fix," MACRA created the merit-based incentive payment system (MIPS) and a program for developing, evaluating, and adopting value-based alternative payment models (APMs). These programs were intended to offer physicians an opportunity to earn meaningful Medicare payment updates based upon the delivery of quality care. Unfortunately, to date, the expectation that MACRA would establish sustainable, reasonable physician payments has not been realized. Currently, physicians are frustrated by burdensome administrative requirements to meaningfully participate in MACRA programs. Sufficient positive payment updates have been elusive. Like its SGR predecessor, MACRA has produced a flawed payment system requiring annual Congressional intervention. Fundamental reforms are again needed.

ASA commends this committee for its ongoing to leadership to address Medicare physician payment challenges. As the committee continues its work, it is critical that the next iteration of Medicare payment reform ensure reasonable payment rates. As a starting point, two fundamental flaws in the current system must be addressed to move Medicare toward appropriate payment rates – an underfunded Medicare physician payment "bucket" and a punitive budget neutrality mechanism. To ensure sustainable payments for independent practices, ASA recommends the following reforms:

- **Any reforms to the system must include additional funds to support appropriate payments for physician services, including an annual inflation update such as provided for in H.R. 2474, the Strengthening Medicare for Patients and Providers Act.** Medicare payments for physician services lag far behind the increasing costs of providing those services.[2] A Congressional commitment to better fund Medicare physician payments is essential to supporting independent, community-based practices.
- **The punitive budget neutrality system must be reformed.** Mandating deep cuts to certain physician services to increase payments for other physician services has weakened independent anesthesiologists' practices. Congress must modernize this dangerous mechanism that pits physician against physician. H.R. 6371, the Provider Reimbursement Stability Act represents an important first step in reform.

Profit-driven health insurance companies: Congressional oversight needed

In addition to pressures exerted by the broken Medicare physician payment system, the economic sustainability of independent anesthesiologists' practices is also threatened by the behavior of large commercial health insurance companies.

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[2] Avalere. "Physician Payment for Some Services Lags Behind Inflation." September 11, 2023. https://avalere.com/insights/physician-payment-for-some-services-lags-behind-inflation

Consolidation and vertical integration have allowed health insurance companies to expand in size and influence. These insurance companies leverage their market-dominance to overpower independent community anesthesiologists' practices, including many small and medium sized practices. Payment rates are often dictated – not negotiated. Using a variety of business practices, front-line physician groups are starved of sustaining payments while corporate profits grow. Recent examples include:

United Health Group (UHG) and Change Healthcare (CHC) Inadequate Response to Cyberattack – The UHG and CHC response demonstrated a lack of accountability and goodwill toward the health care system. Despite significant resources, UHG and CHC did not notify medical groups, including anesthesiologists, early or consistently once the cyberattack was discovered. Instead, as the claims process ground to a halt CHC and UHG extended little direct assistance to impacted physicians, offering individual groups only a fraction of funding needed to maintain basic operations.[3,4]

Disregard for Complex Patients - Insurance companies, including Aetna and Blue Cross Blue Shield plans, are proposing to cut payments for anesthesiologists who provide services to complex patients. Patients expect their premiums are paid to ensure the most appropriate care. By arbitrarily removing payments for complex patients, insurance companies are bucking a trend in health care – that patient care be individualized and that cost savings occur because of enhanced care for the most vulnerable patients. In recent weeks, insurers announced policies to no longer pay for anesthesiology physical status modifiers, an important payment modifier that captures anesthesia care provided for high-risk patients with significant medical conditions.[5]

"Shared Savings" Schemes - Insurance companies have devised proprietary arrangements to obtain generous fees from employers for slashing payments to frontline health care professionals. One insurer reaped an "annual windfall of about $1 billion in fees…" according to a New York Times expose. "The formula for Multiplan and the insurance companies is simple: The smaller the reimbursement [paid to the physicians] the larger the fee."[6]

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[3] Harter, Ron. "Statement to U.S. Senate Finance Committee. Hearing: Hacking America's Health Care: Assessing the Change Healthcare Cyber Attack and What's Next?," April 30, 2024. https://www.asahq.org/advocacy-and-asapac/fda-and-washington-alerts/washington-alerts/2024/05/asa-urges-continued-congressional-scrutiny-of-united-health-groups-change-healthcare-shutdown.

[4] Kahn, Chip. Siegel, Bruce. "Insurers response to the Change breach failed providers." Modern Healthcare, April 8, 2024. https://www.modernhealthcare.com/opinion/change-healthcare-breach-insurers-chip-kahn-bruce-siegel.

[5] ASA Strongly Opposes Recent Blue Cross Blue Shield Policy Change to Physical Status Modifiers. www.asahq.org. April 10, 2024. https://www.asahq.org/advocacy-and-asapac/fda-and-washington-alerts/washington-alerts/2024/04/asa-strongly-opposes-recent-blue-cross-blue-shield-policy-change-to-physical-status-modifiers.

[6] Hamby, Chris. "Insurers Reap Hidden Fees by Slashing Payments. You May Get the Bill. New York Times," April 7, 2024. Insurance Companies Reap Hidden Fees as Patients Get Unexpected Bills - The New York Times (nytimes.com)

Insurers Withholding Payments as Part of the No Surprises Act (NSA) Independent Dispute Resolution (IDR) Process – Despite unambiguous statutory requirements in the NSA, insurance companies have not paid physicians who have been awarded payments by the independent arbiter in the IDR process.[7] Insurance companies earn interest on their cash by not making payments in a timely, fair manner.

Inappropriate prior authorization requirements - Insurers continue to use burdensome prior authorization requirements to override physician judgement and deny patients' access to care.[8] Congress should use its authority to curtail the harmful behavior displayed by insurance companies including:

- **Holding UHG and CHC accountable for repairing the harm to physicians and for ensuring future protections.**
- **Scrutinizing insurance companies that divert premium dollars away from patient care to corporate profits.**
- **Ensuring the enforcement of the mechanisms of the No Surprises Act requiring timely insurers' payments to prevailing parties in the IDR process.**
- **Passing the "Improving Seniors' Timely Access to Care Act" to address insurers' prior authorization abuse.**

The future of community-based, independent anesthesiologists' practices is contingent upon their economic viability. Reasonable and timely payment from both government and commercial payors are essential to ensuring that practices are stable and have the wherewithal to withstand unwanted sale and acquisition. Congressional action on long-needed, fundamental Medicare payment reforms and on reforms and oversight of large, profit-driven health insurance companies are important steps toward ensuring independent practices are able to continue to serve their communities.

Thank you for this hearing. We look forward to working with you in support of our independent anesthesiologists' practices.

Please contact Manuel Bonilla, American Society of Anesthesiologists, Chief Advocacy Officer, at 202-289-7045 or M.Bonilla@asahq.org with any questions.

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[7] Harter, Ron. "Federal Independent Dispute Resolution (IDR) Operations Proposed Rule." February 1, 2024. https://www.asahq.org/advocacy-and-asapac/fda-and-washington-alerts/washington-alerts/2024/02/asa-comments-on-improvements-to-the-no-surprises-act-idr-process.

[8] Rucker, Patrick. Armstrong, David. "A Doctor at Cigna Said Her Bosses Pressured Her to Review Patients' Cases Too Quickly. Cigna Threatened to Fire Her." ProPubica. April 29, 2024 Cigna Pressured Her to Review Patients' Cases Too Quickly, Says Former Cigna Medical Director — ProPublica.

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Statement

of the

American Hospital Association

for the

Committee on Ways and Means

Subcommittee on Health

of the

U.S. House of Representatives

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

May 23, 2024

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners — including more than 270,000 affiliated physicians, 2 million nurses and other caregivers — and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to provide our perspective on the financial and regulatory burdens facing physician practices.

FACTORS DRIVING PHYSICIAN PRACTICE ACQUISITIONS

Much like hospitals and health systems, physicians across the country are facing increased costs, inadequate reimbursements and administrative burdens from public and private insurer practices. These factors create major barriers to operating an independent physician practice. As a result, physicians are increasingly looking for alternative practice settings that will provide financial security so they can focus more on clinical care and less on managing their own practice. Hospitals and health systems are an appropriate partner to help physicians alleviate many of these burdens.

Commercial Insurer Policies and Practices

Onerous policies from commercial health insurers have spurred many physicians to seek employment instead of maintaining their own practices. According to a recent survey of physicians conducted by Morning Consult on behalf of the AHA, 84% of employed physicians reported that administrative burden from payers — including prior authorization and reporting requirements — has adversely impacted their ability to operate an independent practice.[1] In the same survey, 81% of physicians reported that commercial insurer policies and practices interfered with their ability to practice medicine.[2]

Excessive prior authorization requirements and inappropriate denials of coverage for medically necessary services are a pervasive problem among certain plans in the Medicare Advantage (MA) program. These insurer practices result in delays in care and add financial burden and strain to the health care system, including increased staffing and technology costs to comply with plan requirements. Additionally, the administrative burden of prior authorization requirements and processes further strain the health care workforce and contribute to provider burnout. In fact, Surgeon General Vivek Murthy, M.D., issued a recent advisory that notes that burdensome documentation requirements, including the volume of and requirements for prior authorization, are drivers of health care worker burnout.[3]

Escalating Costs

Managing a physician practice often includes significant operational costs associated with maintaining electronic health records and patient portals, processing billing and claims submissions, including managing prior authorization requirements, and office rent, among other expenses. The costs associated with these requirements range from $20 for a primary care office visit to as high as $215 for a procedure at an inpatient surgical center.[4]

Compounding that problem, low reimbursement rates from public payers like Medicare and Medicaid are another barrier to the practice of medicine in a private practice setting. Reimbursement updates have failed to account for rising inflation and increasing input costs like supply chain disruptions and workforce shortages. Appropriately accounting for these trends is essential to ensure that Medicare payments for professional services more accurately reflect the cost of providing care. Medicare physician payment was effectively cut 26%, adjusted for inflation, from 2001 to 2023.[5] The widening gap between inflation and physician reimbursement rates poses significant threats to patient access and provider financial stability, particularly for safety net providers.

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[1] https://www.aha.org/system/files/media/file/2023/07/The-Majority-of-Nurses-and-Physicians-Say-That-Health-Insurer.pdf
[2] https://www.aha.org/fact-sheets/2023-06-07-fact-sheet-examining-real-factors-driving-physician-practice-acquisition
[3] https://www.hhs.gov/sites/default/files/health-worker-wellbeing-advisory.pdf
[4] https://jamanetwork.com/journals/jama/fullarticle/2673148
[5] https://www.ama-assn.org/practice-management/medicare-medicaid/advocacy-action-leading-charge-reform-medicare-pay

As a result of these factors, 94% of physicians believe it has become more financially and administratively difficult to operate a practice in recent years.[6]

SETTING THE RECORD STRAIGHT ABOUT PHYSICIAN ACQUISITIONS

While a disproportionate amount of attention has been placed on hospitals' acquisition of physician practices, the reality is that large commercial insurers including CVS Health and UnitedHealth Group have recently spent billions of dollars to acquire physician practices. In fact, non-hospital entities including health insurers have acquired 90% of physician practices over the last five years.[7]

UnitedHealth Group is now the single largest employer of physicians in the country with over 10% of physicians in the U.S. employed or affiliated. We urge this committee to examine the costs and impact on health care access and affordability associated with this widespread acquisition of America's physicians by corporate health insurance companies.

Hospitals and Health Systems Preserve Access to Care

Hospitals have offered a lifeline to physician practices struggling to keep their doors open, especially in rural areas. The challenging economics of providing care in rural communities contribute to gaps in access. Rural communities, by nature, generally have fewer people and therefore do not generate the health care utilization to finance the full range of health care services. In addition, caring for rural patients can be more costly on a per patient basis as patients in rural communities tend to have more complex health care needs, are much more likely to be uninsured, and are more likely to rely on public programs when they do have coverage. As such, many providers have struggled to stay open and provide care to their patients and community.

Hospitals have stepped in to support these access points for rural patients. Despite the fact that hospital have only acquired 6% of all physician practices in the last five years, hospitals were 2.5 times more likely than other entities to acquire practices in rural areas.[8] Commercial insurers in particular are overwhelmingly focused on larger, more profitable markets where the financial upside is greater. Median household income was on average 18.4% higher in counties where insurers acquired physician practices compared to counties where hospitals acquired physician groups.[9] Additionally, the county level population where commercial insurers acquired physician practices was on average 61.4% larger than it was for hospitals.

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[6] https://www.aha.org/system/files/media/file/2023/07/The-Majority-of-Nurses-and-Physicians-Say-That-Health-Insurer.pdf
[7] https://www.aha.org/system/files/media/file/2023/06/Private-Equity-and-Health-Insurers-Acquire-More-Physicians-than-Hospitals-Infographic.pdf
[8] AHA analysis of Levin Associates data on physician medical groups between 2019 and 2023.
[9] Ibid.

POLICY RECOMMENDATIONS

The AHA supports the following policies to address the burdens and costs associated with operating independent physician practices.

Commercial Insurer Accountability. Reduce administrative burdens like prior authorization that contribute to provider burnout and delay access to care.

- The AHA supports regulations and legislative solutions that streamline and improve prior authorization processes, including the Improving Seniors' Timely Access to Care Act, which would codify many of the reforms in the Interoperability and Prior Authorization Final Rule.

- Gold-carding programs substantially reduce administrative burdens and costs by streamlining access to care for Medicare beneficiaries. The AHA supports the GOLD Card Act of 2023 (H.R. 4968), which would exempt providers from requiring prior authorization for a MA plan year if the provider had at least 90% of prior authorization requests approved the preceding year.

Physician Payment Reform. Current reimbursement for physicians is woefully inadequate and fails to account for inflation. The AHA supports legislative and regulatory changes to ensure more sustainable physician reimbursement and to facilitate transition to value-based care.

- The current conversion factor updates scheduled in MACRA are insufficient since they are scheduled to begin in 2026 and will only result in a .75% conversion factor update for qualifying advanced Alternative Payment Model (APM) participants and .25% for all other providers. This will exacerbate the widening gap between inflation and physician reimbursement rates. While the one-time conversion factor updates provided in the Consolidated Appropriations Acts of 2022, 2023 and 2024 have provided needed relief in the interim, we encourage more sustainable, real-time approaches to updating the conversion factors in pace with inflation. Annual conversion factor updates should be made to reflect changes in input costs and inflation outside of budget neutrality.

- To support the transition to value-based payment, the AHA urges Congress to extend APM incentive payments and for CMS to remove problematic high/low revenue thresholds that preclude rural and critical access hospitals from obtaining necessary resources for infrastructure investment. We support the Value in Health Care Act (H.R. 5013/S. 3503), which would extend incentive payments, remove revenue distinctions and improve financial benchmarks to ensure participants are not penalized for their own success.

Provider Well-being. We urge Congress to continue to address health care worker well-being by supporting the Dr. Lorna Breen Health Care Provider Protection Reauthorization Act (H.R. 7153/S. 3679), which would provide grants to help health

care organizations offer behavioral health services to prevent burnout and suicide for health care workers through 2029.

CONCLUSION

The AHA appreciates your efforts to examine the increased burdens and costs facing physician practices and looks forward to working with you to address these issues.

June 6, 2024

I am submitting comments in response to the House Ways and Means Subcommittee hearing on May 23, 2024, entitled "The Collapse of Private Practice: Examining the Challenges Facing Independent Medicine."

I am a physician in solo practice in Odessa, Texas. Odessa is a city with a population of 110,000. It is part of the Midland-Odessa combined statistical area, which has a population of 340,000 and is situated about halfway between El Paso and Fort Worth. Despite the overall population, this area has struggled for a number of years to attract and retain physicians. The reasons are multiple; barren landscape, lack of good schools, and limited family-friendly venues (museums, amusement parks, etc.) are some of the factors. However, the physician shortage has become especially problematic in the past few years, and economics is a big reason for this.

When I opened my practice In Odessa 17 years ago, the reimbursement rate from Medicare was sufficient to cover the cost of providing care, and the rates from commercial payers were enough to encourage physicians to open practices here instead of going to a larger city that (at least at first glance) appears to offer a better overall quality of life and a larger pool of potential patients. The health insurance market in Odessa at that time had a number of participants, and competition for customers kept health insurance premiums in a much more reasonable price range than what is seen now. In addition, the commercial payers knew that they needed a robust network of physicians to attract and retain customers, and they were therefore more willing to negotiate with physicians when offering contracts.

However, over the past 12 years, I have seen a steady drop in my practice's gross revenues despite efforts to accommodate a higher patient volume. Part of this is due to commercial payers reducing their rates, and part of this is due to high-deductible plans causing patients to decline or delay procedures. If you factor in the effects of inflation, especially when it comes to labor costs, it's no wonder that a number of independent physicians here in Odessa in the past few years have chosen to retire early, move to another location, or sell their practices to a hospital or private equity. The net effect is that patients here have fewer options if they need to see a primary care physician. Many are forced to utilize urgent care and the emergency departments instead, which is far more costly for the patient and the insurer in the long run. Those who need to see a specialist are either facing long wait times for an appointment or having to travel all the way to Lubbock or the Dallas/Fort Worth area.

The failure of Medicare physician payments to keep up with inflation is an important reason why independent practices are struggling. However, the lack of competition in the health insurance industry is perhaps an even bigger issue. When I opened my practice, most commercial payers reimbursed physician practices at a higher rate in Odessa than in the large metropolitan areas in Texas because they realized that was the rate necessary to attract and retain a large number of physicians for each specialty. However, the landscape has changed considerably over the past few years. Commercial payers now have an incentive to keep their list of in-network physicians as small as possible. Thanks to how the "No Surprises Act" is being implemented, it is to a payer's advantage to be out-of-network. Furthermore, payers do not have to worry about losing customers as a result of having very few in-network physicians,

as their competitors have dwindled in number, and the remaining ones are all moving to reduce the number of physicians in their networks as well. Additionally, the payers have become very adept at reducing coverage while placing the blame at the feet of others. In the past few years, payers have routinely changed existing coverage policies without informing the patient or physician. When the physician sends the claim for a service that was previously covered, it is now commonplace for the payer to deny the claim and tells the patient that he/she does not owe anything either, as the charges are not allowed per the contract between the physician and the payer. The payer refers to these denials as its efforts to reduce "fraud, waste, and abuse"; in actuality, it is an attempt by the payer to change the terms of its contracts with physicians unilaterally and without advance notice. If the physician orders a medication that was previously covered by the payer, there is a good chance that it will now be denied. If the patient calls the payer, he/she will be told that it is "very easy" to get it approved and the physician just needs to notify the payer that it is needed. When the physician's office then tries to contact the payer, the process is anything but easy; it can sometimes require spending over an hour on the phone with multiple individuals, only to be told in the end that it is not on the formulary. If a prior authorization form is then completed and submitted, it is frequently denied without any evidence that it was reviewed by a physician. The current system rewards efforts by payers to deny care and create uncompensated administrative work for physicians. Unless the federal government acts to create checks and balances, the situation will continue to worsen over time.

I know of a number of physicians in solo practice locally and in other small communities who are seriously considering closing their practices. In larger communities, some of these physicians are opting out of insurance and setting up cash-only practices. In rural areas and small cities like mine, the patient volume is not sufficient for cash-only practices to be very successful. The net result is that these communities will see reduced access to physicians, especially specialists. If Congress does not want to see these communities lose the physicians they currently have, it needs to do four things:

1. Enact Medicare physician payment reform and pass legislation such as H.R. 2474, which would give annual Medicare inflation updates to physician-owned practices.
2. Level the playing field by having Medicare increase its payments for care at physician-owned clinics so that it matches what is paid for the same care at a hospital-owned clinic.
3. Address the issue of consolidation in health care, especially where the health insurance plans are concerned, and enact legislation that would increase competition.
4. Increase transparency by health insurance plans regarding their coverage policies and make them fulfill their contracts with physicians and their obligations to their customers (i.e. the employers and patients).

Thank you for your consideration.

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June 4, 2024

The Honorable Jason Smith
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Dear Chairmen Smith and Buchanan, Ranking Members Neal and Doggett:

The American Chiropractic Association (ACA) submits the following comments regarding the Subcommittee on Health hearing on May 23, 2024, titled, "The Collapse of Private Practice: Examining the Challenges Facing Independent Medicine." ACA thanks the Committee for facilitating the hearing and allowing us to provide a statement for the record. Our comments are directed specifically to access and participation issues facing both providers and patients.

ACA is the largest professional organization in the United States representing doctors of chiropractic (DCs). ACA members lead the chiropractic profession through collaborative relationships in public health, support for research and evidence-based practice, and the active reporting of functional outcome assessment measures to ensure the health and well-being of the estimated 35 million Americans who seek chiropractic services each year.

Regarding patient access, since the chiropractic benefit was first included in Medicare in 1972, beneficiaries have been limited in the services they can receive from their chiropractor. DCs are currently not allowed to furnish existing covered Medicare services that fall within their scopes of practice to their patients. This artificial limitation restricts chiropractors from providing their patients a continuity of care as they age into Medicare, putting beneficiaries at a distinct health disadvantage. This limitation has persisted for over 50 years with no scientific or valid policy basis.

Beneficiaries seeking to obtain chiropractic services face many obstacles in the Medicare system. These obstacles may require the beneficiary to experience delays, inconveniences, and the added expense (copays, time, travel, etc.) of seeing a second provider when such visits are unnecessary. For example, if a DC determines that the beneficiary needs an x-ray, laboratory test or other diagnostic procedure, current policy does not even allow DCs to "order" those covered services, and thus, in those instances further unnecessary visits and beneficiary expenses are required in order to obtain the needed "order" from a second Medicare provider who will often turn around (especially in the case of diagnostic imaging, for example) and order the service from a third Medicare provider.

Because Medicare's chiropractic policy is stuck in 1970-era health policy, patients are, in effect, channeled to other providers whose standard treatment regimen may involve the use of drugs, spinal injections, or surgery for a range of spinal conditions. Chiropractic services have been demonstrated through research to be a less costly and safer alternative in many of these situations and are routinely covered by private insurance and Medicaid. As policymakers seek to prevent the use of unnecessary drugs and surgery, DCs are poised to assist in the opioid effort by lowering the reliance on those drugs, especially in cases involving spinal-related pain. To the extent that current policy arbitrarily restricts access to chiropractic services, it exacerbates these problems.

Needed legislation would not add any new reimbursable services to Medicare that are not already covered services and delivered by existing providers. Legislation would simply seek a modification of existing statute to ensure that doctors of chiropractic are allowed to furnish and order "existing covered services" which they are currently permitted to do under state law.

Fortunately, to correct this disparity, the Chiropractic Medicare Coverage Modernization Act, legislation to allow Medicare beneficiaries full access to current services chiropractors are allowed to provide under their state licensure, has been introduced in both the House and the Senate in the 118th Congress. The House bill, H.R. 1610, was introduced earlier this session by your colleague Rep. Greg Steube (R-Fla.) and currently has over 160 bipartisan cosponsors, including a majority of Ways and Means Committee members. A Senate companion bill, S. 799, was introduced at the same time as the House bill and currently has 13 bipartisan cosponsors. In order to give Medicare beneficiaries access to the benefits they are authorized, we urge Congress to pass this vital legislation this session.

Regarding provider participation, in 2010, health care providers were promised a "balanced playing field" when Congress passed the Patient Protection and Affordable Care Act (PPACA), with the goal of improving the accessibility, quality, and affordability of health care. With the passage of the PPACA, Congress enacted first-of-its-kind provider nondiscrimination coverage requirements on health insurance issuers as well as group health plans covered by the Employee Retirement Income Security Act of 1974 (ERISA).

Specifically, participants in ERISA-covered health benefit plans and other group health benefit and insurance plans are entitled to PPACA coverage requirements and may enforce those requirements by using the ERISA enforcement measures as well as enforcement by state agencies and HHS. PPACA amended the Public Health Service Act to prohibit discrimination based on provider license in terms of coverage and participation. (Section 2706(a)) of the Public Health Service Act, 42 U.S.C. § 300gg–5). This requirement prohibits health insurance issuers and group health benefit plans from discriminating against health care providers if those providers act within the scope of their license or certification.

Section 2706(a) directly and specifically prohibits group health plans or health insurance issuers from discriminating against licensed health care providers and the services they provide in terms of "coverage" and "participation." However, health care providers met nothing but resistance from major insurance companies, State insurance departments (which were obligated under PPACA to enforce 2706(a)) and even HHS itself.

In responding to a defective informal guidance issued by HHS and other federal agencies, which was subsequently withdrawn, the Senate Committee on Appropriations added its voice as to the statute's intent. The Senate Committee in its Report dated July 11, 2013 (113-71, to accompany S. 1284) stated, "Section 2706 of the PPACA prohibits certain types of health plans and issuers from discriminating against any health care provider who is acting within the scope of that provider's license or certification under applicable State law, when determining networks of care eligible for reimbursement. The goal of this provision is to ensure that patients have the right to access covered health services from the full range of providers licensed and certified in their State. The Committee is therefore concerned that the FAQ document issued by HHS, DOL, and the Department of Treasury

on April 29, 2013, advises insurers that this nondiscrimination provision allows them to exclude from participation whole categories of providers operating under a state license or certification. In addition, the FAQ advises insurers that section 2706 allows discrimination in reimbursement rates based on broad 'market considerations' rather than the more limited exception cited in the law for performance and quality measures. Section 2706 was intended to prohibit exactly these types of discrimination. The Committee believes that insurers should be made aware of their obligation under section 2706 before their health plans begin operating in 2014. The Committee directs HHS to work with DOL and the Department of Treasury to correct the FAQ to reflect the law and congressional intent within 30 days of enactment of this act."

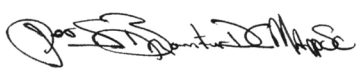
More recently, Congress has made clear that federal implementation to date has not been sufficient. In December 2020, the *Consolidated Appropriations Act of 2021* was signed into law, which included the *No Surprises Act*. Section 108 of the *No Surprises Act* requires the Secretaries of the Departments of Health and Human Services, Labor, and Treasury to issue a proposed rule no later than January 1, 2022. Based on the regulatory timeline required under Section 108, a final rule should have already been promulgated to permanently implement these protections against provider discrimination.

In addition to the above, an August 2023 deadline was published in the Spring 2023 Unified Agenda of Regulatory and Deregulatory Actions. The need for prompt rulemaking is critical because many private health insurers continue to discriminate against health care providers based on their licensure. We are deeply concerned that it is now almost two years past the January 1, 2022, statutory deadline for rulemaking stated in the *No Surprises Act* as part of the *Consolidated Appropriations Act of 2021.* Without an enforceable rule, many non-MD/DO providers face undue barriers to providing care based on discriminatory policies from insurers. We are very concerned that numerous deadlines have passed to promulgate this rule and we encourage the agencies to release this rule in the very near future.

Despite the above, and after many years of seeking enforcement of the protections of 2706(a), health care providers have not been able to overcome the obstacles placed before them by big business to achieve the promises for a "level playing field" made to them under the PPACA. Without enforcement, health plans will continue to discriminate against providers, especially non-MD/DO providers who are working within their scope of practice to provide essential health care. A strong and enforceable rule is a critical element to ensuring that patients have access to the care they deserve from the provider of their choice. This will increase competition, drive down costs and benefit consumers. Now, however, many of those same companies are moving rapidly to consolidate their dominance through private equity ownership and consolidation of health care organizations.

ACA appreciates the opportunity to provide these comments to the committee. If you have any questions regarding our remarks, please contact John Falardeau, ACA Senior Vice President for Public Policy and Advocacy, at jfalardeau@acatoday.org or (703) 812-0214.

Sincerely,



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President

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Statement for the Record of the American College of Gastroenterology
House Committee on Ways and Means Health Subcommittee
"The Collapse of Private Practice: Examining the Challenges Facing Independent Medicine"
Thursday, May 23, 2024

The American College of Gastroenterology (ACG) appreciates the opportunity to provide this Statement for the Record concerning the House Committee on Ways and Means Health Subcommittee hearing entitled, "The Collapse of Private Practice: Examining the Challenges Facing Independent Medicine." We applaud the Committee for taking steps to address the financial and regulatory burdens that independent medical providers experience, which would improve access to patient care.

ACG is a physician organization representing gastroenterologists and other gastrointestinal (GI) specialists. Founded in 1932, and representing nearly 20,000 GI clinicians, ACG's mission is to enhance the ability of our members to provide world class care to patients with digestive disorders and advance the profession through excellence and innovation based upon the pillars of patient care, education, scientific investigation, advocacy, and practice management.

Our top policy priorities are to increase access to patient care and preserve the sanctity of the patient-provider relationship. Specifically, ACG believes that:

1. Medicare physician reimbursement impacts patient care and access to health care services.
2. The lack of Medicare physician reimbursement reform contributes to physician practice consolidation and provider burnout and slows down healthcare innovation and the development of new technologies in patient care.
3. Medicare physician reimbursement must keep up with inflation and the rising costs of providing healthcare services, just like healthcare facilities and hospitals.
4. The "budget neutrality" provision in Medicare reimbursement statute is unfair, unwarranted, and is a leading cause of annual Medicare reimbursement temporary fixes and legislative emergencies.
5. Any quality reporting program tied to Medicare reimbursement must be carefully implemented, including an accurate assessment of the time, practice burdens, and costs associated with these quality reporting programs.
6. Prior authorization and step therapy protocols should be eliminated or meaningfully restricted to preserve patient care and prevent avoidable adverse events.

The Role of Congress in Medicare Reimbursement Reform

The U.S. is experiencing one of the greatest crises in the healthcare workforce today. GI practices cannot compete with staffing shortages in a time of declining reimbursement. The annual "doc fix"—legislation

passed by Congress to decrease cuts to provider reimbursement—is due to an antiquated Medicare reimbursement system and overdue need for reform. This is a larger, systemic problem that impacts patient care and the practice of medicine.

Congressional action is the only solution to address Medicare reimbursement reform. Budget neutrality and lack of inflationary updates are the root issues related to physician payment. The *Social Security Act* (the Act) provides that overall Medicare reimbursement spending cannot be higher than the total spending of the baseline year or starting point. Based on ACG's review of the Medicare provisions in the Act, the "base year" is 1994. Due to budget neutrality requirements, increases to one specialty's reimbursement requires cuts to another. Specifically, changes in relative value units (RVUs) over $20 million require a decrease in overall reimbursement applied via a conversion factor (CF) reduction to preserve budget neutrality. This is problematic given the $20 million threshold is in statute and has neither changed nor been adjusted for inflation since it was established in 1994. Congressional action is critical to fix this system, given Congress is the only branch of government that can make these permanent reforms.

We also urge Congress to remain mindful of its actions that may exacerbate reimbursement issues. Specifically, Congress should not pass legislation that results in incremental cuts to Medicare reimbursement, such as laws with corresponding impacts due to pay-as-you-go (PAYGO) and/or sequestration. These provisions (and the budget neutrality requirements) adversely impact overall reimbursement.

Further, the calculations under the Medicare Physician Fee Schedule (PFS) are simply antiquated and failing. They also include limited transparency for providers to fully understand or recreate the calculations. Congress has repeatedly had to step in for what has now become an annual routine of temporary corrections to forgo cuts to providers. Of note, under current law, *there is no administrative or judicial review of Medicare reimbursement changes*. We urge Congress to ensure that the Centers for Medicare & Medicaid (CMS) follow the law when establishing regulations. Only Congress has the oversight, jurisdiction, and authority to make any changes. The lack of administrative and judicial review significantly impacts physicians' ability to understand both why and how their reimbursement is changing on an annual basis and to take steps to hold the agency accountable for these changes.

In its March 2024 report[1], the Medicare Payment Advisory Commission (MedPAC) recommended an increase for physician payment that is 50 percent of the projected Medicare Economic Index (MEI) increase (for 2024, this would be an additional 1.3 percent increase). MedPAC also recommended a permanent update to physician payments, as opposed to the annual "doc fix" that has occurred in recent years. While ACG is encouraged to see MedPAC's recommendation tying reimbursement to the MEI, doing so at only 50 percent would still result in Medicare payment reimbursement lagging behind inflation given the ever-increasing costs of running a practice. Furthermore, unlike Congress, MedPAC recommendations are just that – non-binding recommendations.

How Medicare Physician Pay Compares to Inflation and Other Medicare Providers

[1] *See* https://www.medpac.gov/wp-content/uploads/2024/03/Mar24_MedPAC_Report_To_Congress_SEC.pdf.

The discrepancy between the cost of running a practice and payment, illustrated by the two charts below, is a leading contributor to patient access challenges, consolidation, and provider burnout. The administrative burden of participating in Medicare (e.g., Merit-based Incentive Payment System (MIPS)) also exacerbates these issues.

Chart One includes analysis from the American Medical Association (AMA) which estimates that, adjusted for inflation in practice costs, Medicare physician pay has effectively declined 30 percent between 2001 and 2024.

Chart One
Medicare updates compared to inflation in practice costs (2001-2024)

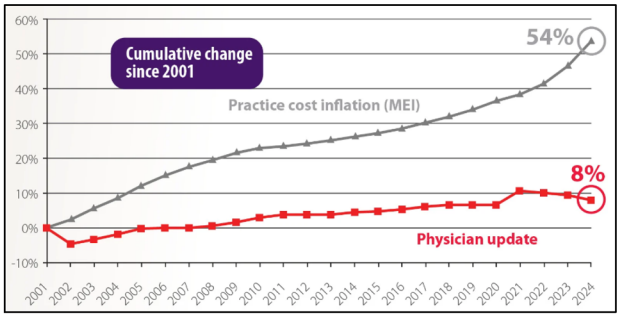
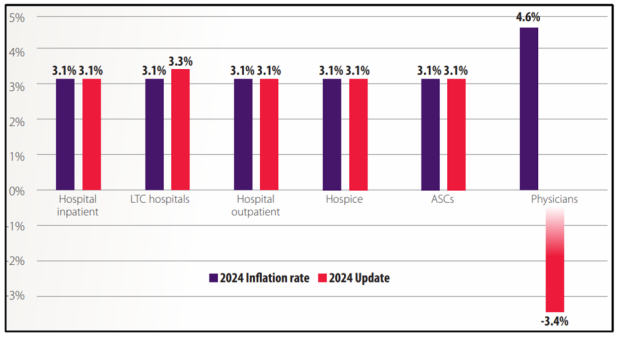


Chart Two illustrates a comparative analysis from AMA on Medicare physician reimbursement across various facilities. Of note, in 2024, Medicare payment updates are scheduled for all providers *except for* physicians.

Chart Two
Medicare payment updates for providers in 2024



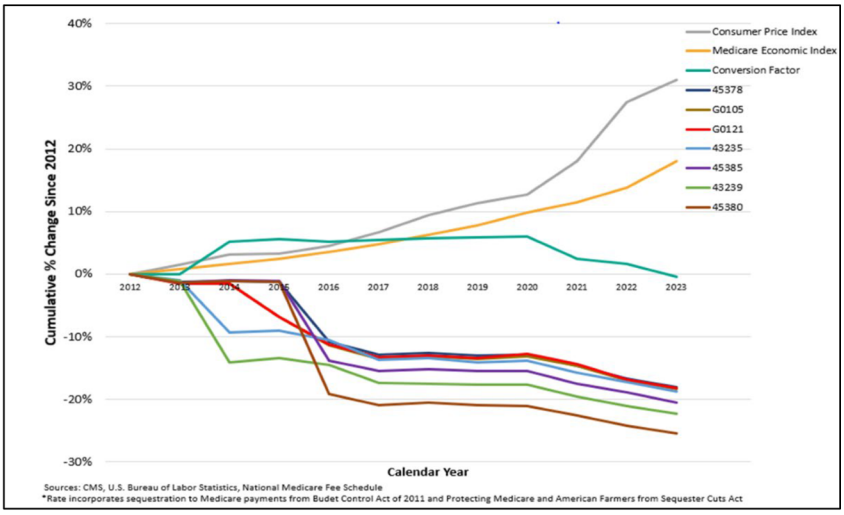
How Payment for GI Services Compares to Various Inflationary Measures and Updates

Physicians, unlike hospitals and outpatient facilities, do not receive an annual inflationary adjustment to Medicare payment. ACG continues to support policies which would provide an annual PFS update tied to inflation (measured by the MEI, ACG's best estimate of the cost of running a practice).

This is compounded by Medicare's budget neutrality provision, which requires overall reimbursement spending not to exceed the baseline year of 1992. As a result, any increase to one specialty's reimbursement means cuts to another's – a "robbing Peter to pay Paul" paradox. Congress passed the *Omnibus Budget Reconciliation Act of 1989*, which established the components of the CF and annual update. The CF is a dollar amount that reflects the legislative, regulatory, and reimbursement policy changes for that year. Prior to 2015, the MEI, in combination with the sustainable growth rate (SGR) formula, was used to annually update the CF.

Chart Three further illustrates how payment for GI services has decreased, given inflation is not considered when establishing physician payment.

Chart Three



Independent Practices—the Lifeblood of the Community—are Dying Without Congressional Help

The community doctor, whether it is a family practice or specialty like gastroenterology, is the lifeblood of local communities. A vibrant community needs access to healthcare services. Yet, it is estimated that it requires roughly $100,000 just to start an independent medical practice.[2] More than 100,000 doctors have left private practice and become employees of hospitals and other corporate entities since 2019.[3] Nearly three in four physicians are employees of larger health care entities or other corporations.[4] Further, the cost of managing a medical practice—whether in primary care or a specialty—has surged and labor costs, rent, and premiums for malpractice insurance have grown more expensive. [5] Physicians have had to make significant investments in information technology, cybersecurity, and electronic health records (EHRs).

According to a new analysis, in the past 10 years, there has been a dramatic shift in physician practice ownership as less than half of doctors now work in private practices. Doctors are continuing to abandon private practice in favor of direct or indirect hospital employment, according to an AMA study of physician practice arrangements.[6] Between 2012 and 2022 the share of physicians working in private practices fell by 13 percent, from 60.1 percent to 46.7 percent. In contrast, the share of physicians working in hospitals as direct employees or contractors increased from 5.6 percent to 9.6 percent in the same 10-year time period and the share of physicians working in practices at least partially owned by a hospital or health system increased from 23.4 percent to 31.3 percent, according to a benchmark analysis from the AMA.[7]

In addition, the "Physician Practice Benchmark Survey" found that, in 2022, 46.7 percent of doctors worked in wholly-owned physician practices, down from 49 percent in 2020 and 60 percent in 2012, the first year of the survey. Conversely, 31.3 percent of doctors worked in practices that were wholly or partially hospital-owned, up from 30.5 percent in 2020 and 23.4 percent in 2012.[8] The percentage of doctors employed directly by hospitals or working as contractors rose to 9.6 percent from 9.3 percent in 2020 and 5.6 percent in 2012. Respondents cited the ability to negotiate higher payment rates as the biggest reason for joining a hospital, with 79.5 percent calling it "important" or "very important." That was followed by the need to better manage payers' regulatory and administrative requirements (71.4 percent) and wanting to obtain better access to costly resources (69 percent).[9] While practice ownership has declined among physicians of all ages, the sharpest drop—from 44.3 percent to 31.7 percent—occurred among doctors under age 45. The smallest decrease, from 54 percent to 49.7 percent, was among those age 55 to 64.[10]

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[2] *See* https://www.businessnewsdaily.com/8910-opening-a-medical-practice.html.
[3] *See* https://www.physiciansadvocacyinstitute.org/PAI-Research/Physician-Employment-and-Practice-Acquisitions-Trends-2019-21.
[4] *See* https://www.physiciansadvocacyinstitute.org/PAI-Research/Physician-Employment-and-Practice-Acquisitions-Trends-2019-21.
[5] *See* https://www.mgma.com/mgma-stats/mgma-poll-an-almost-universal-financial-pinch-on-medical-practices-as-inflation-rises.
[6] *See* https://www.medicaleconomics.com/view/ama-analysis-private-practice-dwindling; https://www.medicaleconomics.com/view/employed-physicians-outnumber-independent-physicians-first-time-ever.
[7] *See* https://www.ama-assn.org/system/files/2022-prp-practice-arrangement.pdf.
[8] *See* https://www.medicaleconomics.com/view/pay-productivity-up-for-doctors-in-hospital-owned-practices.
[9] *See* https://www.medicaleconomics.com/view/top-8-worst-administrative-hassles-according-physicians.
[10] *See* https://www.ama-assn.org/press-center/press-releases/ama-examines-decade-change-physician-practice-ownership-and.

Unfortunately, the days of the trusted community doctors and specialists like many of ACG's members are changing. Data illustrates that the costs and quality of care provided in independent practice versus larger, integrated practice and health systems impact patient care differ.[11] In short, the independent physician has direct control over the quality of patient care. This is not to disparage in any way the quality of care in other settings – but it should never be forgotten that it is only in an independent practice in which the physician is the direct and final arbiter of such decisions and actions. This is a matter of great pride among gastroenterologists and, historically speaking, all physicians. While different practices and markets have unique challenges, Congress can address some common issues that lead to barriers to health care access and physician burnout.

Physician Burnout Continues to Rise Significantly

Physician burnout is a major threat to health care quality, patient outcomes, and the vitality of the medical workforce. More than half of U.S. physicians report at least one symptom of burnout—nearly twice the rate of the general working population—and many also experience depression, anxiety, or suicidal ideation. Burnout is estimated to cost the health care system at least $4.6 billion annually, with the greatest burden attributable to turnover and work-hour reductions among primary care physicians.[12]

According to *Medscape's* 2024 "Physician Burnout and Depression Report," published in January 2024, gastroenterology has among the highest percentage of burn-out practitioners at 50 percent.[13] The top factors contributing to physician burnout include, in part: too many bureaucratic tasks (62 percent); too many hours at work (41 percent); insufficient compensation (38 percent); lack of control/autonomy (32 percent); and government regulations (13 percent).[14] The forces that are driving burnout are the pressure to care for too many patients with little time and few resources as well as reimbursement and administrative burdens.

Further, providers experience administrative and financial burden associated with participation in MIPS. For 2024, CMS estimated roughly 38 hours of work per clinician was required, at a cost of nearly $7,800. Recent research published in JAMA suggests those figures are woefully low, where an average of $12,811 per physician was spent to participate in MIPS in 2019.[15] In addition, clinicians and administrators spent more than 200 hours per physician on MIPS-related activities. It is critical that Congress act to reduce these burdens.

ACG is committed to addressing provider wellness and physician burnout. We have published various articles and educational materials on methods to improve the mental well-being of our membership and colleagues. ACG is making every effort to support clinical gastroenterology and our communities. However, we need Congress's help. Independent practices are stretched and stressed, and the system is breaking.

Conclusion

[11] *See* https://hms.harvard.edu/news/what-happens-when-private-equity-takes-over-hospital#:~:text=National%20study%20of%20quality%20of,younger%20and%20less%20disadvantaged%20patients.
[12] *See* https://jamanetwork.com/journals/jama-health-forum/fullarticle/2802872.
[13] *See* https://www.beckersasc.com/asc-news/physician-specialties-with-the-highest-burnout-rates.html#3.
[14] *See* https://www.beckersasc.com/asc-news/the-factors-contributing-to-physician-burnout.html.
[15] *See* https://jamanetwork.com/journals/jama-health-forum/fullarticle/2779947.

ACG appreciates your leadership in addressing the many challenges providers, especially GIs, face in the U.S. healthcare system. We urge your continued commitment to addressing the financial and regulatory burdens that independent medical providers experience through enacting legislation reforming physician payment and decreasing administrative burden. We look forward to working with the Committee to ensure increased access to care for patients.

Statement for the Record of the
American College of Osteopathic Family Physicians

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

The American College of Osteopathic Family Physicians (ACOFP) appreciates the opportunity to provide this Statement for the Record in connection with the House Committee on Ways and Means Health Subcommittee hearing entitled, "The Collapse of Private Practice: Examining the Challenges Facing Independent Medicine." ACOFP is the professional organization representing more than 26,000 practicing osteopathic family physicians, residents, and students throughout the U.S. who are committed to advancing our nation's health care system by improving health care delivery and outcomes and ensuring that patients have access to high-quality care. We applaud the Committee's leadership in identifying the financial and regulatory burdens that independent medical providers face and how these continued challenges impact patient care.

Many of ACOFP's members practice in independent solo and small family medicine private practices, but their numbers have declined in recent years. More and more of these practices are being acquired by larger practices, private equity, and hospitals because of their inability to compete financially with these organizations. Other practices are closing altogether. ACOFP believes it is essential that policymakers support private practices—especially solo and small family medicine practices in rural and underserved areas—which can tailor how they provide care to best meet the needs of the communities they serve and remain a critical access point for primary care. In many areas, family physicians are the primary source of care, and even before the COVID-19 pandemic, solo and small independent practices faced barriers, including physician shortages, low reimbursement, and overly burdensome regulations. It is critical that Congress and the federal government support family medicine; otherwise, patients across the country will lose access to care.

Osteopathic family physicians face an increasingly challenging environment providing Medicare beneficiaries with access to care. They are essential to the nation's public health system and play a critical role in providing care to Medicare beneficiaries. Despite osteopathic family physicians' contributions to patient care and public health, they have been forced to contend with Medicare payments that do not cover the cost of providing care. The failure of the Medicare Physician Fee Schedule (PFS) to keep pace with the increasing cost of providing care has created an unstable financial environment for osteopathic family physicians.

Physicians need financial stability. Many of our members are small-business owners who provide care in independent solo and small practices and have been struggling to remain open because they lack the resources that large physician groups or hospitals have to cope with administrative burdens, pay staff and facility costs, and purchase essential technology. The consequences of independent practices closing are severe because once a primary care physician office closes in a community, it is very difficult to attract new physicians to serve that community.

ACOFP urges Congress to pass legislation to support stable Medicare reimbursement so physicians can provide much needed care to beneficiaries. Specifically, ACOFP supports the *Strengthening Medicare for Patients and Providers Act* (H.R. 2474), which would address the rising costs of operating medical practices by providing an annual inflation-based update to the PFS tied to the Medicare Economic Index (MEI). Providing an inflationary update to the PFS would help physicians address the rising costs of operating an independent medical practice.

In addition, significantly higher reimbursement for specialists relative to primary care physicians contributes to the current imbalance between primary and specialty care. As more family physicians reach retirement age, the U.S. is facing shortages of 18,000–48,000 primary care physicians by 2034.[1] More needs to be done to address this shortage and increase the number of residents choosing family medicine. In addition to legislation to increase physician reimbursement, ACOFP urges the Committee to consider legislation to address physician shortages, which especially impact rural areas. Specifically, ACOFP supports the *Rural Physician Workforce Production Act of 2023* (S. 230 / H.R. 864), which would provide solutions to physician shortages such as establishing a Medicare graduate medical education (GME) methodology for hospitals training rural residents, enabling hospitals such as critical access hospitals and sole community hospitals to receive Medicare GME funding under this new methodology, and allowing for the growth of rural resident training programs under the Medicare program. This legislation is an important step toward strengthening the physician workforce, especially since residents tend to practice where the train.

Furthermore, administrative burden, including cumbersome electronic health record (EHR) systems, utilization management policies (e.g., prior authorization), and continuously changing regulatory rules, are forcing physicians to spend more time on administrative tasks rather than spending time with patients. Physicians spend even more time on these burdensome tasks after hours. These burdensome paperwork requirements are also contributing to the physician shortage and are inhibiting appropriate patient care. Many physicians, burned out by paperwork requirements, retire early or leave medical practice for another profession, especially those in independent solo and small practices where they do not have the resources to manage all these paperwork

[1] *The Complexities of Physician Supply and Demand: Projections from 2019 to 2034*. Association of American Medical Colleges. June 2021. Accessed January 12, 2023. https://www.aamc.org/media/54681/download.

requirements. As more of these practices are forced to close or relocate, healthcare shortages increase, and more communities lose access to care.

Thank you for your leadership in addressing the challenges that osteopathic family physicians face in our health care system. ACOFP is committed to working with the Committee to reduce financial and regulatory burdens for independent solo and small physician practices to improve patient care.

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Statement for Hearing on
"The Collapse of Private Practice: Examining the Challenges Facing Independent Medicine"

House Committee on Ways and Means
Subcommittee on Health

June 6, 2024

AHIP is the national association that represents health insurance plans that provide coverage, services, and solutions for over 205 million Americans through employer-sponsored insurance, the individual insurance market, and public programs such as Medicare and Medicaid.

We appreciate the Subcommittee's interest in protecting competition in the provider market. AHIP believes patients should be able to affordably receive the health care they need in their communities. Health plans contract with independent practices and seek to create value-based arrangements with those practices to increase patient access to quality care while also working to reduce unnecessary costs, including those driven by care that is not evidence-based or that may be unnecessary or harmful for patients. Unfortunately, growing consolidation among certain providers and private equity acquisition of independent practices[1] has reduced competition and increased the cost of care.[2] To that end, we appreciate the opportunity to comment on the Subcommittee's May 23 hearing on the causes of the reduction of independent practices via closure or buy-outs.

As the Committee considers the impacts of the decline of independent physician practices, we believe it is important they focus on the primary drivers of consolidation that are constricting the marketplace and limiting choice for Americans. In addition, payors are looking for ways to partner with providers to advance outcomes and access for our mutual c, patients.

Reduction of Independent Practices Driven by Hospital Consolidation and Private Equity
A significant trend over the past decade is the substantial vertical consolidation of previously independent physician groups and physician practices into hospitals and other provider-based systems. The percentage of physician practices owned by hospitals doubled over 2010-2018[illegible], dramatically reducing the care options for all Americans, especially for those in medically

[1] https://www.amjmed.com/article/S0002-9343(23)00589-2/fulltext
[2] https://jamanetwork.com/journals/jama-health-forum/fullarticle/2795946

underserved areas. A key reason that hospitals and health care systems acquire independent physician groups and physician practices is to increase their negotiating leverage with commercial payers to achieve higher prices – an incentive that is not present when health plans integrate care delivery.[3] Further, researchers find that these higher prices do not correlate with increases in care quality and could even worsen clinical outcomes.[4] As a result, Americans are faced with provider markets that offer lower quality care at a higher price.

Private Equity
By 2018, private equity represented 45% of all health care mergers and acquisitions.[5] Physician practices have not been immune to private equity's growing influence over the provider market, with the number of physician practices bought by private equity increasing by over 6 times from 2012-2021.[6]

Many private equity firms are focused on extracting short-term financial gains. When these types of private equity firms acquire control over important specialties or ambulance providers, a common strategy is to exercise their market power by refusing to participate in health plan networks or demanding higher prices from health plans for such participation. A study of price increases and utilization by practices following private equity acquisition showed that newly acquired practices increased their prices by over 20% and increased health care costs by increasing the volume health care services provided.[7] These short-term gain-driven strategies also lead to poorer patient outcomes.[8]

In addition, private equity firms focused on short-term returns are more likely to reduce headcount and make other changes in a manner that does not consider the longer-term implications for patients. The outcome is drastically higher costs for the same, or worse, care resulting in higher out-of-pocket costs and higher premiums for patients.[9]

Medicare Advantage Offers Better Care by Partnering with Provider Practices
More than 33 million American seniors and people with disabilities choose to enroll in Medicare Advantage (MA), representing over half the Medicare program's enrollment. MA plans are

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[3] https://jamanetwork.com/journals/jama-health-forum/fullarticle/2795946
[4] https://www.nber.org/papers/w30928
[5] https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2769549
[6] https://www.antitrustinstitute.org/wp-content/uploads/2023/07/AAI-UCB-EG_Private-Equity-I-Physician-Practice-Report_FINAL.pdf
[7] https://jamanetwork.com/journals/jama-health-forum/fullarticle/2795946
[8] https://jamanetwork.com/journals/jama/fullarticle/2813379?guestAccessKey=e0cef9be-d55c-4bcf-8892-412af8f24355&utm_source=For_The_Media&utm_medium=referral&utm_campaign=ftm_links&utm_content=tfl&utm_term=122623
[9] *Id.*

critical to supporting racially, ethnically, and economically diverse communities by providing affordable, comprehensive, and integrated care delivery. In addition, MA plans work with physicians and other providers to deliver integrated, coordinated care and make investments in innovations in care delivery. This is better for the health care system as a whole, including independent provider practices and the beneficiaries they serve.

Peer reviewed research shows that MA plans outperform fee-for-service Medicare across a range of metrics, including better quality of care and better clinical outcomes.[10] A recent study found that when comparing MA and fee-for-service Medicare enrollees who turned 65, and after adjusting for enrollment differences across the two programs, MA enrollees had over 70% fewer hospital readmissions and 24% fewer preventable inpatient admissions.[11] Collectively that means that, after controlling for socioeconomic and patient characteristics, avoidable hospitalizations and readmissions are 1.7 times and 3.8 times higher, respectively, in fee-for-service Medicare than in MA. The researchers suggest that "MA beneficiaries have better quality of care outcomes."[12] They further posit that these findings "may be a direct result of the improved care rather than care rationing or reduced access" and that MA plans are able to "target inappropriate care while retaining high-value care."[13]

Additional studies have found better outcomes for patients with specific chronic diseases when they are covered by MA. For example, MA enrollees with end-stage renal disease have lower mortality and reduced utilization rates.[14] Further, MA members with diabetes and cardiac disease experienced fewer emergency room visits and hospitalizations and better-quality scores compared with fee-for-service Medicare beneficiaries.[15]

Research shows that MA provides better value and care and that seniors enrolled in MA have better health outcomes than those in FFS. In addition, MA plans provide better access to preventive health care, which can help providers detect illnesses at an early stage and reduce health risks. MA's supplemental benefits, care coordination, and focus on detecting and treating preventable diseases at earlier stages are helping to create better outcomes.

Value of Prior Authorization to Protect Patients

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[10] https://pubmed.ncbi.nlm.nih.gov/34533909/
[11] https://www.inovalon.com/news/new-research-from-inovalon-and-harvard-university-finds-medicare-advantage-beneficiaries-have-superior-quality-outcomes-relative-to-traditional-medicare/
[12] *Id.*
[13] *Id.*
[14] https://pubmed.ncbi.nlm.nih.gov/32897788/
[15] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6365159/

Prior authorization is a proven tool that allows health plans to facilitate clinically appropriate, evidence-based care for enrollees and help prevent unnecessary, inappropriate, or more costly care like those being pushed by many private equity acquired practices. An AHIP clinical appropriateness project with Johns Hopkins found that almost 90% of health care providers in the study practice consistent with evidence-based standards of care across the clinical areas included in the study.[16]

However, thirty percent of all heath care spending in the United States may be unnecessary, and in many cases harmful to patients. Every year low-value care costs the U.S. health care system $340 billion with 87% percent of doctors reporting negative impacts from low-value care.[17]

Health plans continue to collaborate with providers to implement innovative solutions to improve the prior authorization process to reduce unneeded care and to promote evidence-based care. Through efforts to 1) provide feedback to providers on their performance relative to their peers and professional society guidelines, 2) target prior authorization to areas prone to variation and inappropriate use, 3) promote electronic prior authorization, and 4) waive prior authorization for providers with demonstrated track records of delivering evidence-based care, health plans are improving the efficiency with which prior authorization requests are processed and approved.

Conclusion

Acquisitions of independent physicians by hospitals and private equity firms harms not just independent practice physicians but also patients. Every American deserves access to affordable, high-quality coverage and care from providers that are focused on their patients' health and not a private equity firm's short-term financial goals. AHIP looks forward to working with Subcommittee members to advance policy changes that will spur more robust competition and provide all Americans with more health care choices and better quality at lower costs.

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[16] AHIP_AppropriatenessMeasures_2022.pdf

[17] https://vbidcenter.org/initiatives/low-value-care/?utm_source=ACHP&utm_medium=referral&utm_campaign=Low-Value-Info#:~:text=Low-value%20care%20can%20be,annually%20in%20wasteful%20health%20spending.

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June 6, 2024

VIA ELECTRONIC DELIVERY
The Honorable Vern Buchanan
Chairman
House Committee on Ways and Means
Subcommittee on Health

The Honorable Lloyd Doggett
Ranking Member
House Committee on Ways and Means
Subcommittee on Health

RE: Hearing on the Collapse of Private Practice: Examining the Challenges Facing Independent Medicine

On behalf of the American Independent Medical Practice Association ("AIMPA"), we want to thank the Subcommittee on Health for its leadership in holding a hearing on May 23, 2024, on the challenges facing independent physician practice. Independent physicians are crucial pieces of our nation's health care infrastructure, and we look forward to working with the Subcommittee and the Committee on Ways and Means, as a whole, to ensure that independent medical practices can continue to thrive and meet the needs of the tens of millions of patients they serve.

AIMPA is a physician-led national advocacy organization representing more than 8,700 physicians in approximately 550 independent medical practices in 43 States and the District of Columbia. Each year, these independent practices care for more than 20 million patients in the fields of primary care, internal medicine, cardiology, dermatology, emergency medicine, gastroenterology, hematology/medical oncology, nephrology, neurosurgery, ophthalmology, orthopedic surgery, otolaryngology, radiation oncology, urology, and women's health. AIMPA's mission is to promote and protect high-quality, cost-efficient care furnished in the independent medical practice setting.

We submit these comments to focus on three topics the Subcommittee and witnesses considered during the May 23, hearing:

In Part I, we examine the drivers of health care market consolidation and the implications of that consolidation on patient access to affordable health care in the independent practice setting.

In Part II, we discuss one of the ways in which independent medical practices have been able to preserve their independence from an ever-consolidating hospital, health system, and vertically-integrated payor landscape. That mechanism for maintaining independence -- through collaborations with private equity-backed management services organizations ("MSOs") -- has enabled independent practices to drive innovation, expand access to high quality and affordable health care services, including in previously underserved communities, and remain a robust, competitive counterbalance to care delivered in other sites of service.

In Part III, we urge this Committee -- and federal policymakers more broadly -- to ensure that independent medical practices continue to have access to the tools needed to compete on a level playing field with hospitals, health systems and payors that are acquiring medical practices at an ever-accelerating pace.

I. Drivers of Health Care Consolidation and the Implications for Patient Access to High Quality, Affordable Health Care in the Independent Practice Setting.

Consolidation of the health care industry is well-documented, but the reason for that consolidation -- "the why" -- is often overlooked or misunderstood, particularly when it comes to the challenges faced by physicians caring for patients in independent medical practices and *especially* with respect to those independent practices that choose to pursue transactions with private equity-backed MSOs. Understanding the "why" is a critical foundation for any meaningful discussion about how to tackle the topic of consolidation from a policy-making perspective. In this Part I, we address that issue, focusing not only on the "business" objectives of transactions but also the more important, patient-focused objectives of these transactions.

We start with a fundamental flaw with the economics of health care delivery in this country. Over the last 23 years (2001-2023), Medicare reimbursement rates in the physician office setting have declined, on an inflation-adjusted basis, by approximately 30 percent, dramatically outpaced by the Medicare Economic Index ("MEI") and by even larger increases in payment rates in the hospital setting (including in provider-based clinics) and in consumer prices, as illustrated in the following graph:[1]

[1] Sources: Federal Register, Medicare Trustees' Reports, Bureau of Labor Statistics, Congressional Budget Office. See also American Medical Association, Economic and Health Policy Research, September 2022 (noting that for 2001-2022, when adjusted for inflation in practice costs, Medicare physician payment declined 22 percent), *available at* https://www.ama-assn.org/sites/ama-assn.org/files/2022-09/medicare-updates-inflation-chart.jpg (last accessed April 26, 2024).

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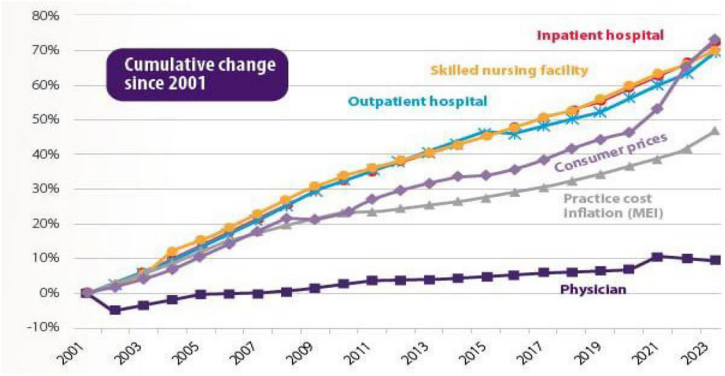

Competition is skewed when reimbursement in one site of service -- independent medical practices -- so dramatically trails reimbursement in the outpatient hospital setting and practice expenses as measured by the MEI. Simply put, a more than 20-year decline in reimbursement, on an inflation adjusted basis, is not a sustainable model for physicians who want to continue delivering care to their patients in independent medical practices.

But the structure of Medicare reimbursement only tells part of the story.

Hospitals, health systems, academic medical centers ("AMCs") and vertically-integrated commercial payors ("pay-viders") enjoy a massive competitive advantage in the marketplace as compared to individual independent medical practices by virtue of their economies of scale, volume purchasing power, physician recruitment and facility development resources, information technology platforms, data analytics, regulatory expertise, and value-based care capabilities. It is implausible to think that independent practices can survive -- let alone thrive -- when they are at such a competitive disadvantage as compared to physician groups owned by hospitals, health systems, AMCs, and pay-viders with their robust infrastructures that dwarf the business support and financial resources of even the largest independent medical practices.[2]

Given all the headwinds they confront -- particularly physicians in small independent medical practices -- it is not surprising that 74,500 physicians became employees of hospitals from 2019 through 2023.[3] As of January 2024, hospitals and health systems employed more than half of all

[2] See, e.g., "UnitedHealth Group Profits Eclipse $5.4 Billion as Optum and Health Plans Roll Despite Rising Costs," Forbes (stating that UnitedHealth Group's medical provider business, Optum, reported second quarter revenues soared 25% to $56.3 billion and operating earnings grew 13% to $3.7 billion, led by Optum Health) (July 14, 2023), *available at* https://www.forbes.com/sites/brucejapsen/2023/07/14/unitedhealth-group-profits-eclipse-54-billion-as-optum-and-health-plans-roll-despite-rising-costs/?sh=648e2f194e72 (last accessed April 27, 2024).

[3] Physicians Advocacy Institute, "Updated Report: Hospital and Corporate Acquisition of Physician Practices and Physician Employment 2019-2023, slide 11 (April 2024) ("4/24 PAI Report") , *available at* https://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/PAI-Research/PAI-

physicians (55.1%), with the percentage of hospital-employed physicians increasing by 5.9% over just the last two years.[4] This is a remarkable figure considering that a little more than a decade earlier, only a quarter of physicians (25.8%) were employed by hospitals or health systems.[5]

Whether to leave one's own medical practice for hospital or health system employment presents physicians with a Hobbesian choice, because moving into a larger institutional provider setting often leads to a loss of autonomy and, in most instances, shifts care into a higher-cost setting for patients and our health care system as a whole.

So again, we return to the question of "why." Why do some physicians in independent practice elect to remain in independent practice and partner with an MSO that is often financially backed by private equity? These doctors are consciously choosing not to sell their practice to a hospital or health system or to become affiliated with another larger institutional provider.

Instead, these physicians want to remain in an independent practice setting where they maintain their autonomy and, yet, they want resources that help them open new office locations in underserved communities, build ambulatory surgery centers where procedures can be done for a fraction of the cost as compared to the hospital setting, compete for the best and brightest physicians coming out of residency and fellowship programs, aggregate data across a broader platform of practices in their own specialties to develop clinical guidelines and other best practices to enhance the quality of care they deliver, and bring into community practices state-of-the-art technologies to diagnose and treat patient injuries, illnesses, and diseases that hospitals, health systems, and vertically-integrated "pay-viders" are able to obtain by virtue of their scale and financial resources.

That objective -- delivering better, faster and more cost-efficient care to patients in an economically-viable independent practice setting -- is at the heart of why some independent practices collaborate with private equity-backed MSOs. As we now show, that objective is being realized across medical specialties and in communities across the country for the benefit of patients and our health care system as a whole.

II. The Positive Impacts of Independent Medical Practice Collaborations with Private Equity-Backed Management Services Organizations.

Two critical questions to consider are (i) how transactions involving health care providers and private equity funds affect patients and providers and (ii) whether the claimed goals and objectives of these transactions have been realized post-transaction. We present here the perspective of physicians who care for patients in independent practices that receive business support from private equity-backed MSOs.

We start with an important clarification about the nature of the transactions whose effects we will discuss. Contrary to the false narrative that private equity-backed MSOs are designed to circumvent bans on the corporate practice of medicine or force physicians to prioritize investor

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Avalere%20Physician%20Employment%20Trends%20Study%202019-2023%20Final.pdf?ver=uGHF46u1GSeZgYXMKFyYvw%3d%3d (last accessed April 26, 2024).

[4] 4/24 PAI Report, slide 14.

[5] 4/24 PAI Report, slide 5.

profits over patient care, the MSO model preserves physician control over patient care. Practices remain physician-owned and physician-led. Clinical decisions remain the prerogative of physicians. In the experience of physicians whose independent practices are part of AIMPA, private equity-backed MSOs have provided the business resources that enable physicians to focus on what they do best -- providing great care for patients in a high-quality, convenient setting that costs patients and our health care system less than if the identical services were furnished in a hospital.

We want to emphasize this point. **No corporate entity -- whether a private equity firm, an MSO, a hospital, or insurance company -- should interfere with the clinical judgment of physicians or otherwise control health care decisions.** The appropriate role of an MSO, regardless of whether it is financially backed by a private equity fund, is to provide resources to independent practices to expand access to high quality, cost-efficient care while physicians in those practices exercise their own clinical judgment about the appropriate course of care for their patients.

We now provide concrete examples of how partnerships between independent practices and private equity-backed MSOs promote lower health care costs and improved working conditions, while fostering high-quality patient care and driving innovation across the health care system.

Reducing the Total Cost of Care ("TCC"). The TCC in the independent practice setting is far less than in other settings. A recent study found that the cost of services in the hospital setting was 12% to 26% higher than the cost in the independent practice setting.[6] The same has long held true when comparing the cost of care for procedures in independent ambulatory surgery centers ("ASCs") versus hospital outpatient departments ("HOPDs").[7] The furnishing of infusion services provides an additional example of the profound cost differential between identical services furnished in independent practices as contrasted with HOPDs.[8]

In addition to facilitating care in lower-cost, convenient settings, private equity-backed MSOs provide independent medical practices with access to data analytics, clinical decision support tools, innovative technologies, and centralized support services that reduce the TCC while improving patient outcomes. These MSOs provide specialty-focused data aggregation and analytics capabilities to drive down avoidable utilization of diagnostic tests, hospital services and expensive prescription drugs -- an endeavor that most independent practices do not have the human capital or financial resources to replicate without MSO support. By way of example:

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[6] Beaulieu ND, Chernew ME, McWilliams JM, et al. Organization and Performance of US Health Systems. JAMA. 2023; 329(4):325-335. doi:10.1001/jama.2022.24032, *available at* https://jamanetwork.com/journals/jama/article-abstract/2800656 (last accessed April 25, 2024).

[7] Commercial Insurance Cost Savings in Ambulatory Surgery Centers, Healthcare Bluebook, Ambulatory Surgery Center Association, HealthSmart (review of commercial medical-claims data found that U.S. healthcare costs are reduced by more than $38 billion per year due to the availability of ASCs as an appropriate setting for outpatient procedures as an alternative to HOPDs with more than $5 billion of the cost reduction accruing to patients through lower deductible and coinsurance payments), *available at* https://www.ascassociation.org/asca/about-ascs/savings/private-payer-data/shifting-procedures-to-ascs/commercial-insurance-cost-savings-in-ascs (last accessed April 25, 2024).

[8] The 2024 Medicare reimbursement rate for CPT Code 96413 (chemo administration; intravenous infusion; up to 1 hour) is $322.68 in hospital outpatient departments and only $129.16 in an in-office setting.

- In partnership with an MSO supporting independent dermatology practices, physician leaders created a Medical Advisory Board ("MAB") to oversee the integrity and quality of the independent practices' clinical program. The MAB, which is staffed exclusively by physicians, established clinical guidelines for its providers that not only improve the quality of care but reduce its cost. The MAB also developed evidence-based guidelines for the prescribing of medicines and tests. These guidelines have resulted in the practice of better, safer medicine and reduced costs for patients.

- An MSO supporting independent gastroenterology practices assists physicians in monitoring CMS's ASC-9 Quality Measures and implementing the quality measure, "Endoscopy/Polyp Surveillance: Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients." In furtherance of the practices' value-based contracts, the MSO assisted the practices in tracking patients considered average risk for colorectal cancer who have a negative colonoscopy with a good bowel prep and are recommended for a repeat colonoscopy at 10 years rather than 5 years, thereby avoiding unnecessary colonoscopies.

- An MSO supporting independent oncology practices assisted a partnered practice in creating genetic tumor marker tests to identify cancers, access the latest therapy protocols, and expand the practice's bone marrow service to provide stem cell transplants for patients. At the same time, the MSO brought laboratory and pathology support to independent medical practices that improved the physicians' ability to diagnose patients efficiently and promptly, resulting in cost savings of approximately 40% for patients and eliminating lengthy wait times for results.

- An MSO supporting independent gastroenterology practices provides those practices with access to an FDA-approved, AI-powered polyp detection system that enables physicians to detect colorectal polyps through enhanced visualization during screening colonoscopies. This technology increases adenoma detection rates ("ADR") by 14.4% -- and each 1% increase in ADR decreases the risk of interval cancer by three percent. Without access to capital, most independent medical practices could not afford this technology, which saves lives while reducing the cost of care.

- Other independent medical practices supported by MSOs have implemented multimillion-dollar linear accelerators that expand access to radiation therapy treatment outside the more expensive hospital setting (urology), total joint programs in the lower-cost ASC setting (orthopedic), and genetic testing centers for cancer patients (urology) -- all of which would have been difficult, if not impossible, but for MSO access to capital and support.

Private equity-backed MSOs also provide expertise and resources to facilitate independent medical practices' participation in value-based care models, further reducing the TCC for patients and payors:

- An MSO supporting independent gastroenterology practices enabled the practices it supports to enter value-based payer contracts with quality and community engagement metrics and to earn performance incentives.

- An MSO supporting independent oncology practices facilitated practice participation in value-based care initiatives by incorporating quality and utilization metrics and utilizing sophisticated reporting and analytics tools. The practices earned shared savings performance payments in the first two years of the program. These oncology practices are often very small, and the MSO is able to help those practices develop and implement more than 20 value-based payment arrangements among the independent practices, including the development of analytics and data reporting necessary to operationalize complex value-based contracts.

Likewise, private equity-backed MSOs help independent practices navigate the labyrinth of MIPS reporting requirements. As but one example, an MSO supporting an independent oncology practice helped that practice better understand how to transcribe data in the practice's electronic medical record into the required fields for MIPS reporting that, by itself, resulted in more accurate MIPS reporting from a quality category performance of 53.55% and an overall MIPS score of 65/100 to a quality score of 95% and an expected overall MIPS score of 100/100.

In sum, private equity-backed MSOs help independent medical practices reduce the TCC by providing access to capital and facility development services that allow practices to provide care in lower-cost settings while also providing sophisticated technologies, data analytics, and other business support that foster value-based care.

Improving Quality and Patient Outcomes. Private equity-backed MSOs provide data aggregation and analytics capabilities, information technology platforms, and other business expertise that enable physicians to standardize clinical guidelines and implement quality initiatives. These initiatives produce quality/outcomes improvements and often a correlating decrease in the TCC, positively impacting the patient care experience.

- Independent women's health practices supported by an MSO have educated their providers on how to perform procedures safely in the medical office setting that do not need to be performed in an ASC or hospital. This shift to office-based procedures lowered costs and improved patient experience, with an office-based procedure rate more than twice industry average -- 59% vs. 27%. These independent practices also have a primary cesarean section rate of 16% -- six percentage points lower than the industry average. With the MSO's support, these independent practices launched an initiative incorporating consistent, guideline-driven behavioral health screening, treatment, and referral resources, with more than 300,000 women screened for behavioral health disorders and over 5,000 women referred for collaborative care, which integrates the provision of behavioral health services with primary care and facilitates communication among providers. Nearly nine in ten patients in this collaborative care program experience a significant improvement in their behavioral health screening scores.

- An MSO supporting independent emergency medicine practices was able to help physicians who furnish clinical care in 90 different emergency departments ("ED") substantially improve key quality and operational results. Overall, these practices reduced ED door-to-clinician wait times by 34% and ED door-to-hospital admit times by 21%, resulting in faster treatment and better patient outcomes. To do so, the MSO utilized a Clinical Leadership Council to develop and operationalize tools, resources, best practices, and solutions, together with a data warehouse and analytics to improve clinical flow and related outcomes for a variety of ED settings. Not surprisingly, patient satisfaction has increased, with more than two-thirds of patients giving the highest possible rating.

- With the help of its MSO partner, an independent gastroenterology practice instituted an initiative to ensure that all laboratory stains meet national benchmarks (i.e., no over-staining), formed physician-driven quality and peer review committees, and instituted standardization of bowel preps (down from over 90 forms of prep among practices supported by the MSO to a handful of best-practices), resulting in higher quality colonoscopies and better patient experiences.

- An MSO supporting independent ophthalmology practices created an Innovation Center that centralizes quality assurance, patient safety, education, and research functions for affiliated practices. The Center includes a clinical data warehouse that draws on electronic health records across practices, allowing for physician monitoring of patient outcomes and the development of best practices.

- An MSO supporting independent gastroenterology practices analyzed data from nearly three million patients to develop a clinical dashboard and comprehensive care management program that is leading to better health outcomes and lower costs by minimizing unplanned episodes of care -- such as ED visits. The MSO is expanding the data in the dashboard to include laboratory and radiology data to provide more robust outputs to help further improve patient care and prepare the practices for value-based care initiatives at national scale. The MSO allows gastroenterology practices across the country (not just the practices supported by the MSO) to access the dashboard and metrics, promoting the cost-effectiveness of care across the specialty.

- An MSO supporting independent oncology practices aided in the recruitment of a molecular pathologist and Ph.D. to support the on-demand interpretation of highly complex, difficult-to-read genomic tests for all physicians whose practices are supported by the MSO. These experts are available for immediate consultation to all physicians supported by the MSO. They can review gene alterations present in tumor specimens and discuss which standard therapies might be appropriate and which clinical trials would most likely benefit the patient.

Expanding Access to Care. Private equity-backed MSOs help independent medical practices expand care delivery options in urban settings and create additional access points for high-quality, lower-cost care in rural and other underserved communities. This comes in the form of access to capital and facility development expertise to open additional clinic sites and develop ASCs as well

as greater infrastructure to recruit physicians and advanced practice providers ("APPs") to the independent medical practice setting. All these efforts result in expanded access to lower-cost care than in the institutional setting. This support is often most profound in rural and underserved communities, enabling independent practices to offer more highly specialized services and obviating the need for patients to travel substantial distances for specialty and subspecialty care.

- In the past two years, an MSO supporting independent urology practices helped one of the practices recruit four urologists. Adding those doctors directly benefited patients by reducing wait times for appointments from as many as eight weeks to two weeks or less. In some cases, the practice is seeing patients the same day. With additional doctors, the practice was able to open clinics in three historically underserved communities lacking state-of-the-art urologic care.

- An independent oncology practice, with the assistance of its MSO partner, expanded its geographic reach and access to cancer care into northern Georgia and rural areas in Tennessee by recruiting additional physicians into these previously underserved communities.

The partnerships between independent practices and private equity-backed MSOs have expanded access to care in other ways beyond the recruitment of physicians to rural and other underserved communities.

- MSOs have sponsored virtual tumor boards and virtual grand rounds, bringing leading experts from the nation's most highly respected AMCs into a virtual setting through which physicians in independent medical practices across the country -- in more remote communities as well as major metropolitan areas -- can benefit.

- Similarly, MSOs have helped independent medical practices expand access to clinical trials and thereby offer patients access to innovative therapies. Traditionally, clinical trials were the domain of AMCs. Today, a network of independent medical practices supported by an MSO creates a single point of access to a large number of providers so that their patients can participate in clinical trials. The MSOs also serve as a single point of contact to ease administrative burdens associated with clinical trials. This has meant that patients outside of urban areas can enroll in clinical trials. In turn, clinical trial enrollment better represents diverse communities to ensure the therapy is safe and effective for all subpopulations. This democratizes clinical trials by creating more equitable access to those trials.

Recruitment and Impact on the Workforce. Private equity-backed MSOs help independent practices compete against health systems and AMCs for physician talent while increasing access in rural and other underserved communities. As a physician in an independent gastroenterology practice stated:

> We hired six providers in Colorado in the last six months. This allowed us to increase access for our patients by decreasing wait times to see a provider. We could not have done this without a dedicated MSO partner investing in recruiting. We have been able to serve rural communities in Wyoming, as well as improve access

> in Colorado Springs. Recruiting to a place like Wyoming is exceedingly difficult, yet we are investing in patients by investing in more physicians to improve access so that patients in Wyoming receive the care they deserve while cutting down on drive times that could be as much as six hours to a major metropolitan city. We can hire transplant hepatologists and interventional endoscopists to smaller cities, which again increases access and quality of care in a lower cost setting. We are expanding the types of services offered, while providing treatment that was previously unavailable in many communities in Colorado and Wyoming.

Similarly, an ophthalmologist whose independent practice is supported by an MSO explained:

> We have several rural communities that are difficult to recruit to and whose size makes it difficult to cover the cost of a full-time health care provider. However, we have expanded services to smaller and rural communities -- such as in North Topeka, Kansas, and Festus, Missouri -- by having ophthalmologists rotate through some of the many optometric offices in these areas. As a result, we can locally provide additional in-office services, including chalazion debridement, lid biopsies, tarsorrhaphies, intravitreal injections, and diabetic lasers.

Physicians are not the only providers who benefit from additional resources to support the care they offer patients. APPs benefit from enhanced training programs that small practices often lack the resources to provide.

- An MSO supporting independent oncology practices created an APP committee that spent a year developing a curriculum and framework that any of its partnered practices can use to educate their newly-hired APPs. The MSO helped launch an "APP Academy" in January 2024 that currently has 15 APPs participating.

- In partnership with a national medical society, an MSO supporting independent gastroenterology practices developed a comprehensive training curriculum for APPs and a virtual library of lectures that is available for free to all APPs across the country, regardless of the medical practice in which they work.

MSOs support independent medical practices' clinical teams with the management of recruiting and onboarding of employees, payroll services, employee relations, legal compliance efforts, and employee engagement. With respect to non-clinical employees, MSOs have expert recruiting professionals who screen applicants for interviews, train managers on best practices in interviewing with role-specific interview guides, attend job fairs, and ensure overall vacancy rates are kept as low as possible. All this business management support -- to which physicians employed by hospitals, health systems, AMCs and pay-viders are accustomed -- enables physicians in independent practices to devote more time to caring for their patients.

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III. Federal Policymakers Should Ensure that Independent Medical Practices Have Access to the Tools Needed to Compete on a Level Playing Field with Hospitals, Health Systems and Payors that Acquire Medical Practices.

Transactions involving private equity funds, such as transactions between independent medical practices and private equity-backed MSOs, do not warrant more robust reporting requirements or more rigorous review than transactions involving other health care market participants. To the contrary, private equity-backed MSOs bolster the ability of independent medical practices to compete against institutional providers by providing high quality care in a lower cost and more convenient setting.

Neither Congress nor federal agencies should take action that further tilts the playing field in favor of care delivery in HOPDs, health systems, or vertically integrated pay-viders. Instead, federal policy -- whether through legislation or regulation -- should be developed in a way that ensures that physicians in independent medical practices have the resources they need to remain a robust competitive counterbalance to large institutional providers.

AIMPA looks forward to continuing to engage with the Committee on how we can address the challenges confronting independent medical practices so that they can continue improving patient outcomes, expanding access to high quality care, and lowering costs by serving as a critical part of our country's health care delivery system.

Sincerely,

Paul Berggreen, MD
AIMPA, President

Jack Feltz, MD
AIMPA, Chair, Federal Health Policy

cc: The Honorable Jason Smith, Chair, House Ways and Means Committee
The Honorable Richard Neal, Ranking Member, House Ways and Means Committee
The Honorable Cathy McMorris Rodgers, Chair, House Energy & Commerce Committee
The Honorable Frank Pallone, Ranking Member, House Energy & Commerce Committee
The Honorable Ron Wyden, Chair, Senate Finance Committee
The Honorable Mike Crapo, Ranking Member, Senate Finance Committee

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House Committee on Ways & Means Subcommittee on Health
1100 Longworth House Office Building
Washington, DC 20003

Statement of the American College of Rheumatology
Re: The Collapse of Private Practice: Examining the Challenges Facing Independent Medicine
June 6, 2024

On behalf of the 8,500 American College of Rheumatology (ACR) members, I write in response to the May 23, 2024, Ways and Means Health Subcommittee Hearing on The Collapse of Private Practice: Examining the Challenges Facing Independent Medicine. The ACR appreciates the opportunity to provide our feedback on the causes of the current crisis facing healthcare professionals fighting to open and maintain private practices and potential legislative solutions.

The trend of private practices having to sell to hospital systems, private equity, and other larger financial institutions was brought about by many factors. However, the ACR agrees with the panelists who spoke in front of the committee on May 23, 2024, that the combination of 1) the administrative burden of prior authorization and 2) inadequate reimbursement for providing care to Medicare patients is insurmountable for many private practices. Additionally, many private practices sell due to the growing physician workforce shortage which leaves practices with no way to meet demands or with no one to take them over when physicians retire.

1. Medicare Reimburses Less then the Cost of Care

For too long physician practices have been expected to pay high wages to their care team and other staff, and foot the bill for technology, rent, malpractice insurance, medical supplies, marketing, and legal advice on five fewer dollars from Medicare than in 2001 when those dollars are worth 105% less. In 2024 the Medicare Physician Fee Schedule (MPFS) conversion factor is $32. 74, lower than it was in 2001. If the MPFS conversion factor were tied to inflation, it would be $67.39. Additionally, under the current system of Medicare funding, there are across-the-board cuts each year to reimbursements to physicians treating Medicare patients in the MPFS. As physician-owned practices combat insecurity around varying payments from Medicare for treating patients, these patients' access to care is put at risk.

This is because a provision was included in the Omnibus Budget Reconciliation Act of 1989, which mandated that any estimated increases of $20 million or more to the MPFS—created by upward payment adjustments or the addition of new procedures or services—must be offset by cuts elsewhere. Therefore, each time a procedure code or other service is reviewed and updated to reflect the modern (higher) value the CF is cut to offset that increase.

This legislation created a trend borne of the necessity of smaller physician-owned practices merging with larger multi-specialty groups or selling to hospital systems. Other practices opt out

of the Medicare payment system and only accept private insurance or cash for services. This leaves the most vulnerable Americans, including seniors, the disabled, and those living in underserved communities disproportionately affected and with few options for medical care. As more physicians cut Medicare from their practices, Congress will have to revisit and eventually overturn the budget neutrality requirement for the MPFS.

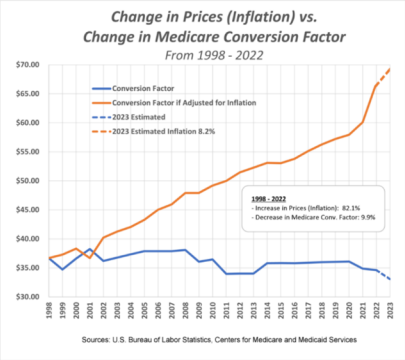
The result? Physician practices are never certain what the reimbursement rate will be each year. So, they squeeze more patients into the schedule daily to make up for the new cuts; leaving physicians and patients dissatisfied. The resulting physician burnout threatens the sustainability of medical care for all Americans and leaves groups like the American College of Rheumatology rushing to Congress annually asking to reduce or eliminate the cuts to the MPFS.

We suggest Congress avoiding putting patient care in jeopardy by passing two pieces of legislation currently before the committee.

First: Support the *Strengthening Medicare for Patients and Providers Act*, (HR 2474) to tie physician payments for treating Medicare patients to inflation by adding a permanent, Medicare Economic Index (MEI) based inflationary update to the MPFS. Physicians are the only healthcare sector that does not receive an inflation-linked increase in Medicare payments.

When inflation is factored in Medicare physician payments plunged 20% from 2001 to 2021. Over the same time, the cost of operating a practice went up 39%. HR 2474 would tie Medicare physician payments to inflation, like all other Medicare payments, and reduce the gaps between the cost of providing the care and the amount that physicians are reimbursed.

In 2024 the MPFS conversion factor is $32. 74, lower than it was in 2001. If the MPFS conversion factor were tied to inflation, it would be $67.39. Physician practices are expected to pay high wages to their support staff to keep pace with inflation, technology, supplies, rent, malpractice insurance, medical equipment, marketing, legal advice, and more on five fewer dollars than in 2001 when those dollars are worth 105% less.



Second: Support *the Provider Reimbursement Stability Act* (H.R 6371) to reduce the impact of budget neutrality requirements on the MPFS by raising the budget neutrality threshold from $20 million to $53 million, then increasing the threshold every five years to reflect the cumulative increase in the MEI and additional policies requiring increased accuracy in accounting for estimates and revisions which will lead to fewer Congressional intervention and more accurate information.

This increased flexibility to make updates without pitting MPFS code users against each other will hopefully save physicians and Congress time while more thorough reforms can be considered. In the long term, the budget neutrality requirement for MPFS is not sustainable. But in the immediate future, this legislation would more than double the amount of new spending in the MPFS before budget neutrality requires cuts.

Additionally, the ACR supports legislation:

- Canceling scheduled cuts to Medicare physician reimbursements.
- Ends the statutory freeze on Medicare physician fee payments related to inflation currently scheduled to last until 2026.
- Ask CMS to weigh the practice expense fairly, & malpractice work components across the board to reimburse providers equitably.
- Reward the value of care provided to patients, rather than administrative burdens–such as data entry–that may not be relevant to the service being provided or the patient receiving care.
- Offer a variety of voluntary payment models and incentives tailored to different specialties and practice settings while ensuring fee-for-service models remain financially viable.
- Provide timely, actionable claims data so physicians can identify and reduce avoidable costs.
- Recognize the value of clinical data registries as a tool for improving the quality of care.
- Address the adverse impact of the balanced budget requirement on physicians through the MPFS, the undervaluation of E/M services, and cognitive care services are critical steps that can mitigate the medical workforce crisis. Specifically for the rheumatology workforce, legislation should address:
    - The current MPFS system where reimbursement codes for procedures are reviewed more often than E/M codes perpetuates substantial compensation disparities at the expense of primary care physicians and cognitive specialties like rheumatology.
    - Work Relative Value Units (RVUs) which systematically depress reimbursements for clinician work.
    - Review office evaluation and management (E/M) codes reviewed as often as procedure codes (every 5-7 years) to ensure appropriate reimbursement.

2. The Burden of Prior Authorization

Prior authorization is a process requiring a medical provider prescribing treatment to obtain approval from an insurance plan before the patient can receive the prescribed treatment. This is a time-consuming process that often involves a patient going to the pharmacy and being turned away because prior authorization has not been obtained. A 2021 study shows that 71% of infusible medication prescribed to treat a rheumatic disease required prior authorization from the insurer before treatment could begin. These treatment delays negatively impacted on patients and allowed disease progression while **more than 95% of the requests were ultimately approved**. While prior authorization may have initially been intended to control costs by reducing unnecessary tests and procedures, health plans now indiscriminately use the process to initially refuse treatment to deter care and create hurdles for patients and physicians that endanger patients' health and cost practices. The process for obtaining the required approval can be lengthy and typically requires a physician or member of the care team to spend many hours each week negotiating with insurance companies—time that should be spent taking care of patients.

A recent national survey found that 87% of physicians report that prior authorization has a significant (40%) or somewhat (47%) negative impact on patients' clinical outcomes. Nearly one-third of physicians surveyed said their patients often abandon treatment due to prior authorization delays. When treatment is delayed or the patient does not return for the prescription, the consequences can be devastating, yet prior authorization can delay treatment for weeks or even months even though most requests are eventually approved—nearly 100% of some treatments. Furthermore, 84% of survey respondents said that the regulatory burdens associated with prior authorization have significantly increased over the past five years, with half of all practices reporting 11 or more requests per week.

As of August 2021, interacting with payers regarding drug utilization management, including prior authorization requirements, costs physicians $26.7 billion. According to the AMA, physicians complete an average of 40 prior authorizations per week. This administrative nightmare eats up roughly two business days (16.0 hours) per week of physician and staff time—time that should not be wasted when access to care is already limited and insurance plans cover the prescribed treatment.

If prior authorization were streamlined in the following ways, ACR members could preserve vital practice resources for patient care and would be more likely to maintain independence:

- Creating a universally accepted prior authorization form with the option to electronically submit.

- "Gold card" legislation, which creates a continuous prior authorization exemption for physicians who earn a 90% approval rate on prior authorization requests for a given service over a period of six months.
- Carrying prior authorizations for stabilizing medications over to new insurance plans.
- Eliminating additional prior authorizations for chronic patients who are stable on a specific medication or therapy by making prior authorization approvals extend for the duration of the treatment without the need for additional or annual renewal.
- Eliminating prior authorization for medications that do not have an equally effective alternative.
- Codifying exceptions to prior authorization requirements where these policies threaten patient health.
- Requiring timely appeals of prior authorization denials with standardized and published processes and determination timelines.
- Increasing transparency by insurance companies through publicizing formularies, specifying which medications require prior authorization and the specific related requirements.
- Requiring insurers to report the prior year's prior authorization approvals and denials and the accompanying timelines to respond to prior authorization requests.
- Requiring peer-to-peer reviews for prior authorization to be assigned to a physician licensed in the same or similar medical specialty.

3. The Growing Physician Workforce Shortage

According to recent projections, the U.S. will face a physician shortage of between 54,100 and 139,000 physicians by 2033, more than two of five currently active physicians will be 65 or older within that time. Forty percent of practicing physicians were feeling burned out at least once a week even before the COVID-19 crisis. The COVID-19 pandemic has exacerbated this issue as we see more burnout, retirements, and career changes from the medical field. This means the rising patient population is competing to see a shrinking pool of doctors, leading to prolonged wait times, delayed, or abandoned care and treatment, and a higher risk of disease progression and disability.

The ACR feels the weight of this issue acutely. There are an estimated 91 million Americans currently living with rheumatic disease and fewer than 5,600 active board-certified rheumatologists to treat them. By 2030, the demand for rheumatologists is projected to exceed supply by over 4,700 rheumatologists as the prevalence of rheumatic disease in our population continues to grow. Many practices currently report at least a six-month wait time to see new patients with rheumatic disease, during which the disease advances.

The care of rheumatology patients requires an interprofessional team consisting of rheumatologists, nurse practitioners, physician assistants, clinic and infusion nurses, pharmacists, rehabilitation specialists, mental health and social workers, and researchers developing new therapies and evaluating clinical services. The healthcare workforce shortage, burnout, research, and education funding challenges, and reimbursement obstacles have affected all members of the rheumatologic interprofessional team, and the ACR supports legislative solutions addressing these issues.

Drivers of the Healthcare Workforce Shortage

There are currently many geographical areas of the United States with limited or no access to a rheumatologist or rheumatology care provider, a trend expected to significantly worsen in the coming decades according to the latest Rheumatology Workforce Study. There is a predicted shortage of 3,845 rheumatologists in the U.S. by 2025, up from previous projections of 2,576. Recent figures suggest that arthritis may be even more common than previously estimated, with an estimated 91.2 million Americans affected in 2015, and the cases are rising.

Additionally, the availability of pediatric rheumatologists is at a crisis level, with fewer than 400 pediatric rheumatologists in the United States providing care at present. Nine states do not have a single board-certified, practicing pediatric rheumatologist and six states only have one. As a result, many children and adolescents with pediatric rheumatic diseases have limited access to high-quality care for their conditions. Rheumatologists trained to care for adult patients do not have sufficient training to provide the highest quality care for pediatric patients while general pediatricians have not received adequate training to treat the intricacies of pediatric rheumatology conditions.

Limited Training Opportunities

The current physician pipeline is being artificially narrowed by the limited number of medical school and postgraduate training slots. The number of residency and fellowship positions has not kept pace with either the number of medical school graduates or the demand for physicians. These numbers are one factor in the decline in medical school enrollment as students do not feel certain they will have access to the necessary training to practice medicine even after graduating from and paying for medical school. Pipelines suggest medical students are growing in number; however, the filling of training positions varies by availability. In adult rheumatology, there are more applications than positions, and in pediatrics, most positions do not fill.

Unfortunately, over 20 years ago, the Balanced Budget Act of 1997 imposed caps on the number of residents for each teaching hospital eligible to receive Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments. These caps have remained in place and have generally only been adjusted as a result of certain limited, one-time programs despite the growing medical workforce shortage. Congress increased the number of Medicare-supported GME positions by 1,000 in the Consolidated Appropriations Act, 2021—the first increase since 1997, nearly 25 years ago. The slots are distributed by the Centers for Medicare and Medicaid Services (CMS) through rulemaking.

While the 1,000 positions recently provided by Congress are an important start to training more physicians, additional support is needed and it should be targeted. Even while Medicare supports physician training by funding GME training positions for specialty care including rheumatology, **nine states still do not have any adult rheumatology fellowship positions and twenty-eight states do not have any pediatric fellowship positions**.

Legislative Solutions to the Limited Training Opportunities

We are simply not providing enough opportunities for medical school graduates to receive training to participate in the medical workforce. To expand the pipeline of new physicians ready to treat patients, Congress needs to fund more GME slots. Although shortfalls, only partially addressed by the 1,000 slots added by the 116th Congress, will affect all Americans, the most vulnerable populations, particularly those in rural and underserved areas, disproportionally feel the impact of the deficit. We are particularly concerned for our seniors because, as the numbers of new Medicare enrollees grow, so does their need for and utilization of healthcare services.

The geographic location of training positions also requires careful consideration. There is currently a maldistribution of physicians including rheumatologists across the country, with many areas, particularly rural areas, having fewer physicians per capita than urban areas.

The ACR believes that residency programs are an important part of medical education, providing hands-on training for medical school graduates. Congress can provide additional funding to expand residency programs, particularly in underserved areas. GME is a necessary public good that must be protected and increased funding is necessary to support a healthcare workforce capable of meeting the needs of America's patient population. **One thousand additional positions represent a step in the right direction but are too few to meaningfully impact the physician shortage. Medicare needs to increase funding for DGME and IME training positions.** Congress should also increase federal funding for nursing education, to address the national nursing shortage and increase the numbers of advanced practice nurses.

Healthcare Workforce Burnout and Early Retirement

The practice of medicine and delivery of healthcare services can be highly demanding and stressful, which can contribute to burnout and early retirement. Newly published research shows that the COVID-19 pandemic accelerated the physician burnout rate. At the end of 2021, nearly 63% of physicians reported symptoms of burnout, up from 38% in 2020. Research shows that large-scale change is needed to address the physician burnout crisis and mitigate the impact of physician retirements on the medical workforce shortage.

Before COVID-19, two main factors were thought to drive physician and advanced practice provider (APP) burnout and early retirement. The first is changes in healthcare delivery. The healthcare industry is constantly evolving, and many providers feel that they are no longer able to practice patient-focused medicine or care for patients in the way that motivated them to pursue medicine as a career in the first place. Healthcare delivery models, such as the rise of electronic health records, the increasingly complex Quality Payment Program requirements, and increased administrative burden, have reduced time with patients and contributed to burnout and early retirement.

The second is that physicians and APPs may retire earlier or transition out of direct patient care if they feel that the potential earnings are no longer worth the cost to them to work or maintain a practice. Declining reimbursement rates and the rising cost of operating a business increase the incentives to sell private practices to larger companies or simply shut down altogether, with a dramatic impact on the community and patients that the practice served.

Legislative Solutions to Physician Burnout and Early Retirement

The ACR supports confidentiality laws that protect physicians and other healthcare providers seeking help for wellness, burnout, and fatigue and removal of inappropriate, stigmatizing questions on licensure and renewal applications. Additionally, health systems and academic medical institutions should remove questions on credentialing and other applications that might prevent physicians, residents, medical students, and other applicants seeking hospital privileges from seeking care for mental wellness.

Policymakers need to address the inordinate amount of time that physicians and other clinicians spend on documentation during patient interactions. **Future legislation should aim to reduce this burden and provide healthcare professionals with more time with patients, rather than paperwork**. The ACR would like to see incentives to ensure that EHR providers, coders, payors, and other vendors implement simplified coding, so providers no longer labor under undue documentation complexity.

Economic Barriers to the Medical Workforce

Medical Education Debt

The cost of graduate-level medical education is substantial for most students. In addition, the economic realities of practicing medicine in the United States have evolved away from the assurance of prosperity that used to be associated with the profession. In addition to the cost of medical education, which can discourage some college students from pursuing a career in medicine, this also affects those already carrying heavy debt from undergraduate education.

Further, those who must undertake several years of residency with very low pay are often unable to begin repaying student debt immediately. As a result, they qualify to have their payments halted during residency through deferment or forbearance processes, but they continue to accrue interest that is added to their balance. The accrual of interest on substantial debt compounds financial concerns. This interest increases the amount of the loan during each year of training, growing the debt for years before a physician is fully trained and able to begin repaying student loan debt.

Legislative Solutions to Mitigate the Impact of Education Debt

It is important to note that rheumatologists and other cognitive specialists are currently excluded from most federal and state public loan forgiveness programs, which prioritize primary care physicians. However, like primary care physicians, rheumatologists and other cognitive specialists provide ongoing care to patients. Rheumatologists and other cognitive specialists primarily bill evaluation and management (E&M) codes and often serve as a principal providers of care for their patients. Therefore, the ACR supports establishing loan forgiveness programs that would encourage cognitive specialists to practice in underserved areas or expanding the application of the current programs to include cognitive specialties.

The ACR also supports legislation that would **allow borrowers to qualify for interest-free deferment on their student loans while serving in a medical internship, residency, or fellowship program**. Currently, the REDI Act (HR 1202) would prevent physicians and dentists from being penalized during residency by precluding the government from charging them interest on their loans during a time when they are unable to afford payments on the principal. The REDI Act does not provide any loan forgiveness or reduce a borrower's original loan balance but recognizes the specific circumstances of those pursuing a medical career.

Limited Access to Workforce for Visa Holders

Immigrants represent disproportionately high shares of U.S. workers in healthcare—a fact underscored during the coronavirus pandemic as the foreign-born have played a significant role in frontline pandemic-response sectors. In 2018, more than 2.6 million immigrants, including 314,000 refugees, were employed as healthcare workers, with 1.5 million of them working as doctors, registered nurses, and pharmacists. Even as immigrants represent 17 percent of the overall U.S. civilian workforce, they are 28 percent of physicians.

Currently, 34,000 Deferred Action for Childhood Arrivals (DACA) recipients – physicians, nurses, dentists, and many others - provide health care to patients in communities across the nation. Meanwhile, the Health Resources and Services Administration (HRSA) estimates that 99 million Americans live in primary care Health Professional Shortage Areas (HPSAs). To put it in perspective, at least 17,000 primary care practitioners would be needed to serve these areas to eliminate their shortage designation. Health professionals with DACA status encompass a diverse, multiethnic population, who are often bilingual and more likely to practice in rural and underserved communities. They are practitioners who provide a tremendous resource to patients who often have challenges with access to health care services or with communication barriers.

According to a 2019 survey of DACA recipients interested in health careers, 97% expressed plans to ultimately work in the neighborhoods in which they grew up, or other underserved areas. That number is consistent with other studies demonstrating that underrepresented individuals in health professions are twice as likely to pursue careers working with underserved populations. Recent court rulings have left the DACA program in legal limbo.

The H-1B visa is for temporary workers in specialty occupations who hold professional-level degrees. It does not have a two-year home residence requirement. The H-1B visa allows a foreign national to enter the U.S. for professional-level employment for up to six years. The H-1B visa is available to graduates of foreign medical schools who have passed the necessary examinations, have a license or other authorization required by the state of practice, and have an unrestricted license to practice medicine or have graduated from a foreign or U.S. medical school.

Currently, J-1 visa-holding resident physicians from other countries training in the US are required to return to their home country for two years after their residency has ended before they can apply for a work visa or green card to work in the US. The Conrad 30 program allows these physicians to remain in the US without having to return home for two years if they agree to practice in a medically underserved area for three years. The Conrad 30 program helps physicians who are educated and trained in the US continue to serve in our medical workforce.

Legislative Solutions to Clearing the Path for Visa-Holding Physicians

International Medical Graduates who seek entry into U.S. programs of Graduate Medical Education (GME) must obtain a visa that permits clinical training to provide medical services. Nearly one-fourth of the active U.S. physician workforce are foreign graduates and international medical graduates (IMG). Nonimmigrant or immigrant visas are needed for IMG physicians and healthcare professionals to legally practice in the U.S. when they are not U.S. citizens. The proportion of residency programs sponsoring H-1B visas for training has gradually decreased in the last few years as the immigration requirements are multistep, costly (for the employer), and often complicated with bureaucratic immigration nuances. **To support the healthcare workforce, future legislation should facilitate easier access to more visas for those seeking roles in the US medical workforce.**

In light of these nationwide health workforce shortages, the DACA program and its corresponding work authorizations are critical to retaining and expanding our nation's health workforce and healthcare capacity. Further:

- The ACR supports the expansion of the Conrad 30 waiver program to allow more J-1 foreign medical graduates to apply for a waiver of the 2-year foreign residence requirement upon completion of the J-1 exchange visitor program.
- The ACR supports legislation that would reallocate unused visas for IMGs to ensure durable immigration status for these medical professionals.

4. Conclusion

Private practices are essential to our communities and should be supported by policy. First, Medicare should reimburse physicians for the actual cost of providing care to patients in that system. Second, payers should not be allowed to drown providers in expensive arbitrary hurdles to deter care. Third, to keep practices viable, Congress needs to support the physician workforce.

The ACR looks forward to partnering with the Ways & Means Health subcommittee as legislative solutions are considered. Please contact Lennie McDaniel, JD, Director of Congressional Affairs, at LMcDaniel@rheumatology.org should you have any questions or need additional information from the ACR or its membership.

STATEMENT

of the

American Medical Association

U.S. House of Representatives

Committee on Ways and Means

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

May 23, 2024

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Statement for the Record

of the

American Medical Association

to the

Committee on Ways and Means

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

May 23, 2024

The American Medical Association (AMA) appreciates the opportunity to submit the following Statement for the Record to the U.S. House Committee on Ways and Means as part of the hearing entitled, "The Collapse of Private Practice: Examining the Challenges Facing Independent Medicine." The AMA commends the Committee for addressing this critical issue that threatens the very existence of private medical practices. The AMA is fighting tirelessly to combat the financial and regulatory challenges that jeopardize the survival of these practices. The situation is dire and multifaceted, involving not only the fallout from the COVID-19 pandemic, but also drastic cuts in physician practice payments relative to inflation, surging practice costs, and overwhelming administrative burdens. These payment reductions and burdens are forcing more and more physicians to either close their doors or merge with larger health care systems, severely limiting competition and patient choice. While the pandemic has amplified existing financial pressures and highlighted the urgent need for continued legislative intervention, the relentless cuts in physician practice payments present an immediate and existential threat to private practices.

The AMA acknowledges Congress's efforts in extending certain policy flexibilities granted during the pandemic. We also appreciate that Congress did act in the Consolidated Appropriations Act, 2024 to mitigate a portion of the latest cut facing physicians. Permitting any additional Medicare cuts to go into effect at this juncture is unsustainable for physician practices and threatens patient access to care. Therefore, to truly safeguard the future of independent practices, Congress must enact comprehensive legislative reforms without delay.

PAYMENT CHALLENGES

The physician payment system is on an unsustainable path that threatens patients' access to physician services. As noted above, physicians in 2024 faced yet another round of real dollar Medicare payment cuts triggered by the lack of any statutory update for physician services tied to inflation in medical practice costs and flawed application of Medicare budget neutrality rules. Congress acted last March to partially mitigate the 3.37 percent reduction that was imposed in January but did not stop the cuts entirely. These cuts come on the heels of two decades of stagnant payment rates. Adjusted for inflation in practice costs, Medicare physician payment rates plummeted 29 percent from 2001 to 2024 because physicians, unlike other Medicare providers, do not get an automatic yearly inflation-based payment update.

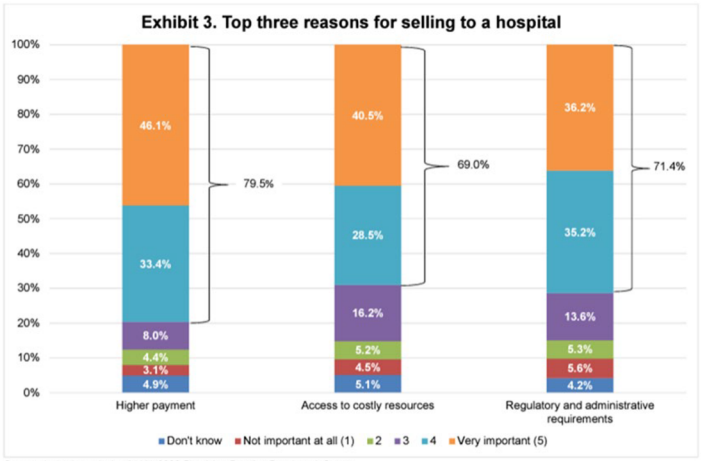
In its 2024 annual report, the Medicare Trustees warned that the program faces "challenges," notably that physician payments are not based on underlying economic conditions – such as inflation – and are not

expected to keep pace with the cost of practicing medicine. The trustees warned of the gap created between rising costs and physician payments, noting that the "quality of health care received by Medicare beneficiaries would, under current law, fall over time compared to that received by those with private health insurance."

The trustees further cautioned that "absent a change in the delivery system or level of update by subsequent legislation, the Trustees expect access to Medicare-participating physicians to become a significant issue in the long term."

The lack of an adequate annual physician payment update within the current Medicare physician payment system is particularly destabilizing as physicians, many of whom are small business owners, contend with a wide range of shifting economic factors when determining their ability to provide care to Medicare beneficiaries. Physician practices compete against health systems and other providers for staff, equipment, and supplies, despite their payment rates failing to keep pace with inflation. In fact, the government's measure of inflation in physicians' costs, the Medicare Economic Index (MEI), rose 4.6 percent this year.

An AMA analysis shows that by far, the most cited reason that independent physicians sell their practices to hospitals or health systems had to do with inadequate payment. Next were the need to better manage payers' regulatory and administrative requirements and the need to improve access to costly resources. Included below is an excerpted figure with more detail. The AMA strongly supports policies that promote market competition and patient choice. Payment adequacy is necessary for physicians to continue to practice independently.



Source: Author's analysis of AMA 2022 Physician Practice Benchmark Survey.
Note: These estimates are based on physicians whose practices had been acquired by a hospital or health system after 2012 and who were practice members at the time of that acquisition (N=282). The bracketed percentage is the sum of important (4) and very important (5).

While we appreciate that Congress passed legislation that mitigated a portion of the severe Medicare payment cuts, this pattern of last-minute stop gap measures must end. As the Committee looks to provide adequate payments to physicians and retain patient access, particularly those in rural and underserved areas, annual Medicare physician payments equal to the full MEI should be enacted to provide an annual update that reflects practice cost inflation.

We urge lawmakers to consider the pressing need for adequate payments to physicians. Specifically, we ask Congress to pass H.R. 2474, the "Strengthening Medicare for Patients and Providers Act," which provides a permanent annual update equal to the increase in the MEI. This bipartisan legislation, which is supported by the entire House of Medicine, falls within the jurisdiction of the House Ways and Means Committee and currently has 142 bipartisan cosponsors. Such an update would allow physicians to invest in their practices and implement new strategies to provide high-value, patient-centered care and enable the Centers for Medicare & Medicaid Services (CMS) to prioritize advancing high-quality care for Medicare beneficiaries without the constant specter of market consolidation or inadequate access to care. The passage of H.R. 2474 will also help physicians avoid the tremendous budgetary stress that characterizes the last-minute nature of annual bills that temporarily stop scheduled payment cuts. Enactment will also alleviate Congress from having to devote precious legislative time to short-term fixes and, in turn, permit greater focus on other pressing health care needs.

Improvements to Budget Neutrality

The AMA also calls for immediate reform to the statutory budget neutrality requirements within the Medicare Physician Fee Schedule. The frequent and significant payment redistributions, sometimes resulting from overestimations of RVU impacts on service utilization, undermine financial stability. The outdated $20 million threshold that triggers budget neutrality adjustments, set in 1989 and unadjusted for inflation, should be raised to $53 million to reflect current economic realities. Moreover, implementing a look-back period would allow CMS to adjust for past misestimates, ensuring a fairer and more accurate payment system. **The AMA urges Congress to pass H.R. 6371, the "Provider Reimbursement Stability Act," another bipartisan bill that is also within the jurisdiction of the Ways and Means Committee. In fact, the Energy and Commerce Committee already took action on a portion of this legislation when it passed H.R. 6545, the Physician Fee Schedule Update and Improvement Act, out of committee in December 2023.**

Merit-based Incentive Payment System (MIPS)

Since the introduction of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), the AMA has been deeply engaged in efforts to implement MIPS as Congress intended, specifically streamlining the previously separate and fragmented quality assurance programs. Despite initial support for MACRA's goals, the reality of MIPS' implementation has been fraught with challenges, particularly for small, rural, safety-net, and independent practices. The COVID-19 pandemic has further complicated the situation, disrupting health care delivery and exacerbating the administrative burdens associated with MIPS.

Following a five-year interruption to the program due to COVID, MIPS now subjects physicians to penalties of up to nine percent unless they meet onerous program requirements. Small, rural, and independent practices, along with practices that care for historically minoritized and marginalized patients, are more likely to be penalized, whereas large group practices, integrated systems, and alternative payment model participants are more likely to receive bonuses.

Data from the 2022 Quality Payment Program Experience Report that was just recently released revealed that MIPS penalties disproportionately affected smaller practices: 27 percent of small practices, nearly 50

percent of solo practitioners, and 18 percent of rural practices were penalized. Of those, 13 percent of small practices, 27 percent of solo practitioners, and two percent of rural practices got the maximum negative penalty of –9 percent. A study from the same year indicated that MIPS scores poorly correlate with actual performance, raising serious concerns about the program's effectiveness and fairness. MIPS is extremely burdensome, and it is costly to participate and do well in MIPS. Compliance with MIPS costs $12,800 per physician per year and physicians spend 53 hours per year on MIPS-related tasks. This high entry barrier is a fundamental reason why less-resourced practices including small, rural, and safety net practices historically do worse in the program. MIPS does not prepare physicians to move to an alternative payment model (APM) and has not been shown to improve clinical outcomes. Worse, a 2022 study in JAMA found MIPS scores are inconsistently related to performance, which "suggests that the MIPS program is approximately as effective as chance at identifying high vs low performance."

Though MACRA requires timely feedback and consultation with stakeholders, there are no enforcement mechanisms to accomplish these provisions. CMS has not met its statutory obligation to provide timely (e.g., quarterly) MIPS feedback reports and has never provided Medicare claims data to physicians despite this requirement going into effect in 2018.

Unfortunately, MIPS is broken and requires a significant overhaul. The AMA has recommended key legislative changes to improve MIPS. These include eliminating the flawed underlying penalty structure that uses penalties applied to poor performers to finance incentives for high-performer, enhancing the relevance and timeliness of CMS feedback, and reducing the administrative load on providers. These recommendations, aimed at making MIPS more equitable, clinically relevant, and less burdensome, remain a key part of our dialogue with Congress.

Repeal of Physician-Owned Hospital Restrictions

The trend toward higher levels of hospital and health plan market concentration around the nation has not benefited patients, who experience higher costs and poorer health outcomes in highly concentrated markets. Declining payment rates and heavy regulatory burdens have made it nearly impossible for physician practices to compete in these markets. Fostering greater competition by dismantling the statutory barrier to physician ownership of hospitals, however, would help preserve physician practices and provide patients with another option to receive high-quality care through integrated, coordinated care delivery.

Fortunately, there is something Congress can do without delay. Low-hanging fruit would be passing H.R. 977/S. 470, the "Patient Access to Higher Quality Health Care Act of 2023," in order to remove a barrier to health care market entry that Congress itself erected. This bipartisan, bicameral legislation permanently eliminates the near prohibition the Affordable Care Act (ACA) placed on Physician-Owned Hospitals (POHs).

Evidence shows that physician-owned practices do not engage in the discriminatory practice of "cherry-picking" patients. Studies, including those by CMS, debunk this myth, affirming that POHs provide care equitably. Also, lifting the ban on physician-owned hospitals would allow physicians to open new hospitals as well as acquire existing hospitals, and in doing so implement alternative care delivery and payment models that create efficiencies that benefit consumers while enhancing care. Competition created by new or expanded physician-owned hospitals through lower costs or higher quality services—or both—will induce traditional hospitals to upgrade their offerings or risk losing market share. Allowing physicians to acquire hospitals, particularly those in rural areas whose future might be uncertain, would

protect access to care that might otherwise be lost. We discussed in more detail the benefit of physician-owned hospitals in testimony last fall.

INNOVATION MODELS AND TECHNOLOGY

The AMA strongly advocates for the permanent removal of restrictions on telehealth access for Medicare patients. The bipartisan "Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act" (S. 2016/H.R. 4189) and the "Telehealth Modernization Act" (S. 3967/H.R. 7623) are critical in this regard, especially amidst a national physician workforce crisis. These bills would extend integral COVID-19 telehealth flexibilities that have markedly improved care accessibility, particularly for patients in rural and underserved areas by allowing telehealth services from any location accessible to a telecommunications system, including homes.

Introduced in the House by two Ways and Means Committee members, specifically Representatives Mike Thompson (D-CA) and David Schweikert (R-AZ), the CONNECT for Health Act would permanently allow Medicare patients in all areas, including both rural and urban settings, to access telehealth services and continue the use of audio-only visits. The Senate companion bill, which was introduced by Senators Brian Schatz (D-HI) and Roger Wicker (R-MS) currently has 65 bipartisan cosponsors. Overall, this legislation currently enjoys substantial bipartisan support and should be expedited through Congress.

Additionally, the Telehealth Modernization Act, introduced by Senators Tim Scott (R-SC) and Brian Schatz (D-HI) along with Representatives Buddy Carter (R-GA) and Lisa Blunt Rochester (D-DE), aims to permanently continue audio-only telehealth services beyond the statutory deadline of December 31, 2024. This is vital for patients who face barriers such as long travel times, workforce shortages, or lack of stable housing, ensuring they have consistent access to care.

Both Acts also propose to remove the requirement for patients to have an in-person visit within six months of an initial telehealth visit for mental health conditions, promoting easier access to virtual mental health services.

Support for the Preserving Telehealth, Hospital, and Ambulance Access Act

As an interim measure, the AMA supports H.R. 8261, the "Preserving Telehealth, Hospital, and Ambulance Access Act," which was also introduced by Representatives David Schweikert (R-AZ) and Mike Thompson (D-CA). This important legislation would extend telehealth provisions including audio-only services, remove geographic and originating site restrictions, and delay in-person requirements for telemental health services through 2026.

This bill also seeks to extend the Acute Hospital at Home Waiver Flexibilities through 2029, responding to requests from the medical community for an extension to continue providing high-quality, cost-effective care at home. This extension is important for physicians to make long-term investments in the infrastructure necessary to support at-home care.

While these legislative measures are steps in the right direction, the AMA urges Congress to make these telehealth flexibilities permanent, allowing for long-term investments in virtual care innovations. This permanency will enable the continued evolution of hybrid models of care delivery, which combine in-

person, telehealth, and remote monitoring services. Such models enhance care continuity and reduce health care delivery fragmentation, ensuring patients receive comprehensive care tailored to their needs.

Change Healthcare and Cybersecurity

The ransomware attack on Change Healthcare in February 2024 highlights the critical importance of robust cybersecurity measures in health care. As a key player in the United States health care payment and operations system, Change Healthcare's disruption continues to have widespread effects, impacting thousands of medical practices, hospitals, pharmacies, and more. This cyberattack not only halted claims processing and payments but also caused significant delays in patient care and forced many to pay out-of-pocket for necessary services.

Following the attack, Representatives Mariannette Miller-Meeks (R-IA) and Robin Kelly (D-IL) spearheaded a bipartisan initiative, with 96 members of the House of Representatives, to address the aftermath. They penned a letter on March 19 to HHS Secretary Becerra, detailing the ongoing challenges faced by physicians and patients and questioning the stringent repayment terms set by CMS in their March 9 announcement regarding advance payments for Part B physicians and other providers.

This incident highlights the health care sector's vulnerability to cyber threats and the potential catastrophic effects on patient safety, privacy, and health care delivery. The sector's dependence on interconnected digital systems for patient records, billing, and payments amplifies the impact of such attacks, compromising both immediate and long-term patient care and operational continuity.

Particularly alarming is the threat to rural, remote, and underserved communities, which rely heavily on digital platforms for telehealth and at-home care services—vital for equalizing access to health care. The cybersecurity weaknesses revealed by the Change Healthcare attack point to a significant risk in our efforts to promote health care equity through digital means. A 2022 AMA study cited in a March 21 letter led by Vice Chairman Vern Buchanan and 19 Ways and Means Committee members highlights that nearly 75 percent of patients are concerned about the protection of their personal health data.

In light of these challenges, it is imperative that Congress allocates adequate financial resources to help physician practices bolster cybersecurity. Protecting digital health care services extends beyond data security; it is about ensuring uninterrupted care for society's most vulnerable.

In addition, the consolidation of health care services by major corporations, exemplified by entities like Change Healthcare and United Optum acquiring numerous practices, exacerbates the vulnerability of private practices. Such acquisitions often result in reduced autonomy for physicians and may prioritize profit over patient-centric care. This trend towards consolidation is particularly concerning as it can lead to the closure of independently operated private practices, which historically have provided personalized and locally responsive health care services. The increasing dominance of large health care corporations further strains the already precarious situation in rural and underserved areas, where the closure of private practices removes critical health care services and worsens access issues. This landscape makes it imperative to implement supportive measures that preserve the operation and integrity of private practices, ensuring that health care remains accessible and tailored to community needs.

Private practices are increasingly vulnerable to cyber-attacks as they become more reliant on digital technologies. The breach at Change Healthcare demonstrates how such incidents demonstrate how financially fragile these practices have become, raising the threat of potential closures. This vulnerability

highlights the broader reality of the risks that private practices face, making them more susceptible to operational disruptions and financial instability.

Electronic Health Records (EHRs)

Another significant challenge in health care innovation and technology is the high cost and complexity associated with implementing and maintaining Electronic Health Records (EHRs). EHR systems are integral to modern health care delivery, offering benefits such as improved patient tracking, data management, and enhanced continuity of care. However, the financial and logistical burdens they place on health care providers, particularly small practices and those in underserved areas, can be substantial.

EHR systems require significant upfront investment and ongoing maintenance costs, which can strain the budgets of private practices. Additionally, the complexity of integrating EHR systems with other health care technologies and ensuring compliance with evolving regulatory requirements demands continuous training and technical support. This can divert resources away from patient care and into administrative tasks, thereby impacting the efficiency and sustainability of practices.

The challenges associated with EHRs highlight the need for supportive policies that help physicians manage the costs and complexities of these technologies. The AMA supports efforts to simplify and streamline technological adoptions in health care, ensuring that innovations like EHRs and telehealth not only enhance patient care but also remain accessible and manageable for all physicians.

THE IMPACT OF PRIOR AUTHORIZATION ON PRIVATE PRACTICE PHYSICIANS

Prior authorization (PA) processes place significant administrative and time burdens on health care staff and physicians, profoundly affecting the operational efficiency and sustainability of private medical practices. This requirement for insurers to approve treatments before they can be administered not only delays diagnosis and treatment but also involves substantial paperwork and diverts critical resources and time that could be better spent on direct patient care.

The extensive administrative duties associated with managing PA requests typically require dedicated staff, increasing overhead costs for private practices. This scenario is particularly burdensome for smaller practices, which may not have the resources to handle such extensive administrative tasks efficiently. Practices often find themselves in a constant battle between managing care delivery and navigating bureaucratic insurance processes, leading to decreased efficiency and increased operational costs.

Moreover, the delays caused by prior authorizations can lead to serious health consequences for patients, including prolonged suffering and the progression of diseases. These delays not only undermine the quality of care provided but also damage the reputation of private practices, potentially leading to a loss of patient trust and business.

Adding to the challenges posed by prior authorization are the issues of payment clawbacks and retroactive denials, which can severely disrupt the financial stability of medical practices. The combination of the administrative burden of managing prior authorizations and the financial risk posed by clawbacks and retroactive denials highlight the need for comprehensive reform in the prior authorization process.

The cumulative impact of these challenges can be dire for private practices. Faced with mounting administrative burdens and the associated financial strain, many practices struggle to remain viable. The inefficiency and high costs can lead to the closure of practices that are unable to sustain operations amidst the demanding requirements of prior authorization processes. The Ways and Means Committee, however,

should be commended for passing legislation in both the 117th and 118th Congress, specifically the Improving Seniors' Timely Access to Care Act, which will address some of the negative aspects of prior authorization. Despite these past legislative actions, the urgent need for additional bills to streamline and more efficiently apply prior authorization remains. This type of legislative reform will ensure that private practices can continue to provide high-quality care without the overwhelming administrative load.

ELECTRONIC FUND TRANSFER (EFT) FEES AND REDUCING ADMINISTRATIVE BURDENS IN HEALTH CARE

The AMA recognizes the need to address financial and administrative inefficiencies that detract from our health care system's ability to serve rural and underserved communities effectively. A pressing issue in this context is the undue financial strain imposed on physicians and health care providers by unnecessary fees for Electronic Fund Transfers (EFTs).

The burden of EFT fees, as outlined in our support for S. 3805, the "No Fees for EFTs Act" in the Senate, and support for H.R. 6487, the corresponding House bill, highlights a significant barrier to the efficient operation of health care practices. These fees, which can range from two percent to five percent of the claim payment, are levied by some health plans and their vendors without explicit agreement from practices, thereby exacerbating the financial and administrative burdens on physicians. This issue is especially significant for health care providers in rural and underserved areas, where financial resources are already stretched thin, and administrative burdens can significantly impact the quality and accessibility of patient care.

By eliminating these predatory fees, the No Fees for EFTs Act would make a meaningful contribution toward reducing administrative complexities and preventing further erosion of financial stability, allowing physicians to allocate more resources towards patient care. In an era where every resource should be directed toward enhancing patient outcomes and accessibility, it is counterproductive to allow such financial inefficiencies to persist. We urge Congress to expeditiously pass this bill, which also falls in the jurisdiction of the Ways and Means Committee, so physicians can devote more resources to things like investment in telehealth and other forms of at-home care.

HEALTH CARE WORKFORCE

The decline in rural physicians and the challenges in graduate medical education directly contribute to the closure of private practices, particularly in rural areas. As fewer physicians choose to practice in these regions, compounded by an aging physician workforce and the insufficient creation of new residency positions, private practices struggle to sustain operations. This lack of medical professionals not only leads to closures but also diminishes health care access in communities that already face significant barriers to care. To prevent further closures and ensure continuous health care provision, it is essential to support the expansion of residency programs and provide incentives for physicians to work in under-served and rural areas. This strategic approach would help stabilize and potentially increase the number of operational private practices in these critical regions.

The AMA is in strong support of the Resident Physician Shortage Reduction Act of 2023 (H.R. 2389/ S. 1302), bipartisan legislation that addresses the escalating physician shortage in the United States This bill proposes to increase the number of Medicare-supported graduate medical education (GME) positions by 2,000 annually over seven years, totaling 14,000 new slots. To combat this, increasing the number of rural residency positions is essential. Studies show a significant retention of residents within the state or near their training location post-graduation. Despite this, the percentage of medical students from rural

backgrounds has declined sharply, contributing to the shortage of physicians willing to practice in these areas.

In addition to expanding the cap on GME slots, it is vital to extend the cap-building period for new and existing GME programs, especially in rural hospitals. This would allow these institutions more time to develop their programs and attract residents, helping to alleviate the physician shortage. Moreover, alleviating the debt burden through federal scholarships and loan repayment programs, increasing funding for programs like the Teaching Health Center Graduate Medical Education, and supporting rural training initiatives are essential steps.

PHYSICIAN BURNOUT

In addition, physician burnout is a significant factor contributing to the closure of private medical practices across the country. The relentless administrative burdens discussed throughout this statement, coupled with the high demands of clinical care, have led many physicians to experience severe stress and burnout, diminishing their capacity to operate their practices effectively. This chronic stress not only impacts the quality of patient care but also affects the financial viability of these practices.

The consequences of burnout extend beyond individual health issues and directly impact the operational stability of private practices. As more physicians opt to retire early, reduce their hours, or leave the profession altogether, the sustainability of private practices is severely threatened. This trend not only disrupts continuity of care for patients but also exacerbates health care access issues, particularly in underserved or rural areas where medical practices are already sparse.

CONCLUSION

The AMA implores Congress and all stakeholders to recognize the imminent and severe threats to independent medical practices. The fabric of our health care system, woven with the dedication and expertise of these practices, is unraveling under the compounding pressures of unsustainable financial models, burdensome regulations, and systemic inequities. We urge immediate and decisive action to correct the course with comprehensive legislative reforms that ensure equitable payment models, reduce administrative burdens, expand support for rural and underserved areas, and secure our health care infrastructure against emerging threats.

The AMA and physician community stand ready to work with Congress to preserve the legacy and future of independent physician practices, ensuring that they continue to provide high-quality, personalized care to all communities across the nation. This is not just a call for action; it is a plea to safeguard the heart of American health care before it is too late.

Statement for the Record

Submitted by APTA Private Practice

to

U.S. House Ways & Means Health Subcommittee

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

May 23, 2024

APTA Private Practice
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On behalf of the almost 4,000 members of APTA Private Practice, a section of the more than 100,000-member American Physical Therapy Association (APTA), we appreciate the opportunity to submit the following Statement for the Record to the U.S. House Ways & Means Health Subcommittee as part of the hearing entitled; "The Collapse of Private Payment: Examining the Challenges Facing Independent Medicine."

As experts in rehabilitation, prehabilitation, and habilitation, physical therapists (PTs) play a unique role in society in prevention, wellness, fitness, health promotion, and management of disease and disability for individuals across the age span. Physical therapists help individuals improve their overall health and prevent the need for avoidable health care services. Like others who took a chance to work in the private practice sector of health care, our membership owns, operates, and works in private practice settings. APTA private practice members put their patients first, while also taking on the role of business owners, with expertise in management, billing, and marketing, amongst a long list of other non-clinical tasks.

Physical therapists face unique challenges under the Medicare Physician Fee Schedule (MPFS). Physical therapists and physical therapist assistants (PTAs) play a critical role in the delivery of services to beneficiaries who have chronic care conditions; however therapists and other non-physician providers who are paid under the MPFS are often overlooked when it comes to enacting meaningful reforms to payment and administrative burden challenges.

We are dedicated to working with you to make changes in order to keep our members in business and continuing critical access to physical therapy services for Medicare beneficiaries. As we outline below, there are common sense policy changes we can achieve to address the barriers PTs are continuously facing as it relates to inadequate payment, administrative burden, workforce challenges, and anti-competitive business practices.

Inadequate Medicare Payment

Over the last three years, therapy providers have received some of the largest cuts of any health care provider as a result of budget neutrality policies. At the same time, therapy providers are subject to legacy reductions to payment for services that date back to the days of the sustainable growth rate (SGR) formula, excessive administrative costs, and lack of opportunities to participate in innovative and value-based programs.

The financial pressures of declining Medicare payments and escalating administrative burdens are impacting practices and their patients. In a survey of our membership this year, private practice PTs had to make difficult decisions in order to avoid complete financial ruin by doing the following: closing clinics, reducing clinic hours, and/or waitlisting patients. As physical therapy is not an acute service, patients with limited access may see furthering decline in their condition and may not easily be able to find a convenient alternative for ongoing care. We believe there is a better way forward in order to not hinder patient care and bankrupt private practices.

Reform the Medicare Physician Fee Schedule

Providers under the MPFS do not receive the annual inflationary update which virtually all other Medicare providers can rely on to better weather periods of fiscal uncertainty. Providing an annual inflationary payment update to the MPFS' conversion factor (CF) based on the Medicare Economic Index (MEI) will provide much-needed stability to the Medicare payment system. The MEI is a measure of inflation faced by health care providers with respect to their practice costs and general wage levels.

Health care providers, including physical therapists, continue to face increasing challenges as they seek to provide Medicare beneficiaries with access to timely and quality care. Congress has taken action to mitigate some of the recent Medicare Fee Schedule cuts on a temporary basis, nevertheless, reimbursement continues to decline.

The failure of the MPFS to keep pace with the true cost of providing care, combined with year-over-year cuts resulting from the application of budget neutrality, sequestration, and the lack of opportunity for positive payment adjustments through the Quality Payment Program (QPP), clearly demonstrates that the fee schedule is broken. Increasingly thin operating margins disproportionately affect small, independent, and rural practices, as well as those treating low-income or other historically under-resourced or marginalized patient communities.

An inflationary update will provide budgetary stability to clinicians - many of whom are small business owners– as they contend with a wide range of shifting economic factors such as increasing administrative burdens, staff salaries, office rent, and purchasing of essential technology. Providing an annual inflation update equal to the MEI for fee schedule payments is essential to enabling practices to better absorb payment distributions triggered by budget neutrality rules, performance adjustments, and periods of high inflation. It will also help providers invest in their practices and implement new strategies to provide high-value care. We support and encourage the Subcommittee to consider H.R. 2474, Strengthening Medicare for Patients and Providers Act led by Representatives Raul Ruiz, MD (CA-25), Larry Bucshon, MD (IN-08), Ami Bera, MD (CA-06), and Mariannette Miller-Meeks, MD (IA-01).

Eliminate an Outdated and Flawed Therapy-Specific Medicare Payment Policy

The Multiple Procedure Payment Reduction (MPPR) policy was first implemented in 2011 and applies to physical therapy, occupational therapy, and speech-language pathology services provided under Medicare Part B. Because of MPPR, when therapists bill more than one "always therapy" service (identified by the Current Procedural Terminology (CPT) code) on the same day for the same patient, all therapy services beyond the first are subject to a reduction in the practice expense portion of that code. Under this policy, the therapy service with the highest practice expense value is reimbursed at 100%, and the practice expense values for all subsequent therapy services, provided by all therapy providers, are reduced by 50%. The work and malpractice components of the therapy service payment are not reduced.

In the 2011 MPFS, the Centers for Medicare & Medicaid Services (CMS) first proposed the implementation of a 25% MPPR across therapy services. Congress reduced this reduction

amount to 20% in the Physician Payment and Therapy Relief Act of 2010 (H.R. 5712). This 20% MPPR was in place from January 1, 2011 to March 31, 2013. Without any further analysis demonstrating a need to increase the MPPR, Congress implemented a permanent 50% MPPR in the American Taxpayer Relief Act of 2012, which was implemented by CMS on April 1, 2013. The average payment per therapy claim in 2013 (after MPPR) was 8.5% less than the average therapy claim in 2010 (before MPPR).

The American Physical Therapy Association, APTA Private Practice, American Occupational Therapy Association, and the American Speech-Language-Hearing Association have opposed the MPPR policy since its inception. It is inherently flawed, because the American Medical Association RVS Update Committee (RUC), which assigns values to CPT codes, already ensures that any potential duplication in work or practice expense is addressed as part of the code valuation process. Certain efficiencies that occur when multiple therapy services are provided in a single session were explicitly taken into account when relative values were established for these codes.

The application of MPPR to the "always therapy" codes results in an excessive and duplicative reduction of these codes and is having a significant impact on the financial viability of therapy practices, and ultimately impacting access to vital therapy services. The percentage of payment reduction was arbitrarily decided and does not reflect actual utilization data regarding how many units of a therapy service are typically delivered in a treatment session, and it does not recognize that PT, occupational therapy (OT), and Speech-Language Pathology (SLP) interventions are separate and distinct from each other.

MPPR also applies across therapy disciplines delivered on the same date regardless of the distinct services and supplies provided to the patient. While the first therapy discipline would receive payment under MPPR at 100% for the first unit and 50% of the practice expense for all other units, a second or third discipline delivering services on that date would have all provided service units reduced. This occurs even though the equipment, clinical staff, and supplies utilized for one therapy service have no overlap with the other services provided.

This policy penalizes providers when scheduling multiple therapies on the same date which disproportionately affects beneficiaries in rural and underserved communities where transportation issues may require therapy services to be delivered on the same day to reduce the need for repeat visits to the clinic to receive separate therapy discipline services. We encourage the Subcommittee to fix this outdated law to provide fair relief to therapy providers.

Allow Medicare Patients Choice in Their Therapy

Currently, PTs, OTs, and SLPs may not opt out of being Medicare-enrolled providers if they provide services to Medicare-eligible beneficiaries. Opting out of Medicare to allow for direct contracting with patients, a practice afforded to other providers, would ultimately improve access to care, rather than have therapy providers refuse Medicare patients due to reimbursement challenges noted above. To provide true patient choice and ensure access to the most appropriate care, PTs, OTs, and SLPs must be able to opt out of the established enrollment rules set by the Medicare program. Other providers, including physicians, physician assistants, dentists, podiatrists,

optometrists, social workers, psychologists, nurse midwives, dietitians, and other eligible providers already have this right. Therapists should have the same rights as other health care providers in this regard.

Denying a patient access to a therapist with expertise because that provider is not enrolled in Medicare can also negatively impacts patients' clinical outcomes. It is imperative that Medicare enrollees have the opportunity to choose the most appropriate provider and model of care to meet their needs. Medicare's inflexible policies have stifled implementation of innovative programs that can support the long-term health and wellness of Medicare beneficiaries. Certain evidence-based therapy interventions cannot be reimbursed under current Medicare payment policies.

Allowing therapy providers to opt out would give Medicare beneficiaries the opportunity to benefit from these critical interventions to which they are currently denied access. According to an independent report published by Dobson & Davanzo in October 2023, allowing physical therapists, occupational therapists, and speech-language pathologists to opt-out is estimated to save the federal government $139.6 million over ten years.

Administrative Burden

Given the current pressures on therapy providers, we are united in seeking opportunities to reduce administrative burden without compromising patient safety or quality of care as a way to mitigate the impact of these payment cuts for therapy providers and our physician colleagues, as well as to best serve our patients expeditiously and without financial risk to their therapist providers.

Reform Medicare Advantage Prior Authorization

Prior authorization frequently results in administrative burdens for providers which diverts precious time away from patient care and delays approval for necessary physical therapy services. It is not uncommon for therapists to follow all required guidelines from a Medicare Advantage (MA) plan and still receive rejections. Furthermore, it is not clinically appropriate to ration care solely based upon the volume of services. In many cases, the patient understands that delaying care may severely hinder their recovery, but is wholly unaware of the presence of prior authorization and utilization management hurdles that result in physical therapists and other providers being forced to decide between furnishing an uncovered service at their own expense or risk the patient's health and well-being by waiting for a plan to authorize medically necessary care. We look forward to working with the Subcommittee on new legislation this Congress to address these concerns.

Create a Sensible Plan of Care

Medicare Part B guidelines permit Medicare beneficiaries to receive therapy evaluation and treatment services with or without a physician order. The PT, OT, or SLP may evaluate that patient, formulate a plan of care, and commence treatment. However, under current certification requirements, the therapy provider must submit the plan of care to the patient's physician and have it signed within 30 days in order to receive payment. The time and resources spent by both

therapists and physicians in procuring a timely signature adds unnecessary cost, potentially delays essential services, and fails to contribute to improved quality of care.

We support and encourage the Subcommittee to consider H.R. 7279, the Remove Duplicative Unnecessary Clerical Exchanges (REDUCE) Act, bipartisan legislation led by Representatives Lloyd Smucker (PA-11) and Don Davis (NC-1). This policy would clarify a new care coordination model such that when outpatient therapy services are provided under a physician's order, the plan of care certification requirements shall be deemed satisfied if the qualified therapist submits the plan of care to the patient's referring physician within 30 days of the initial evaluation. The order would confirm the physician's awareness of the therapy episode and proof of submission of the plan of care would demonstrate the coordination and collaboration between the physician and the therapist.

For a physician who ordered therapy services, they would have 10 business days after receiving the plan of care to modify it. When a patient began therapy services without an order, the receiving physician would have 30 calendar days to modify the plan of care.

Align Supervision Requirements of PTAs Across Medicare

Medicare allows for general supervision of physical therapy assistants by PTs, and occupational therapy assistants (OTAs) by OTs, and in all settings, except for outpatient private practice under Medicare Part B, which requires direct supervision. Medicare doesn't even require PTAs practicing in intensive care units (ICUs) to have direct supervision – general is sufficient.

While therapy providers must comply with their state practice act if state or local practice requirements are more stringent than Medicare's, the standard in 48 states is general supervision of PTAs and OTAs, making this outdated Medicare regulation impacting only private practices more burdensome than almost all state requirements. Standardizing a general supervision requirement for private practices will help ensure continued patient access to needed therapy services and give small PT private practices more workforce flexibility to meet the needs of beneficiaries.

We support and encourage the Subcommittee to consider H.R. 4878, the Enabling More of the Physical and Occupational Workforce to Engage in Rehabilitation (EMPOWER) Act led by Representatives Debbie Lesko (AZ-8) and Annie Kuster (NH-2). This policy addresses the problem by enacting language to change the Medicare supervision requirement for PTAs and OTAs in private practice from direct to general supervision in states with licensure laws that allow for it.

This legislation would also direct the Government Accountability Office (GAO) to conduct an analysis of how the Medicare Part B 15% payment differential for services provided by PTAs and OTAs, which went into effect in 2022, has impacted access to physical therapy and occupational therapy services in rural and medically underserved areas, across all Medicare Part B settings. Beneficiaries in those areas are twice as likely to receive PT or OT services from an assistant. The GAO report will make it clear whether this payment differential is disproportionately impacting these regions.

According to an independent report published by Dobson & Davanzo in September 2022, this change in supervision is estimated to save the federal government $271 million over 10 years.

Allow Uninterrupted Access to Physical Therapy

The ability to bring in a replacement provider during a provider's temporary absences for illness, pregnancy, vacation, or continuing medical education is known as locum tenens.

The 21st Century Cures Act of 2016 contained a provision that added physical therapists to the health care professionals who may use locum tenens under Medicare. This allows a physical therapist to bring in another licensed physical therapist to treat Medicare patients and bill Medicare through the practice provider number during temporary absences. The law, however, applies only to physical therapists in non-Metropolitan Statistical Areas, Medically Underserved Areas (MUAs), and Health Professions Shortage Areas (HPSAs) as defined by the U.S. Department of Health and Human Services (HHS). This limitation prohibits many physical therapists in private practice from taking needed absences without interrupting patient care. Locum tenens arrangements are beneficial to both patients and providers, as care is continued by another licensed, qualified provider during a temporary absence.

We support and encourage the Subcommittee to consider H.R. 1617, the Prevent Interruptions in Physical Therapy Act of 2023 led by Representatives Gus Bilirakis (FL-12) and Paul Tonko (NY-20). This legislation would enable all physical therapists to utilize locum tenens arrangements under Medicare regardless of the geographic area or population served.

Workforce Challenges

The constant downward pressure on reimbursement and various administrative burdens has had a significant impact on physical therapist and physical therapist assistant workforce issues. In October 2023, APTA Private Practice and APTA released a joint report, "APTA Benchmark Report: Hiring Challenges Continue in Outpatient Physical Therapy Services."[i] The report calls for expanded need for PTs in the outpatient setting. Over 22,000 PT providers left the profession during the COVID-19 pandemic leaving a void for clinics seeking to hire qualified physical therapists, especially in rural settings.

The vast majority of practices reported openings of at least 5%, with a 10.1% total vacancy rate across all employee categories (physical therapists, physical therapist assistants, and support personnel). This was down from the 2022 report of a 16% total vacancy rate.

While the overall vacancy rate was lower in 2023 compared with 2022, hiring challenges are increasing for many practices. Almost 40% of practices with openings are facing a higher vacancy rate now than they did last year. The distribution of vacancy rates varies by position type, clinic size, and location. Company growth was the most frequently cited reason for current position openings, pointing to a greater need overall for physical therapist services.

As private practice PTs, we compete with a multitude of settings for talent and more often than not, we are unable to compete financially with larger health care systems who can provide higher salaries. This problem is magnified when attempting to staff clinics in rural areas.

Anti-Competitive Business Arrangements

Rapid consolidation and vertical integration in health care has led to anti-competitive business arrangements that limit patient choice, increase cost, and create an unlevel playing field for private practitioners. A study reported in JAMA Health Forum in September of 2023 supports our members' reality by concluding that primary care physicians in large health systems steer patients to their health system resulting in increased costs of care.[ii] Often using physician incentives to minimize the "leakage" of referrals that go outside their system. We encourage and support legislation that re-levels the playing field for providers and ensures all patients have real choice in the care they need.

Conclusion

The pressure on private practice health care is impacting all providers, not just physicians. When faced with year after year payment cuts, the inability to keep staff, the administrative burdens we bear from Medicare, all while trying to provide the best care we can for our patients, it's not difficult to imagine a scenario where access to care is lost or further consolidation is realized. We are determined to find a way forward to make things better for PT private practices and our patients. We look forward to working with you on the unique challenges our members face.

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[i] https://www.apta.org/news/2023/10/18/vacancy-report-2023

[ii] JAMA Health Forum, Anna D. Sinaiko, PhD; Vilsa E. Curto, PhD, Katherine Ianni, BA; et al., Utilization, Steering, and Spending in Vertical Relationships Between Physicians and Health Systems, September 1, 2023. https://jamanetwork.com/journals/jama-health-forum/fullarticle/2808890

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Statement prepared for:
U.S. House of Representatives Committee on Ways & Means
Health Subcommittee

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

May 23, 2024

The Association for Clinical Oncology (ASCO) is pleased to submit this statement for the record of the hearing entitled, "The Collapse of Private Practice: Examining the Challenges Facing Independent Medicine." ASCO appreciates the Committee holding today's hearing to discuss financial and regulatory burdens facing independent medical providers, including oncologists.
ASCO is a national organization representing nearly 50,000 physicians and other health care professionals who care for people with cancer. ASCO members are dedicated to conducting research that leads to improved patient outcomes and are also committed to ensuring that evidence-based practices for the prevention, diagnosis and treatment of cancer are available to all Americans.

Independent physician practices are increasingly closing due to the dual pressures of administrative burdens and inadequate Medicare payment policies. The administrative demands, including complex documentation requirements, billing procedures, and compliance with numerous Medicare regulations, consume substantial time and resources that could otherwise be devoted to patient care. These burdens are exacerbated by the financial strain imposed by insufficient Medicare reimbursements, which often fail to cover the costs of providing care. Consequently, many private practices find it unsustainable to operate, leading to closures or mergers with larger healthcare systems that can better absorb these challenges. This trend undermines the autonomy of private practitioners and reduces patient access to personalized, community-based medical care.

Prior Authorization

An ongoing source of frustration across the oncology care team, in all practice settings but particularly burdensome among independent practices, is payer-mandated prior authorization requirements. ASCO recently published the results of a survey of its U.S. members to assess the impact of prior authorization on cancer care.

Nearly all participants reported that patients had experienced harm due to prior authorization mandates, including significant impacts on patient health such as disease progression (80%) and loss of life (36%). The most widely cited harms to patients reported were delays in treatment (96%) and diagnostic imaging (94%); patients being forced onto a second-choice therapy (93%) or denied therapy (87%); and increased patient out-of-pocket costs (88%).

The survey also reflected the burden on providers from the prior authorization mandates. Nearly all respondents report experiencing burdensome administrative requirements, delayed payer responses, and a lack of clinical validity in the process. The survey also found that, on average:

- It takes a payer five business days to respond to a prior authorization request.
- A prior authorization request is escalated beyond the staff member who initiates it 34% of the time.
- Prior authorizations are perceived as leading to a serious adverse event for a patient with cancer 14% of the time.
- Prior authorizations are "significantly" delayed (by more than one business day) 42% of the time.

Over the past several years, Members of Congress have become increasingly concerned about the use of prior authorization in MA plans. The House of Representatives unanimously passed the *Improving Seniors' Timely Access to Care Act* (S. 3018/H.R. 3173) in September 2022. This bipartisan legislation, developed with input from ASCO, finished the 117th Congress with 380 combined cosponsors — 53 senators and 327 representatives — supporting the legislation. Importantly, more than 500 organizations representing patients, health care providers, the medical technology and biopharmaceutical industry, health plans, and others endorsed the legislation. We anticipate the legislation will soon be reintroduced in the 118th Congress, and if passed, would codify the CMS final rule on electronic prior authorization, improving beneficiary access to access to necessary and lifesaving services and ease the administrative burden on physicians and payers.

Step Therapy

Step therapy is a utilization management tactic often referred to as "fail first," where patients are required by their insurance provider to try and fail medications chosen by a payer before the payer will cover the medication originally prescribed by the patient's health care provider. Step therapy policies are generally inappropriate for use in oncology due to the individualized nature of modern cancer treatment and the lack of interchangeable clinical options. Step therapy can lead to disease progression and irreversible damage to a cancer patient's health, undermines and threatens the doctor-patient relationship, and further exacerbates health inequities. This process not only limits the physician's ability to tailor treatments based on individual patient needs and clinical judgment but also consumes valuable time and resources. Doctors must navigate extensive paperwork, frequent communication with insurance companies, and often lengthy appeals processes to justify the need for prescribed medications. This administrative load detracts from direct patient care and can delay the initiation of the most effective treatment, potentially compromising patient outcomes and increasing frustration for both patients and healthcare providers.

ASCO has endorsed the *Safe Step Act* (H.R. 2630/S. 652), led by Representatives Brad Wenstrup (R-OH), Raul Ruiz, MD (D-CA), Mariannette Miller-Meeks, MD (R-IA) and Lucy McBath (D-GA) and Senators Lisa Murkowski (R-AK), Maggie Hassan (D-NH), Roger Marshall, MD (R-KS), and Jacky Rosen (D-NV). This legislation puts important patient safeguards from step therapy protocols in place for ERISA-governed

health plans by requiring exceptions when the treatment is contraindicated, expected to be ineffective, likely to cause adverse reaction, or the patient is stable on treatment already selected.

ASCO urges Congress to pass the *Safe Step Act* to ensure that patients have access to effective and timely treatments, and that physicians are able to decide the right treatment for their patients at the right time.

Copay Accumulators

In addition to prior authorization and step therapy, copay accumulators are another utilization management technique that has a negative impact on independent providers, their practices, and their patients.

In recent years, health insurance companies, employers, and pharmacy benefit managers (PBMs) have shifted costs for specialty prescription medicines to patients. To help patients afford the cost of their prescriptions, pharmaceutical manufacturers or charitable organizations often offer copayment assistance, which can reduce or eliminate the patient share of payment for medications. This has led to a rise in insurers and PBMs implementing "copay accumulator" programs, which can negate the intended benefit of patient assistance programs, remove a financial safety net for patients who need specialty medications, and result in increased out-of-pocket costs and poorer health outcomes.

Copay accumulators prevent patient assistance funds from applying toward a patient's annual out-of-pocket maximum or deductible, lack transparency, increase costs for patients, result in poorer health outcomes, and increase administrative burden for providers.

The *Help Ensure Lower Patient (HELP) Copays Act* (H.R. 830/S. 1375), led by Representatives Buddy Carter (R-GA-1), Nanette Diaz Barragan (D-CA-44), Mariannette Miller-Meeks, MD (R-IA-1), and Diana DeGette (D-CO-1) and Senators Tim Kaine (D-VA) and Roger Marshall, MD (R-KS), would prohibit the use of copay accumulators and require health plans and PBMs to count the value of copay assistance toward a patient's cost-sharing requirements. ASCO urges Congress to pass the *HELP Copays Act* to protect patients from harmful insurance and PBM practices that raise patient out-of-pocket drug costs.

Physician Burnout

Oncology care teams face significant clinician burnout, leading to early retirement or individuals leaving the field. Burnout in oncology has been linked to provider shortages and the increased demand for health care services from an aging population. Providers of all types, including independent, report stress and burnout directly stemming from increased administrative and financial burdens from payer policies, such as prior authorization, step therapy, and copay accumulator programs.

To address burnout and support independent practices, ASCO supports reauthorization for programs authorized under the *Dr. Lorna Breen Health Care Provider Protection Act* (H.R. 7153/S. 3679) that aid physicians in combatting and coping with burnout in the workplace. ASCO also recommends enactment

of policy solutions to address administrative burdens, which impede the delivery of quality patient care and lead to burnout.

Physician Payment Reform

ASCO supported the passage of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) as a replacement for the flawed Sustainable Growth Rate (SGR) formula for Medicare physician reimbursement. Since its enactment, ASCO has provided extensive education to its members as well as significant input to the Centers for Medicare and Medicaid Services (CMS) around necessary refinements to the program to ensure its efficacy in the agency and for Medicare beneficiaries they serve. Unfortunately, physicians still face the same uncertainty MACRA was intended to address – financial instability within the Medicare payment system.

In repealing the SGR, MACRA specified a 0% update to the Medicare Physician Fee Schedule (MPFS) Conversion Factor (CF) for a period of six years, followed by a 0.25% annual increase for Merit Based Incentive Payments System (MIPS) participants and a 0.75% annual increase for Advanced Alternative Payment Model (APM) participants thereafter. While Congress provided temporary relief in 2021 and 2022, physician reimbursement was cut in 2023 and again in 2024. In the Consolidated Appropriations Act of 2024, passed on March 9, 2024, Congress included a +1.68% adjustment to the MPFS CF for the remainder of 2024. This increase resulted in a 1.68% reduction to the 3.37% CF. This did not apply retroactively, with claims with dates of service prior to March 9 reimbursed using the original conversion factor.

Failure of the MPFS to keep up with increasing labor, supplies, rent, and other practice expenses influences a growing site-of-service shift from independent physician practices to off-campus outpatient hospital departments paid for by the Outpatient Prospective Payment System (OPPS). Rather than addressing the lack of sufficient payment under the MPFS, Congress directed CMS to reduce payments to new off-campus outpatient hospital departments, thereby encouraging further shifts into on-campus departments. Instead of encouraging value-based care, this consolidation results in reduced beneficiary access to community-based healthcare services. Congress must ensure that future payment updates within the MPFS are sufficient to sustain beneficiary access to community-based physician care.

While we appreciate Congress' efforts to help stabilize physician payment, ASCO hopes to see a longer-term solution. We strongly support and encourage lawmakers to support the *Strengthening Medicare for Patients and Providers Act* (H.R. 2474). This legislation aims to provide an annual update to a single conversion factor under the MPFS that is based on the Medicare Economic Index (MEI). This inflationary increase will help providers keep up with rising healthcare costs. Moreover, ASCO supports the *Providing Relief and Stability for Medicare Patients Act of 2023* (H.R. 3674) and the *Provider Reimbursement Stability Act of 2023* (H.R. 6371), legislation that would increase resources across all Medicare service codes. Following the initial increase, the fee schedule would see annual adjustments based on the MEI. ASCO appreciates the inclusion of the provision to update direct costs associated with practice expense relative value units (RVUs) once every five years. Lastly, both bills would address

over- and under-utilization estimates, which impacts budget neutrality in the MFPS. These consistent investments in Medicare services are crucial to the vitality of our profession and the quality of care we provide.

MIPS Budget Neutrality and the Exceptional Performance Bonus

For performance year 2021, there were a total of 954,664 MIPS-eligible clinicians under the Quality Payment Program (QPP) MIPS track.[1] Of that total number, 951,744 (99.7%) avoided a negative payment adjustment. Almost 84% achieved exceptional performance and earned positive payment adjustments ranging from +0.09% to +1.79%. Only those clinicians scoring high enough to earn an exceptional performance bonus actually received any positive payment adjustment. Clinicians who received a positive score, but did not reach the exceptional threshold, received a payment adjustment of 0% due to the budget neutrality requirement of MIPS as established by MACRA (i.e., absent the "exceptional performance" bonus, the number of negative adjustments equals the number of positive adjustments). As only 0.31% of clinicians received a score below the threshold (and received a 7% penalty), the only real source for a positive payment adjustment came from the $500 million annual "exceptional performance" bonus. With the sunsetting of the ability to earn this bonus in performance year 2022, it is very likely that high-scoring clinicians participating in MIPS going forward will receive little to no positive adjustment through MIPS; this is compounded by the 0% statutory update to the MIPS track until 2026 and the lack of an inflationary update to the MPFS.

When the MIPS track of the QPP was originally envisioned, it was thought that a budget-neutral system would provide rewards to high performers, while penalizing low performers. Experience has shown us that small and rural practices disproportionately bear the burden of growing penalties, which in the aggregate are far too small to result in any meaningful distribution to higher performers. The budget-neutral nature of MIPS should be re-examined, as should the exceptional performance bonus. We urge the Subcommittee to consider legislation to not only address budget neutrality in the MPFS as outlined above but also in MIPS.

Provider Participation in APMs

MACRA provided for a time-limited, annual payment incentive to Qualifying APM Participants (QPs) equal to 5% of estimated aggregate payment amounts for covered professional services. The incentive payment was intended to encourage participation in advanced APMs and has been critical in assisting physicians to develop the infrastructure necessary for the transition to value-based payment models.

Unfortunately, the combination of a lack of specialty-specific advanced APMs, financial uncertainty throughout the COVID-19 pandemic, and delays in the rollout of certain APMs (e.g., Oncology Care First, now named Enhancing Oncology Model) has resulted in many physicians being unable to qualify for this incentive. The payment incentive for advanced APMs was extended by 1.8% under the Consolidated

[1] 2021 Quality Payment Program Experience Report. Available at: https://qpp-cm-prod-content.s3.amazonaws.com/uploads/2433/2021%20QPP%20Experience%20Report.pdf

Appropriations Act of 2024. While we appreciate Congress' efforts to ensure providers can successfully participate in value-based payment models in the short-term, longer-term solutions are necessary to address the incentive gap we are nearing. Specifically, we encourage Congressional support for the *Value in Health Care Act of 2023* (S. 3503/H.R. 5013) to extend incentive payments for eligible APMs for an additional 2 years. Additionally, Congress should consider long-term solutions, beyond the 5-year cap outlined in the legislation to ensure financial stability in the program.

Further, to qualify for the APM incentive, physicians must meet either the Medicare Payment Threshold Option or Medicare Patient Threshold Option. These thresholds are meant to ensure that physicians meaningfully participate in alternative payment models. Many specialty physicians will find it difficult to qualify under the currently specified thresholds. For example, oncologists who participate in a Medicare Shared Savings Program (MSSP) Accountable Care Organization (ACO) naturally have lower payment and patient threshold scores due to receiving referrals from primary care physicians outside of the ACO. As a result, many ACOs are considering whether to remove specialists from their participating physician lists so that the remaining physicians may be deemed QPs.

Even within specialty-specific models, specialists may find that the limited scope of models- the EOM includes only seven cancer types- makes it difficult to meet the specified thresholds. Congress should extend the current 50% payment threshold and 35% patient threshold and should also direct CMS to remove barriers to participation in multiple APMs, such as allowing a single practice (identified by a Tax Identification Number) to participate in multiple ACOs.

Conclusion

Thank you for your commitment to improving the current regulatory and financial burdens facing oncologists to ensure patient access to care. ASCO stands ready to serve as a resource as you continue this much needed dialogue. Please contact Kristine Rufener at Kristine.Rufener@asco.org with any questions.

Association for Clinical Oncology

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Statement for the Record

of the

College of American Pathologists

United States Senate Finance Committee

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

June 5, 2024

Chairman Jason Smith
Ways and Means Committee
Washington, DC 20515

Ranking Member Richard Neal
Ways and Means Committee
Washington, DC 20515

Dear Chairman Smith and Ranking Member Neal:

The College of American Pathologists (CAP) appreciates the opportunity to share our views with the Committee regarding challenges facing independent medicine. As the world's largest organization of board-certified pathologists and leading provider of laboratory accreditation and proficiency testing programs, the CAP serves patients, pathologists, and the public by fostering and advocating excellence in the practice of pathology and laboratory medicine worldwide.

Although patients may never meet the pathologist on their care team, they can be assured that these physicians deliver quality patient care at every step. On any given day, pathologists in hospitals and private practices impact nearly all aspects of patient care, from diagnosing cancer to managing chronic diseases such as diabetes through accurate laboratory testing. Pathologists ensure laboratory quality so that diagnostic testing is safe and accurate. Often, they guide primary care and other doctors, determining the right test, at the right time, for the right patient. The influence of pathology services on clinical decision-making is pervasive and constitute a critical infrastructure and foundation of clinical medicine.

However, despite this critical role, pathologists are facing increasing pressures – both financial and regulatory/administrative – that threaten the financial viability of pathology practices and the ability of pathologists to provide care for patients. As a result, seventy-two percent of pathology practice leaders, according to the CAP's Practice Leader

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Survey,[1] reported that their practice experienced a detrimental effect due to decreased reimbursement rates of pathology services over the last five years. For example, 35% reported an inability to fund an adequate number of pathologists and/or other laboratorians, 26% reported increased turn-around time for pathology reports, and 9% had to decrease or completely discontinue some on-site pathologist services at one or more hospitals.

Further, our members are seeing more examples of insurance companies dictating medical decisions with the primary goal of boosting revenue under the guise of controlling costs – and there is little pathology practices can do to combat this. As you know, the health insurance industry is a highly consolidated one, and in recent years insurers have increasingly flexed their market power to impose rate cuts and other burdens on pathologists. According to an American Medical Association (AMA) report on competition in health insurance, in 90% of metropolitan service area-level markets, at least one insurer had a commercial market share of 30% or greater, and in 48% of markets, a single insurer's share was at least 50%.[2] Insurer consolidation and the instability within the health care marketplace more broadly is often cited as a reason for the merging/consolidation of physician practices. The goal being to gain negotiating power and respond to capital expenditures and other costs[3].

For pathology, the impact of these unstable market trends is illustrated in the CAP's Practice Leader Survey Report, in which about one-quarter of pathology practice leaders reported that their physician clients have been acquired by a corporation or health care system (26%), of whom 59% reported that the acquisition of their clients had a negative impact on their pathology practice.

At the same time, pathologists must also expend time and resources to meet billing and reporting requirements that are exacerbated by the Medicare Access and CHIP Reauthorization Act's (MACRA) incredible complexity. MACRA was originally passed to end a cycle of Medicare payment cuts and reward value-based care, yet today we are faced with continued financial instability within the Medicare physician payment system and value-based care that is not incentivized or attainable for most physicians. On top of that, consider the instability within the Medicare Physician Fee Schedule (PFS), numerous other state and federal rules, electronic health records and utilization management programs, and it is no surprise that there is a national burnout rate of more than 50 percent among physicians at a time when health care system is facing a critical shortage of physicians.

To ensure that physicians can remain in practice, we need to combat insurer consolidation and provide Medicare payments that are predictable and stable. It is imperative that Congress invest in physicians today and the workforce of tomorrow. Now

[1] Practice leaders are those in leadership or administrative roles with specific knowledge of the practice's financial, operational, and billing information.

[2] https://www.ama-assn.org/system/files/competition-health-insurance-us-markets.pdf

[3] https://www.healthcarevaluehub.org/advocate-resources/publications/addressing-consolidation-healthcare-industry

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more than ever, patients should be able to rely on the expertise of pathologists and the availability of appropriate testing.

Combating Private Payer Challenges

Recently, our members have reported increasing requirements from insurers that result in fractured care, which by its nature disrupts health care quality and adds unnecessary burden for patients and their physicians. For example, insurers are increasingly steering patient care to preferred providers outside the hospital or health system, which prevents the local pathologist from participating in care coordination at the time of initial diagnosis or correlating these critical initial findings with subsequent surgical specimens obtained in the hospital. As we recently explained to Horizon Blue Cross Blue Shield in New Jersey (Attachment 1), for patients who live further away from the health system/hospital, returning to receive care after the results have been returned may be difficult, and more likely to result in delayed care and compromised health outcomes. It should be up to the patient and their doctor to determine where diagnostic services occur, with the common goal of delivering the best outcome.

As this trend grows, it will likely lead to an overall increase in cost as cases will more frequently be requested for second review at the treating facility, which could lead to additional delays in care. We also have serious concerns about increasing prior authorization and utilization management policies that have the potential to inappropriately limit physician and other health care provider decision-making in the provision of patient care. As we explained to Wellmark[4] in Iowa and South Dakota, exclusion criteria will likely compromise establishment of the correct diagnosis in many cases.

Health insurance plans are also slashing reimbursement across the board – or ceasing reimbursement for critical services altogether – without any individual physician/practice consideration, leaving many pathologists in serious financial jeopardy. Blanket rate cuts that lower reimbursement below the cost to provide the services may benefit a select few laboratories and cut costs for the payer, but they threaten the financial viability of many smaller or rural laboratories and pathology practices. Furthermore, the recent Change Healthcare cyberattack is further straining resources and threatening private practices around the country.

Ensuring Sustainable Provider Financing

Inflationary Update

Over the last 5 years payments to pathologists have decreased by approximately 4.6 percent, while physician practice costs (medical supplies, lab personnel costs, professional liability insurance) have increased by nearly 13.8 percent. In 2024 alone, pathologists are anticipated to experience a net 5.7 percent reduction in Medicare Physician Fee Schedule reimbursement as payments are expected to fall by close to 1.1 percent while expenses are expected to increase by over 4.6 percent. The lack of an

[4] https://documents.cap.org/documents/Wellmark-Letter-v.3.pdf

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annual inflationary update for pathologists, especially those that operate small businesses, compounds the wide range of shifting economic factors impacting the practice of pathology, such as increasing administrative burdens, staff salaries, office rent, and purchasing of essential technology when determining their ability to provide care to Medicare patients. The absence of an annual inflationary update, combined with the physician fee schedule's statutory budget neutrality requirements and ongoing Medicare payment cuts, further compounds the difficulties pathologists face in managing resources to continue caring for patients in their communities. **Therefore, the CAP requests that the Committee pass legislation to provide an inflationary update to the Medicare Physician Fee Schedule.**

Budget Neutrality

Budget neutrality is another barrier to achieving high-quality, high-value health care. These requirements lead to arbitrary reductions in reimbursement unrelated to the cost of providing care and lead to an unpredictable reimbursement system from year to year. The CAP acknowledges that budget neutrality is a politically appealing option to control rising health care costs. However, the CAP urges Congress to think more creatively and expansively about ways to manage health care costs which do not generate such significant instability for health care providers, threatening beneficiary access to essential health care services.

Because of the continuous reimbursement cuts caused by the physician fee schedule's budget neutrality requirements and the lack of an inflationary update, the cost of providing patient care is becoming unsustainable. As costs exceed revenues, laboratory workforce shortages will worsen, labs will close or consolidate, and/or pathologists will retire. The result: increased wait times in the emergency department, longer time before receiving a diagnosis of cancer, potential for increased errors in testing and delays in specimen collection and turnaround time for laboratory results and access to these critical services become further constrained. **Therefore, the CAP requests that the Committee pass legislation to eliminate, revise, or replace the budget neutrality requirements in Medicare.**

Improving the Effectiveness of MACRA

The cost and burden of participation in MIPS has been much higher than anticipated, particularly for small and/or rural practices, and the proposed upsides have been slow to materialize. Thus, within MIPS, the administrative and financial burden of participating far outweighs any marginal improvements in cost and quality that could possibly be ascribed to MIPS participation. The CMS's policies and the evolution of MACRA threatens single-specialty, community-based practices. As currently envisioned by the CMS, both MVPs and APMs significantly favor multispecialty practices, thereby encouraging consolidation.

Furthermore, while the CMS wants to see all Medicare beneficiaries and most Medicaid beneficiaries enrolled in an accountable care relationship by 2030, it is unclear how single-specialty, community-based practices can effectively participate in the CMS's

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vision. The CMS has not explicitly articulated how this transition will occur, nor what they see as the primary accountable care relationship model for specialists. Finally, the underlying PFS has created significant financial instability for physician practices, and dissatisfaction with MACRA that may further discourage participation in value-based care models in the future. To that end, the CAP recommends the following to improve the effectiveness of MACRA:

- **Maintain meaningful quality measures.** The Centers for Medicare & Medicaid Services (CMS) is attempting to replace process measures: measures that look at whether the clinician did what he or she was supposed to do (example: annual hepatitis screening for active drug users) with outcome measures: what was the outcome of the procedure (example: decrease in lower back pain). Although pathologists do not have direct attributable control over the outcome of most procedures, and therefore do not have outcome measures, the importance of high-quality pathology in the process of care delivery is undeniable. Therefore, process measures have been and remain very important as a basis for ensuring quality health care and efforts should be taken to protect them.

- **Reduce the complexity of MIPS compliance and scoring.** Participating in MIPS is costly and burdensome. Compliance with MIPS costs $12,800 per physician per year and physicians spend 53 hours per year on MIPS-related tasks[5]. Congress should encourage innovation around solutions that minimize physician administrative, financial, and technological burdens of participation which do not improve the quality of patient care. CMS must work with stakeholders to assess burden-reduction mechanisms that acknowledge variability among different specialties. The technological burden of participation falls disproportionately on small and rural practices who may not have the resources to invest repeatedly in new technology[6]. CMS in conjunction with the Office of the National Coordinator for Health Information Technology (ONC) should utilize all available levers to increase access of practices and clinical data registries to hospital data to minimize the burden of reporting.

- **Preserve MIPS track and traditional reporting options.** The CMS should not sunset the traditional MIPS reporting option unless it can be clearly demonstrated that all clinicians are meaningfully participating in MVPs. Similarly, although MIPS was intended to be a temporary program as clinicians moved into APMs, the CMS should not sunset MIPS in favor of APMs until metrics show meaningful and complete APM participation.

- **Extend the APM bonus and APM participation requirements.** Without the incentive payment, providers will be less able to afford continued participation in Advanced APMs (considering operating costs and needed infrastructure) and

[5] https://jamanetwork.com/journals/jama-health-forum/fullarticle/2779947

[6] https://www.rand.org/pubs/research_reports/RR2882.html

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will be less likely to take on any new participation (given significant transformation investment costs). Not only does it appear this will further constrain pathologists' ability to participate in Advanced APMs but, like CMS, we are concerned about what this could do to "the availability and distribution of funds in the budget-neutral MIPS payment pool."

- **Require consideration of stakeholder input in APM development.** The CAP is concerned that models are being developed by Center for Medicare and Medicaid Innovation (CMMI) that dramatically change providers' clinical decision-making without considering the input of those specialties impacted by the model. Thus, the CAP has sought to ensure physicians, especially the societies that represent physicians participating in and affected by new payment models, have input into new model development. Additionally, the Physician-Focused Payment Model Technical Advisory Committee (PTAC) provides an important opportunity for specialists to develop their own models and submit them for review and recommendation to the Secretary for Health and Human Services (HHS), yet CMMI has not tested as proposed any specialist-developed APMs recommended by the PTAC. More innovative payment and delivery models must be developed in an open and transparent fashion with the input of those specialties impacted by the models.

- **Reform the PTAC process.** The CAP is supportive of PTAC's role in the review and recommendation of payment models developed by physicians to HHS, particularly where specialists have not had the opportunity to participate in existing models. Specialists included in the models, though, should be consulted prior to model submission to ensure effective collaboration and to preserve and ideally improve the care of patients. When physicians are included in models submitted to the PTAC, but unaware of them, they cannot optimize care coordination for patients or support and encourage meaningful physician participation.

- **Prohibit mandatory APM participation.** The CAP understands that the concern over participation challenges inherent in voluntary models, but we strongly believe APM participation must be voluntary to avoid harmful consequences on physicians and their patients. For example, a Government Accountability Office report found that mandatory participation could negatively impact patient care and financial sustainability if participants are not able to leave the model. It also found that mandatory participation could impact organizations' ability to support other voluntary models for which they may be better equipped.

In short, private payer challenges, declining reimbursement, increased administrative and regulatory burdens continue to threaten the financial viability of physician practices. Declining reimbursement means not being able to cover the cost of services resulting in practice closures, consolidation, and/or retirement. Additionally, administrative, and regulatory burdens increase operating costs,

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don't improve patient outcomes, and force pathologists to spend more time on paperwork and less time providing necessary patient services. To that end, the CAP encourages the Committee to pass policies to reign in private payers, stabilize the physician fee schedule, and reduce regulatory burdens in MACRA. The CAP appreciates the opportunity to provide these comments for the record. Please contact Darren Fenwick at dfenwic@cap.org or 202-354-7135 if you have any questions regarding these comments.

Sincerely,

/S/
Donald S. Karcher, MD, FCAP
President

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April 25, 2024

Sent via email

Denise O'Connor
Assistant General Counsel
Horizon Blue Cross Blue Shield of New Jersey

Eric Berman, MD
Chief Medical Officer
Horizon Blue Cross Blue Shield of New Jersey

Dear Ms. O'Connor and Dr. Berman:

On behalf of the College of American Pathologists (CAP), thank you and others at Horizon for taking the time to meet with us earlier this month. We appreciate your willingness to hear our concerns on behalf of our members and their patients. As we stated on the call, our interest is in ensuring insurer-imposed policies do not disrupt care coordination, add patient burdens, or compromise quality care. Unfortunately, we continue to see a number of these issues with recent actions by Horizon.

To start, we are still hearing from pathologists and practices in New Jersey – including since our call – expressing significant and genuine confusion over the recent changes. As you explained it to us, these changes are the result of Horizon's recent decision to enforce a policy that has been in effect since 2011. This "enforcement" is to ensure that, per the "Allowable Practice Locations for Pathologists" policy for managed care members, hospital-based pathologists are only "credentialed" and reimbursed for diagnostic services performed on patient specimens obtained in the hospital setting, and that all other specimens are sent to a "preferred" laboratory in the Horizon managed care network. While we acknowledge that Horizon recently revised the policy to provide additional clarity, these revisions have caused confusion in contrast to earlier Horizon policy language for providing pathology services "in a hospital setting." As such, the recent "enforcement" has been jarring. Independent laboratories and others also relied on earlier language in making changes to be in compliance.

Despite the assertion on the call that Horizon has not received any complaints, we know that pathologists and practices have reached out to Horizon for help but have not received calls back or information in return. **Thus, we urge you to address this communication breakdown and provide direct communication to impacted pathologists, including an overview of the policy and an explanation of the changes, and to provide an opportunity for pathologists and practices to ask questions and express their concerns.**

More importantly, the CAP calls on Horizon to reverse their recent decision to enforce this policy, so that clinicians can continue to choose local pathologists who are part of their model of coordinated care, which is an essential element in quality patient care. As we explained on the call, differentiating where specimens are sent, and which pathologists are "credentialed," based only on place of service results in

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fractured care that by its nature disrupts health care quality and adds unnecessary burden for patients and their physicians. In situations where the diagnostic biopsy leads to further hospital-based care (for example, an office-based fine-needle aspiration to diagnose cancer), the current requirement that patient samples be sent outside the local health system or care team prevents the local pathologist from participating in care coordination at the time of initial diagnosis or correlating these critical initial findings with subsequent surgical specimens obtained in the hospital. For patients who live further away from the health system/hospital, returning to receive care after the results have been returned may be difficult, and more likely to result in delayed care and compromised health outcomes.

Further, this requirement adds unnecessary time to treatment since it is typical, and often required, that the hospital-based pathologist confirm the diagnosis and assume responsibility for the patient's treatment. As acquiring outside materials can introduce significant delays in confirming diagnoses, patients may even require a second biopsy in the hospital setting to expedite care, which increases costs that may have been avoided. There are also logistical challenges and risks in dividing increasingly small diagnostic specimens to ensuring complete diagnostic and prognostic evaluation. Finally, some conditions may require rapid diagnosis for treatment (for example, small cell carcinoma) – not always possible when sending samples to outside laboratories – to prevent serious, even life-threatening complications. Pathologists impact nearly all aspects of patient care and are critical members of the health care team, from diagnosing cancer to participating in multidisciplinary conferences with the treating physicians (oncologists, surgeons, etc.) while the care plan is being formulated, to managing chronic diseases such as diabetes through ensuring accurate laboratory testing.

For these reasons, in addition to improved communication with impacted pathologists, we urge Horizon to reverse the recent decision to enforce this policy, and to revise it to support coordinated care for patients. Pathologists know that the right test at the right time makes all the difference for patients. The CAP is committed to improving care and addressing escalating health care costs, but disrupting care coordination can negatively affect a patient's diagnosis, treatment, and outcome. It should be up to the patient and their doctor to determine where diagnostic services occur, with the common goal of delivering the healthiest outcome.

Elizabeth Fassbender, JD, Director, Economic and Regulatory Affairs, is the contact person for further discussions. She can be reached at efassbe@cap.org or 608-469-8975. Thank you for engaging with us on this important issue.

Sincerely,

Ronald W. McLawhon, M.D., Ph.D., FCAP, FAACC
Chair, Economic Affairs Committee

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I am writing to you as a private practice orthopedic surgeon based in the Northeast to express my profound concerns regarding the challenges facing private practice physicians in today's healthcare landscape. Recent trends and policies have created an environment that threatens the viability of private practices, which are essential for maintaining diversity and accessibility in patient care.

One of the most pressing issues is the consolidation of healthcare providers by larger entities such as insurance companies and hospitals. These consolidations have significantly altered the dynamics of the marketplace, often leading to artificial influences on pricing and reimbursement rates. Such practices adversely affect private physicians who strive to provide high-quality care while maintaining financial stability. The competitive imbalance created by these large entities undermines the foundational principles of fair market practices and ultimately harms patient care.

Furthermore, the Federal Independent Dispute Resolution (IDR) process, intended to resolve payment disputes, has proven to be sluggish and inefficient. The prolonged resolution times severely impact the cash flow of physician groups, making it difficult for private practices to survive. Even more concerning is the behavior of insurance companies that refuse to pay the awarded amounts even after losing the IDR process. This blatant disregard for the process and the lack of enforcement mechanisms to hold these companies accountable exacerbates the financial strain on private practices.

Insurance companies frequently deny medically necessary services and refuse to authorize basic treatments, ostensibly to cut costs. This practice effectively holds patients hostage, depriving them of timely and essential care. Additionally, insurance companies often delay reimbursements, banking on the fact that many physician practices lack the resources to manage the administrative burdens required to secure due payments. This creates a David and Goliath scenario where private practices are at a severe disadvantage, struggling against the overwhelming power of insurance companies.

To ensure the survival of private practice physicians and to protect patient access to diverse healthcare options, I urge Congress to take the following actions:

1. **Reform the IDR process** to ensure timely resolutions and enforce payment compliance by insurance companies.
2. **Hold insurance companies accountable** for unjustified denials of medically necessary services and for delaying reimbursements.

3. **Implement measures** to prevent the undue consolidation of healthcare providers, ensuring a fair and competitive market that supports the sustainability of private practices.

Private practice physicians are a cornerstone of our healthcare system, providing personalized care and maintaining the diversity of healthcare options for patients. It is crucial that Congress addresses these issues to rectify the current imbalance of power and ensure that private practices can continue to serve their communities effectively.

Thank you for your attention to these critical issues. I am hopeful that with your support, we can create a more equitable and sustainable healthcare system.

MEDICAL SOCIETY OF THE STATE OF NEW YORK
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STATEMENT OF MSSNY PRESIDENT

DR. JEROME COHEN

TO U.S. HOUSE OF REPRESENTATIVES COMMITTEE ON WAYS AND MEANS

RE: THE COLLAPSE OF PRIVATE PRACTICE: EXAMINING THE CHALLENGES FACING INDEPENDENT MEDICINE

JUNE 4, 2024

The Medical Society of the State of New York (MSSNY) appreciates the opportunity to submit the following Statement for the Record to the U.S. House Committee on Ways and Means as part of the hearing entitled, "The Collapse of Private Practice: Examining the Challenges Facing Independent Medicine." MSSNY commends the Committee for examining the problem of physicians being forced to sell their medical practices to large corporate interests in order to continue to be available to deliver patient care. This is a significant issue that is causing reduced treatment options for patients and longer wait times to be seen by trained physicians.

Recently, the Physicians Advocacy Institute reported that **nearly *four of five* physicians (77.6%) of physicians are now employees of hospitals/health systems and other corporate entities.** The marketplace race to acquire physician practices has resulted in **nearly *six of ten* (58.5%) of physician practices owned by hospitals/health systems and other corporate entities.** The report further found Physician Employment Trends.pdf (physiciansadvocacyinstitute.org) that corporate employment of physicians increased by over 30% in the Northeastern portion of the country.

MSSNY represents tens of thousands of physicians, residents and medical students across New York State, delivering care to patients in solo practice, in small and large group settings, or as employed by large health systems. Our diverse membership is committed to ensuring that all New Yorkers have access to quality and affordable physician-led healthcare.

Our efforts to ensure patients receive needed care is challenged by an ever-increasing encroachment of non- physicians into care delivery, including by health insurers, corporate pharmacy giants, private equity, and even in some cases by market-dominant health systems. Their well-intended but often misguided efforts to improve care and reduce costs frequently come at the expense of limiting treatment options for patients, including by limiting the ability of physicians to advocate for

their patients, or by seeking to replace them altogether with various non-physician providers.

Even prior to the pandemic, excessive and unnecessary administrative hassles imposed by corporate interlopers were causing many physicians to suffer from "burnout" (which also can be referred to as demoralization and moral injury). But the Covid-19 pandemic accelerated this trend, as noted by a 2023 physician survey by the Physicians Foundation that found that, for the 3rd year in a row, 6 in 10 physicians often had feelings of burnout**,** compared to 4 in 10 in 2018. More than half of physicians know of a physician who has considered, attempted, or died by suicide.

The same study reported that 80% of physicians found reduction of administrative burdens to be helpful to eliminating barriers that impact physicians' well-being and ability to deliver high-quality and cost-efficient care. Despite this, nearly 70% of physicians indicated that their workplace culture does not prioritize physician well-being.

As the pandemic recedes, we continue to face numerous public health threats. At the same time the demands on our healthcare system grow due to an aging population and an increasing number of patients with co-morbid conditions. We must take steps to ensure that we have a physician workforce ready to meet the healthcare demands of our diverse population, including those in underserved areas of the State. This includes reducing the excessive administrative, non-patient care delivery demands that were already driving physician burnout prior to the onset of the pandemic, as well as rejecting overbroad proposals that impose even more excessive administrative requirements that interfere with patient care delivery.

To revitalize opportunities for patients to receive care from independently practicing community-based physicians, we must change New York's notoriously poor practice environment. New York is regularly ranked near the bottom in the list of the best states in which to practice medicine. Some of these challenges are driven by New York's excessive regulatory requirements, and exorbitant liability costs. But other factors Congress has the direct authority to fix.

ADDRESSING PRIOR AUTHORIZATION AND OTHER ABUSIVE HEALTH INSURER PRACTICES

As has been identified by many physicians and physician advocacy organizations, one of the significant drivers of the physician exodus from independent practice is excessive administrative hassles that are impossible to manage without enormous staff support. Legislation and other policy changes are needed to counteract pervasive, health insurer-imposed, excessive administrative barriers interfering with patient care delivery. Insurers' market dominance enables the imposition of often challenging rules that limit patients' access to needed care and payment policies that threaten to shutter physician practices.

According to an American Medical Association (AMA) study of U.S. Health Insurance markets, in most regions of New York, there are just two insurers that collectively control nearly half (45%) of New York's health insurance. In several regions of the State, the top 2 insurers control over 60% of the market. This is only going to get worse in New York State with the recent announcement that

Lifetime, the parent company of Excellus and Univera, is planning to acquire CDPHP, the top health insurer in the Capital Region MSA, a locally owned health insurance plan with a history of working collaboratively with community physicians. The practical effect is that physicians must either accept these insurers' terms or join large health systems to stay in business and continue to deliver patient care in the communities they serve.

One of the major dangers of such market domination is that it allows for excessive prior authorization (PA) demands and delays. According to a recent AMA study, 94% of physicians surveyed reported care delays due to PAs, while 80% said that PAs can lead to patients abandoning their treatments. Moreover, 89% reported that excessive PA burdens have had a negative impact on clinical outcomes. Moreover, 58% of the physicians surveyed said that PA had interfered with a patient's ability to perform their jobs.

In a MSSNY survey of New York physicians, 71% of participants said that PAs for prescription medications have increased significantly over the last 5 years, while 64% said that PAs for medical services have increased significantly over the last 5 years.

MSSNY is seeking the enactment of numerous pieces of legislation on the state level to reduce these hassles, including legislation to prevent repeat prior authorization requirements once approved, reduction in the use of step therapy policies that limit patient access to needed prescription medications, and "gold card" policies that prevent health insurers from imposing PA requirements on physicians with proven records of PAs being approved. Congress should also take similar action to ensure these hassle reduction policies are followed by self-insured plans that are beyond the reach of state regulators.

REVISING AND SIMPLIFYING THE MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

Another massive administrative hassle for physicians in the Merit-Based Incentive Payment System. The MIPS program implementation has been fraught with challenges, particularly for small, rural, safety-net, and independent practices. The COVID-19 pandemic has further complicated the situation, disrupting health care delivery and exacerbating the administrative burdens associated with MIPS.

Following a five-year interruption to the program due to COVID, MIPS now subjects physicians to penalties of up to 9% unless they meet onerous program requirements. Small, rural, and independent practices, along with practices that care for historically minoritized and marginalized patients, are more likely to be penalized, whereas large group practices, integrated systems, and alternative payment model participants are more likely to receive bonuses.

Data from the 2022 Quality Payment Program Experience Report that was just recently released revealed that MIPS penalties disproportionately affected smaller practices: 27% of small practices, nearly 50% of solo practitioners, and 18 percent of rural practices were penalized. Of those, 13% of small practices, 27%

of solo practitioners, and 2% of rural practices got the maximum negative penalty of –9%.

A study from the same year indicated that MIPS scores correlate poorly with actual performance, raising serious concerns about the program's effectiveness and fairness. MIPS is extremely burdensome, and it is costly to participate and do well in MIPS. Compliance with MIPS costs $12,800 per physician per year and physicians spend 53 hours per year on MIPS-related tasks. This high entry barrier is a fundamental reason why less-resourced practices including small, rural, and safety net practices historically do worse in the program.

MIPS does not prepare physicians to move to an alternative payment model (APM) and has not been shown to improve clinical outcomes. Worse, a 2022 study in JAMA found MIPS scores are inconsistently related to performance, which "suggests that the MIPS program is approximately as effective as chance at identifying high vs low performance." Though MACRA requires timely feedback and consultation with stakeholders, there are no enforcement mechanisms to accomplish these provisions. CMS has not met its statutory obligation to provide timely (e.g., quarterly) MIPS feedback reports and has never provided Medicare claims data to physicians despite this requirement going into effect in 2018. MIPS requires a significant overhaul.

MSSNY has recommended that the MIPS program be eliminated in it entirety and be replaced with 1) a practicing physician-designed program that has far less administrative burdens and 2) only adopts measures that have been shown to measurably improve patient outcomes.

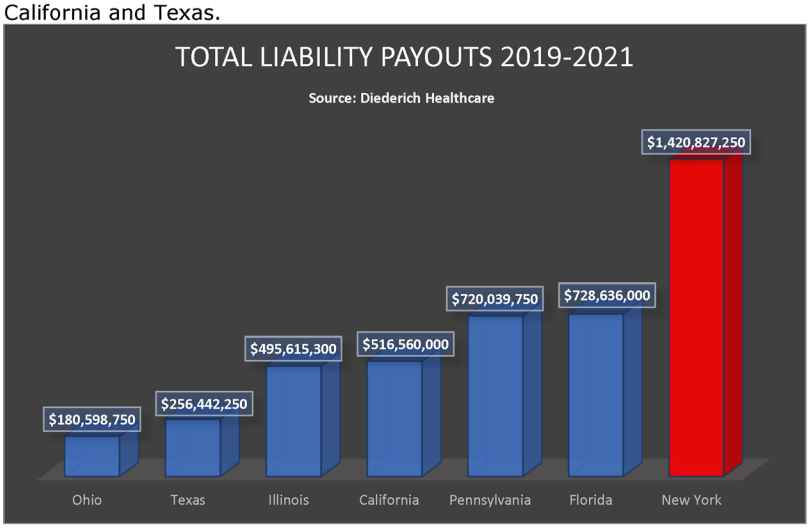
REDUCING EXORBITANT MEDICAL LIABILITY INSURANCE COSTS

Our patients depend upon having ready access to their regional healthcare safety net. As our healthcare system continues its challenging recovery from the enormous strain of the pandemic, while facing Medicare cuts from the federal government, it is imperative to protect our system from de-stabilizing cost increases that impair our physicians and hospitals from hiring critically needed staff and making essential infrastructure investments to enhance care quality and availability. The most significant cost pressure imposed on health care entities and professionals is New York's notoriously excessively high liability costs, which far exceed any other state in the country including more populous states such as California and Texas.

In January 2023 and again in December 2023, New York's Governor Kathy Hochul vetoed legislation that could have significantly increased these already astronomical costs by expanding the types of damages awardable in a wrongful death action. One actuarial study concluded that such legislation would have required medical liability premium increases of nearly 40%. The Governor identified several reasons for vetoing the bill, including that it "would increase already high insurance burdens on families and small businesses and further strain already-distressed healthcare workers and institutions" which would be "particularly challenging for struggling hospitals in underserved communities."

Furthermore, the Governor articulated her concerns that the bill "passed without a serious evaluation of the impact of these massive changes on the economy, small businesses, individuals, and the State's complex health care system."

For example, studies from Diederich Healthcare showed that from 2019-2021, New York once again had the highest cumulative medical liability payouts of any state in the country, $1.4 billion, nearly twice as much as the 2d highest state (Florida) and the 3rd highest state (Pennsylvania). It also had the highest per capita liability payment, 33% more than the 2nd highest state (Pennsylvania). It also far exceeds other large states regularly competing for physicians such as California and Texas.



With New York State unwilling to take on the state's powerful trial lawyers lobby, we need Congress to pass legislation to help contain these exorbitant costs, including measures to contain damages in medical liability actions, ensure qualified expert witnesses and containing interest costs.

ENSURING FAIR MEDICARE PAYMENT

The physician payment system is on an unsustainable path that threatens patients' access to physician services. As you know, in 2024 physician again faced another round of real dollar Medicare payment cuts triggered by the lack of any statutory update for physician services tied to inflation in medical practice costs and flawed application of Medicare budget neutrality rules. Congress acted last March to partially mitigate the 3.37% reduction that was imposed in January but did not stop the cuts entirely. These cuts come on the heels of two decades of stagnant payment rates. Adjusted for inflation in practice costs, Medicare physician payment rates plummeted nearly 30% from 2001 to 2024 because

physicians, unlike other Medicare providers, do not get an automatic yearly inflation-based payment update.

In its 2024 annual report, the Medicare Trustees warned that the program faces "challenges," notably that physician payments are not based on underlying economic conditions – such as inflation – and are not expected to keep pace with the cost of practicing medicine. The trustees warned of the gap created between rising costs and physician payments, noting that the "quality of health care received by Medicare beneficiaries would, under current law, fall over time compared to that received by those with private health insurance." The trustees further cautioned that "absent a change in the delivery system or level of update by subsequent legislation, the Trustees expect access to Medicare-participating physicians to become a significant issue in the long term."

The lack of an adequate annual physician payment update within the current Medicare physician payment system is particularly destabilizing as physicians, many of whom are small business owners, contend with a wide range of shifting economic factors when determining their ability to provide care to Medicare beneficiaries. Physician practices compete against health systems and other providers for staff, equipment, and supplies, despite their payment rates failing to keep pace with inflation. In fact, the government's measure of inflation in physicians' costs, the Medicare Economic Index (MEI), rose 4.6 percent this year. An AMA analysis shows that by far, the most cited reason that independent physicians sell their practices to hospitals or health systems had to do with inadequate payment.

We need Congress to pass legislation to end the annual madness of Medicare payment cuts and replace it with a system that ensures MEI-based increases which are essential for physicians to continue to practice independently.

ENSURING A FAIR DISPUTE RESOLUTION PROCESS

In 2020, Congress passed the No Surprises Act (NSA) ,which removed patients from payment disputes between health insurance companies and out of network providers. The NSA banned physicians from "balance billing" and instead created a quick and fair independent dispute resolution (IDR) process by which physicians and insurers could resolve payment disputes. This IDR process a critical method for our practice to obtain fair payments from private insurers.

The federal IDR law was based largely on the very successful New York model for state regulated health insurance plans implemented in 2015, which included a requirement that decisions be completed with 30 days of submission. Unfortunately, federal agencies overseeing implementation have created an enormous backlog of claim disputes, failing to implement the IDR as called for by the NSA and resulting in numerous lawsuits necessary to ensure that the process remains balanced and not tipping the decisions towards one party on a regular basis.

CMS cannot continue to allow private insurers to sabotage the IDR process to add to their already unprecedented profits. The IDR process must follow the short timelines that are outlined in the law itself, and must be implemented in a fair and simple manner. Specifically, MSSNY is urging that the federal IDR process be fair and ensure the following: (1) the timely processing of claims; (2) directions to the IDR entity that no one data point is deemed in advance to be more important than any other consideration; (3) direction to insurers only to use actual paid rates in consideration of the median contracted rate; (4) directions to insurers not to consider data from other specialties in determining the median contracted rate; (5) direction to insurers not to consider data from other self-funded plans in determining the median contracted rate; (6) direction to insurers that they must present the median contracted rate to the physician in the EOB if they want to use this data point at IDR; (7) direction to insurers to make all raw data available to the disputing physician from which the median contracted rate was calculated so the physician can ascertain whether the median contracted rate was calculated correctly; (8) eliminating the non-refundable administrative fees for physicians to bring a claim to IDR; (9) allowing physicians to batch similar claims; (10) providing live help for phone calls from both federal regulating departments and the IDR entities to facilitate the timely processing of claims; (11) requiring insurers to make payments within 30 days when they lose at IDR (as per the law).

CONCLUSION

As noted above, patient access to independent community-based physician care delivery is under attack from a number of market factors, both unique to New York State but also the result of various federal policies such as budget-neutral Medicare payment policies and oppressive MIPS program. In this regard, MSSNY urges Congress to take a number of steps as recommended above to help revitalize independent medical practices, including ensuring fair Medicare payment updates, a more streamlined quality reporting system, reduction in prior authorization hassles and reduction in medical liability insurance costs.

Thank you again for the opportunity to comment.

Coalition for Patient-Centered Care

May 24, 2024

Representative Vern Buchanan
Chairman
House Committee on Ways and Means
Subcommittee on Health
2110 Rayburn House Office Building
Washington, DC 20515

Representative Lloyd Doggett
Ranking Member
House Committee on Ways and Means
Subcommittee on Health
2307 Rayburn House Office Building
Washington, DC 20515

RE: "The Collapse of Private Practice: Examining the Challenges Facing Independent Medicine" House Ways and Means Health Subcommittee Hearing

Dear Chairman Buchanan and Ranking Member Doggett:

The Coalition for Patient-Centered Care appreciates the Subcommittee holding this important hearing to examine the challenges facing independent medicine. We believe that any discussion about the challenges faced by independent physicians must consider the harmful effects of private equity firms' acquisitions of healthcare providers. As a coalition comprised of physicians and other healthcare stakeholders, many of whom are on the front lines of providing patient care, our membership has first-hand experience of the negative impact these deals have on the public. Our membership has observed that often after a private equity firm takes over an independent physician group, the quality of care for patients goes down, the cost of care to public and private payors goes up, and employee working conditions worsen.

The CPCC represents a diverse group of healthcare industry stakeholders who stand together in opposition to private equity's acquisition and influence over independent physicians that can result in an emphasis on profits and revenue growth over patient interests. Currently, our coalition represents over 13,000 physicians from all 50 states, as well as other stakeholders who share the views set forth in this statement.

Karen Simonton, the CEO of OrthoForum, one of the founding members of the CPCC, described the importance of preserving the independent practice of medicine at a recent Federal Trade Commission (FTC) workshop on private equity, observing that "independent physicians are the foundation of a healthy community."[1] She also emphasized the importance of keeping

[1] Federal Trade Commission, Transcript of "Private Capital, Public Impact: An FTC Workshop on Private Equity in Health Care" (March 5, 2024), https://www.ftc.gov/system/files/ftc_gov/pdf/final-trancsript-ftc-opp-be-private-equity-healthcare-workshop-3-5-24.pdf.

decision-making local to the communities in which physicians serve, stating, "Staffing and facility decisions have to be made at the community center of excellence level, not by a third party who is disinterested in the community. They have to be made in the interest of patients and outcomes and not spreadsheets and income statements."[2]

Overall, our member groups face many federal and state policy issues that impact their ability to provide quality and cost-effective care to their patients. In response to this, we are committed to developing and supporting policies that serve to strengthen and defend the independent practice of medicine. In doing so, we place the highest priority on patient access, efficient treatment processes, and reduced costs.

Impact of Private Equity Acquisitions of Independent Healthcare Providers

We believe that everyone benefits when physicians have the freedom to exercise their best judgement as to the delivery of care and can work directly with their patients to make medical decisions and deliver patient-centered care. Private equity firms do not share this ideal. They seem to be more concerned with maximizing investor profits than advocating for patients. Unfortunately, current U.S. tax law incentivizes private equity firms to acquire healthcare providers and gives them an advantage over other would-be acquisition partners by providing the firms with substantial tax breaks.

Private equity firms have been particularly active in acquiring independent physician groups. Currently, more than half of all specialists in several U.S. markets are owned by private equity firms, according to a recent study by the American Antitrust Institute, the Petris Center at the University of California, Berkeley, and the Washington Center for Equitable Growth.[3] As the *New York Times* summarized, the study found that "[i]n more than a quarter of local markets — in places like Tucson, Ariz.; Columbus, Ohio; and Providence, R.I. — a single private equity firm owned more than 30 percent of practices in a given specialty in 2021."[4] The article added, "[i]n 13 percent of the markets, the firms owned groups employing more than half the local specialists."[5]

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[2] *Id.*

[3] Richard M. Scheffler et al., Monetizing Medicine: Private Equity and Competition in Physician Practice Markets (July 10, 2023), https://www.antitrustinstitute.org/wp-content/uploads/2023/07/AAI-UCB-EG_Private-Equity-I-Physician-Practice-Report_FINAL.pdf.

[4] Reed Abelson & Margot Sanger-Katz, *Who Employs Your Doctor? Increasingly, a Private Equity Firm.*, The New York Times (July 10, 2023), https://www.nytimes.com/2023/07/10/upshot/private-equity-doctors-offices.html.

[5] *Id.*

CPCC members' experience—consistent with independent research, public reports, and even a recent investigation by the Federal Trade Commission (FTC)[6]—is that, after a private equity firm takes over an independent physician group, there are generally adverse effects. These effects often include decreased quality of care for patients, increased cost of care for public and private payors, and deteriorating working conditions for employees.

Regarding higher costs, there is significant evidence that private equity acquisitions of healthcare providers result in higher prices without any evidence of an increase in quality or access to care. For example, a recent study concluded that, after hospital outpatient departments and ambulatory surgery centers contracted with a physician management company (PMC), prices paid to anesthesiologists increased, and were substantially higher if the PMC received private equity investment.[7] Consistent with the study's findings, the FTC brought a lawsuit against private equity firm Welsh Carson, highlighting the harmful price effects of private equity acquisitions of independent physician groups. According to FTC Chair Lina Khan, "private equity firm Welsh Carson spearheaded a roll-up strategy and created [U.S. Anesthesia Partners (USAP)] to buy out nearly every large anesthesiology practice in Texas….[T]hese tactics enabled USAP and Welsh Carson to raise prices for anesthesia services—raking in tens of millions of extra dollars for these executives at the expense of Texas patients and businesses."[8]

As for decreased quality and access to care, while there are many examples, the 2021 sale of an independent physician group at Dartmouth College to private equity backed One Medical, is instructive. In 2012, Dartmouth Health Connect, a primary care physicians office, was opened by the college in connection with Boston startup Iora Health. The office was originally intended to offer accessible and affordable healthcare to college students and the surrounding area. It began with two full-time physicians, a nurse, and other health professionals. After the private equity-backed takeover of the group, however, all that remains is one physician assistant with responsibility for approximately 1,300 patients.[9] In our experience, aggressive cuts in staff-to-patient ratios result in decreased quality of and access to care for patients. Furthermore, they result in job losses and increase stress for healthcare sector workers, contributing to burnout, among other negative impacts.

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[6] Press Release, Federal Trade Commission, FTC Challenges Private Equity Firm's Scheme to Suppress Competition in Anesthesiology Practices Across Texas (Sept. 21, 2023), https://www.ftc.gov/news-events/news/press-releases/2023/09/ftc-challenges-private-equity-firms-scheme-suppress-competition-anesthesiology-practices-across.

[7] Ambar La Forgia et al., *Association of Physician Management Companies and Private Equity Investment With Commercial Health Care Prices Paid to Anesthesia Practitioners*, 182 JAMA Intern Med. 396, (2022), https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2789280.

[8] Federal Trade Commission, *supra* note 4.

[9] Douglas Farrago, *The Metamorphisis and Transformation of a DINO*, DPC News (Oct. 6, 2023), https://dpcnews.com/uncategorized/the-metamorphosis-and-transformation-of-a-dino/.

This issue is particularly important and appropriate for the House Ways and Means Health Subcommittee to consider, as lower quality of care and increased costs have a direct and significant negative impact on federal government spending and, in turn, all American taxpayers. In 2022, 17.8% of Americans were covered by Medicare.[10] When private equity-owned healthcare providers offer lower quality care for higher prices, this contributes to significant increases in the overall cost of care for Medicare patients, putting additional and unnecessary strain on the federal budget.

Conclusion

We commend the Subcommittee for holding this important hearing and urge you to continue to work on addressing these critical policy issues related to the cost and quality of patient care.

Sincerely,

The Coalition for Patient-Centered Care

[10] Preeti Vankar, *Percentage of people covered by Medicare in the United States from 1990 to 2022*, Statista (May 22, 2024), https://www.statista.com/statistics/200962/percentage-of-americans-covered-by-medicare/#:~:text=Medicare%20is%20an%20important%20public%20health%20insurance%20scheme.by%20Medi%20care%2C%20an%20increase%20from%20the%20previous%20year.

UNIVERSITY of HAWAI'I SYSTEM
RHRPC UH Rural Health Research and Policy Center
Office of Strategic Health Initiatives
Rural Health Research and Policy Center

June 6, 2024

To: Chairman Vern Buchanan, Ranking Member Lloyd Doggett, and Members
U.S. House of Representatives Ways and Means Committee
Health Subcommittee

Re: Written comments for the Hearing Record for the Subcommittee Hearing on The Collapse of Private Practice: Examining the Challenges Facing Independent Medicine, held Thursday, May 23, 2024

Thank you for the opportunity to provide written comments for the Hearing Record for the Subcommittee Hearing on The Collapse of Private Practice: Examining the Challenges Facing Independent Medicine, held Thursday, May 23, 2024. This hearing featured five witnesses who discussed a variety of issues impacting independent medicine, including financial and regulatory burdens and barriers to patient care due to consolidation of health care systems.

The University of Hawai'i (UH) Rural Health Research and Policy Center (RHRPC, https://research.hawaii.edu/rhrpc) **was established in 2022 and seeks to translate community health needs into actionable, evidence-based policy solutions.** With a focus on improving the quality, affordability, and accessibility of healthcare in Hawai'i, RHRPC provides critical policy analysis and strategy to support community members' efforts to enact structural changes through policy. UH RHRPC is situated at the level of the UH System. The UH System represents ten campuses across the islands with nearly 50,000 students, and campuses that are both Alaska Native Native Hawaiian-Serving Institutions (ANNHs) and Asian American and Native American Pacific Islander-Serving Institutions (AANAPISIs), as designated by the U.S. Department of Education.

The United States' non-contiguous areas, including Hawai'i, Alaska, Puerto Rico, and U.S.-Affiliated Pacific Islands face significant health workforce challenges and shortages for many reasons, including their geographic remoteness. **Health workforce issues in Hawai'i include relatively low Medicare reimbursement, high cost of living, and geography and remoteness from the continental United States leading to issues with recruitment, retention, high costs, and beyond.** Hawai'i in particular has faced significant challenges recently with emergencies such as the Maui Wildfires, Red Hill fuel contamination crisis, and disproportionate impact of COVID-19 on Native Hawaiians and Pacific Islanders.

UH RHRPC has studied the Centers for Medicare and Medicaid Services (CMS) Physician Fee Schedule (PFS) calculation for the Physician Work (PW) Geographic Practice Cost Index (GPCI) in Medicare with a focus on impacts on Hawai'i. Our research has shown that the calculation methodology could be contributing to the healthcare workforce shortages in Hawai'i by limiting reimbursement for physicians.

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In 2024, Hawai'i has a geographic adjustment for its higher costs for goods and services (Practice Expense GPCI = 1.149), lower costs for malpractice insurance (MP GPCI = 0.561), and no adjustment for physician work effort (PW GPCI = 1.00). Many providers across our state are concerned that Hawai'i's PW GPCI does not adequately account for many challenges faced in Hawai'i, including our very high average prices and very high cost of living (second highest regional price parity in the United States, as measured by the Regional Price Parity Index[1] and highest cost of living measured by the Missouri Economic Research and Information Center Cost of Living Data Series[2]), depressed wages for proxy professions,[3] and difficulty of recruitment and retention for providers in our state due to our geographic isolation and non-contiguous nature.

To address this issue in Alaska, the nation's other non-contiguous state, in 2008 Congress previously provided a 1.5 PW GPCI floor for Alaska through the Medicare Improvement for Patients and Providers Act (MIPPA); however, Hawai'i was not included in this statutory fix. As you know, Hawai'i and Alaska are often treated similarly in federal statute. For example, both states have unique federal poverty guidelines, while the rest of the contiguous states share the same guidelines.[4] Additionally, Alaska and/or Hawai'i are treated differentially in Medicare payment for Durable Medical Equipment[5] and in Medicare payment for telehealth store-and-forward technologies.[6]

We urge the Ways and Means Committee to rectify this incongruence and provide parity for non-contiguous states by passing H.R. 8563, the Protecting Access to Care in Hawai'i (PATCH) Act (introduced by U.S. Representatives Ed Case and Jill Tokuda as well as U.S. Senators Brian Schatz and Mazie Hirono as S. 4395) **to provide the same critical 1.5 PW GPCI floor for Hawai'i as already exists for Alaska**. This action would significantly help independent providers and Hawai'i's health care systems in our remote and geographically isolated location to remain financially viable and continue to serve communities in need, particularly in rural areas that have been so challenged by disasters, transportation barriers, and limited access to health care.

RHRPC greatly appreciates the Ways and Means Health Subcommittee for holding the May 23, 2024, hearing and accepting written comments for the hearing record. Please kindly consider including the PATCH Act in any forthcoming legislative package to address rural health and improve independent practices.

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[1] Economic Analysis, U.S.Bureau. 2023. "SARPP Regional Price Parities by State." https://www.bea.gov/data/prices-inflation/regional-price-parities-state-and-metro-area.
[2] Missouri Economic Research and Information Center, 2023. "Cost of Living Data Series" https://meric.mo.gov/data/cost-living-data-series
[3] Bond-Smith, Steven, Bond-Smith, Daniela. 2024. "How does Hawai'i's economic geography affect its healthcare in Hawai'i" The Economic Research Organization at the University of Hawai'i
[4] https://aspe.hhs.gov/sites/default/files/documents/1c92a9207f3ed5915ca020d58fe77696/detailed-guidelines-2023.pdf
[5] 42 U.S.C. 1395m(a)(1)(10)(A).
[6] (42 U.S.C. 1395m(m)(1).

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Office of Strategic Health Initiatives
Rural Health Research and Policy Center

UH RHRPC is working on a technical paper and policy brief on this topic, which we would be pleased to share with you when they are ready for publication. For questions or more information, please reach out to Diana M V Shaw, PhD, MPH, MBA, FACMPE, Rural Health Policy Specialist at dmshaw@hawaii.edu or John Desfor, MPH, Policy and Data Analyst, at johnd6@hawaii.edu.

Mahalo nui loa (thank you very much) for your kind consideration of Hawai'i's critical health workforce needs, especially in the context of many challenges facing our state.

Sincerely,

Aimee Grace

Aimee Malia Grace, MD, MPH, FAAP
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PARTNERSHIP TO EMPOWER PHYSICIAN-LED CARE

STATEMENT FOR THE RECORD

"The Collapse of Private Practice: Examining the Challenges Facing Independent Medicine"
U.S. Committee on Ways and Means
Subcommittee on Health
June 5, 2024

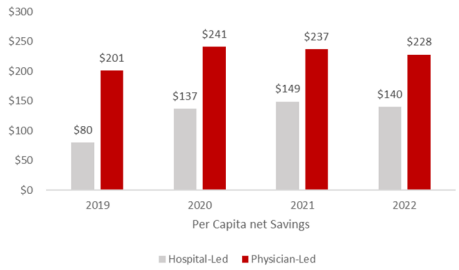
The Partnership to Empower Physician-Led Care (PEPC) is an advocacy coalition supporting value-based care to reduce costs, improve quality, empower patients and physicians, and increase access to care for millions of Americans through a competitive health care provider market. We believe that it is impossible to achieve true value-based care without a robust independent practice community. Our members include Aledade, American Academy of Family Physicians (AAFP), California Medical Association, and Medical Group Management Association (MGMA). We also have individual and small medical group supporters across the country, many of whom are independent physicians/practices and wish to remain so.

We commend the Committee for its attention to the financial and regulatory burdens facing independent medical providers and how continued challenges result in consolidated health care systems and barriers to high-quality patient care. **Our comments highlight the role of value-based care in supporting and preserving today's independent workforce.**

The independent practice landscape has dramatically changed in the last decade. The percentage of U.S. physicians in private practice has decreased from 60.1 percent in 2012 to 46.7 percent in 2022. Increasing investment from private equity and other corporate entities has also contributed to this shift, with the number of physicians employed by corporate entities increasing more than seven percent between January 2019 and January 2024. However, the decline in physician practice ownership does not tell the complete story and does not mean that the independent physician landscape is collapsing.

Many independent practices are doing business differently and turning to value-based care models to generate greater, more predictable revenue streams. This transition is paying off, as independent physicians consistently outperform their hospital counterparts in accountable care models. For example:

- *Medicare Shared Savings Program (MSSP)*: Physician-led accountable care organizations (ACOs) are creating a better experience for patients while lowering costs across the entire system. MSSP results show that, across the health care system, ACOs led by physicians, often called "low revenue," typically create more than twice the Medicare savings per beneficiary than hospital-led ACOs, often known as "high revenue."



- *Next Generation Accountable Care Organization (NGACO) Model*: Physician practices participating in NGACO were more likely to reduce spending in acute care hospital and outpatient facility spending compared to hospital-led NACOs. Physician-led ACOs reduced spending in acute care hospitals by over 37 percent and outpatient facilities by nearly 20 percent. In total, the model was associated with $667 million in gross Medicare savings.

- *Comprehensive Primary Care Plus (CPC+):* Independent practices had greater autonomy to make changes tailored to their local environment and were able to quickly make improvements based on patient feedback, positioning them to adapt and provide flexible care delivery in changing circumstances, such as during the COVID-19 pandemic. For example, some small, independent practices reported pivoting quickly to alternative platforms such as FaceTime, Zoom, and telephone calls as soon as payers began covering services provided through those platforms, while some system-based practices were slower to respond.

Today's independent physician landscape looks different than the prior generation of independent practices. As our health care system prioritizes interoperability, multi-payer alignment, and coordination among specialties and providers, our perspective of 'independence' must change. A provider can no longer succeed operating in a silo, nor would we want them to.

We must shift our perspective accordingly, and focus on supporting practices that are led by physicians who have clinical autonomy and accountability to their patients. This includes ensuring robust Medicare fee-for-service (FFS) reimbursement as a platform for value-based care; leveraging and encouraging more physician-led models; and advancing policies that support independent physicians and promote provider competition.

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We hope you will consider this evidence and recommendations as Congress looks to take legislative and regulatory action to ensure a robust and competitive health care market, supporting our nation's independent physicians in providing high-quality, value-based care.

Sincerely,

Kristen McGovern
Executive Director

Submitted electronically via WMSubmission@mail.house.gov

June 6, 2024

The Hon. Jason T. Smith
Chairman
House Committee on Ways and Means
1011 Longworth House Office Building
Washington, DC 20515

The Hon. Vern G. Buchanan
Chairman
Subcommittee on Health, Ways and Means
2110 Rayburn House Office Building
Washington, DC 20515

Re: Statement for the Record: Subcommittee on Health Hearing, "The Collapse of Private Practice: Examining the Challenges Facing Independent Medicine"

Dear Chairmen Smith and Buchanan:

Thank you for this opportunity to submit these comments regarding the House Ways and Means Committee's Health Subcommittee recent hearing[1] on the financial and regulatory burdens facing independent medical providers and how continued challenges result in consolidated healthcare systems and barriers to patient care. We are grateful for your leadership on these critically important issues.

As Dr. Ashish Jha testified, "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. 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."[2] This current state of affairs informs the main topic of our analysis below: the No Surprises Act's independent dispute resolution (IDR) process.

Introduction

My name is Christopher Sheeron, and I am founder and president of Action for Health.[3] Action for Health is a national, non-profit advocacy organization. In all our work, we attempt to

[1] U.S. House Committee on Ways and Means, Subcommittee Hearing, The Collapse of Private Practice: Examining the Challenges Facing Independent Medicine, May 23, 2024, accessed: https://gop-waysandmeans.house.gov/wp-content/uploads/2024/05/ADVISORY_Health-Subcommittee_May-23-2024.pdf.
[2] Ashish Jha, MD, Testimony to the House Committee on Ways and Means, Subcommittee on Health, May 23, 2024, accessed: https://waysandmeans.house.gov/wp-content/uploads/2024/05/Jha-Testimony-1.pdf.
[3] Action for Health, www.action4health.org.

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educate policymakers, the media, and concerned citizens about critical healthcare issues. Since our founding in February 2020, we have worked tirelessly to ensure fair outcomes for patients and their physicians. Throughout our research and advocacy efforts, we spend considerable time analyzing consolidation, anticompetitive conduct of healthcare system actors, and the collective effects these issues have on patients and physicians.

Our Analysis

Without question, the biggest challenge facing independent medicine—as well as the primary driver of the collapse of private practice specialists—is the egregious regulatory implementation and operation of the NSA's IDR process.

Unfortunately, in the 41 months since the NSA was signed into law,[4] the rules, guidance, and other outcomes from the Departments of Health and Human Services, Labor, and Treasury ("Tri-Departments") have been anything but fair. This regulatory malpractice is in direct defiance of the bi-cameral, bi-partisan efforts in Congress to successfully pass the No Surprises Act.

This law was carefully designed to treat all relevant parties fairly. Your Committee played an exceedingly important role in not only ensuring the law was unbiased, but also providing federal regulators clear directives to implement the law. Additionally, the statue's language is unambiguous as to how disputes between physicians and health insurance companies that enter the federal independent dispute resolution (IDR) process should be decided.

Given how, to date, the Tri-Departments have illegally implemented the No Surprises Act in favor of health insurance companies, these corporations have used this opportunity to threaten cancelation of long-standing contracts with medical providers,[5] narrow their coverage networks,[6] and ultimately jeopardize patients' access to the care they need.[7]

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[4] H.R. 133, Consolidated Appropriations Act, 2021, (P.L. 116-260), December 27, 2020, accessed: https://www.congress.gov/bill/116th-congress/house-bill/133/text.
[5] BlueCross BlueShield of North Carolina, "Necessity to amend rate agreement", November 5, 2021, accessed: https://www.acr.org/-/media/ACR/Files/Advocacy/20211105-BCBSNC-rate-reduction-notice_Redacted.pdf.
[6] BlueCross BlueShield of Tennessee, "A Message from Robin Young", Letter to Employers, August 17, 2022, accessed: https://www.acr.org/-/media/ACR/Files/Advocacy/BCBS-of-TN-Letter-to-Employers.pdf.
[7] American Medical Association, "Surprise billing rule provision jeopardizes patient access to care", December 9, 2021, accessed: https://www.ama-assn.org/delivering-care/patient-support-advocacy/surprise-billing-rule-provision-jeopardizes-patient-access.

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Specifically related to the law's IDR process, health insurance companies have used the administration's failed regulatory implementation to game the system. According to a survey[8] from the Emergency Department Practice Management Association (EDPMA), "95.6% of outstanding claims are 5+ months old from 127 health plans." Even worse, of the 200,000 claims surveyed, "87% of payers did not pay in accordance with the IDR entity decision." EDPMA continued:

> "Payers' blatant disregard of the No Surprises Act's intent and CMS issued guidance undermines the law and guts fair emergency physician reimbursement that underpins emergency care in America. Of the survey respondents, 60% quantified the percentage of payments won in IDR but not paid within the prescribed 30 days. Of these, 1/3 reported 100% noncompliance by health plans; 1/3 reported noncompliance from 89% to 98% of the time; and 1/3 reported noncompliance averaging 37% of the time."[9]

We have also recently learned about a new development concerning the selection process for certified IDR entities (IDREs). If a physician does not respond within hours to CMS—including after normal business hours—then the health insurance company (i.e., the non-initiating party) gets their choice of IDRE. The health insurance company can then use this faulty selection to win the IDR process.[10] This must be stopped immediately.

We, therefore, urge the Ways and Means Committee to: 1.) use every lever of power at its disposal to ensure health insurance companies follow the law, comply with all timelines and deadlines set forth in the statue, and make their required payments on-time; and 2.) force CMS to answer for why they are unfairly targeting initiating IDR parties with an unfair and unrealistic IDRE selection process.

In no uncertain terms, the lawlessness of the Biden administration's regulators, coupled with health insurance companies' greed, has put our nation's healthcare delivery system on the brink of collapse. Independent medical practices across the country are also being forced to close their doors or sell to large health systems, where costs are higher and the care delivered is of lesser quality. As Dr. Timothy Richardson testified during this hearing, "Burdensome regulation and unbalanced reimbursement schemes heavily favor and incentivize the delivery of

[8] Emergency Department Practice Management Association, Survey, "No Surprises Act Independent Dispute Resolution Effectiveness", March 9, 2023, accessed: https://edpma.org/wp-content/uploads/2023/03/EDPMA-Data-Analysis-No-Surprises-Act-Independent-Dispute-Resolution-Effectiveness-1.pdf.
[9] Ibid.
[10] See Appendix I.

care in the often vastly more expensive hospital setting. This uneven playing field threatens the survival of independent physician practice…"[11]

Conclusion

While our nation's independent medical practices are being starved of the resources they need to continue their operations, health insurance companies continue to post record earnings and profits. The Biden administration allowing these companies to manipulate the NSA's IDR process is one of the main drivers of this largesse. Much work remains to steady the IDR ship. However, we are confident that, with your oversight and assistance, the intent and protections of the No Surprises Act can be fully achieved. Patients can then be confident that their physician practices will not collapse and be there for them in their time of need.

Thank you again for this opportunity to provide our comments on your May 23 subcommittee hearing. If we can be of any help to you or your staff, please do not hesitate to contact me directly at (202) 823-2333.

Sincerely,

Christopher G. Sheeron
President
Action for Health

Cc: The Hon. Lloyd Doggett
Ranking Member
Subcommittee on Health

[11] Timothy Richardson, MD, Testimony before the Ways & Means Health Subcommittee Hearing: "The Collapse of Private Practice: Examining the Challenges Facing Independent Medicine", May 23, 2024, accessed: https://waysandmeans.house.gov/wp-content/uploads/2024/05/Richardson-Testimony-1.pdf.

Appendix I

Action Required: New certified IDR entity selected for your dispute

From: Auto Reply Federal IDR Questions <auto-reply-federalidrquestions@cms.hhs.gov>
Sent: Monday, April 8, 2024 5:03 PM
To: [redacted]
Subject: Action Required: New certified IDR entity selected for your dispute

IDR Dispute Status: New certified IDR entity selected for dispute
IDR Reference Number: DISP-1214764

The previous certified Independent Dispute Resolution (IDR) entity selected for **DISP-1214764** was not agreed upon by both parties. **Keystone Peer Review Organization, Inc.** has been selected as the alternative preferred certified IDR entity for this dispute.

Next step:

Please provide the following information by completing the IDR Entity Reselection Response form:

1. **Do you have a conflict of interest (COI)** with the selected certified IDR entity?
2. **Do you agree to the certified IDR entity selected** by the other party to handle this dispute?
3. **If you have a COI or don't agree** with the selected certified IDR entity, review the list of certified IDR entities and **select an alternative preferred certified IDR entity**. Do not select a certified IDR Entity with which you have a COI.

Important: If we don't receive a response from you by **4/8/2024**, we'll proceed with assigning the preferred certified IDR entity selected by **United Healthcare The Empire Plan** for this dispute unless the certified IDR entity is unable to attest that it has no COI. **Be advised the above IDR Entity Reselection Response form link will expire at 11:59 PM ET on the day your response is due.**

Resources

- For guidance related to your role in the Federal IDR process, please see the Federal IDR Guidance for Disputing Parties.
- Visit the No Surprises website for additional IDR resources.

Contact information

For questions, contact us at FederalIDRQuestions@cms.hhs.gov. Please reference your IDR reference number above.

Thank you,
IDR Review Team

Action Required: New certified IDR entity selected for your dispute

From: Auto Reply Federal IDR Questions <auto-reply-federalidrquestions@cms.hhs.gov>
Sent: Thursday, April 11, 2024 1:14 PM
To: [redacted]
Subject: Action Required: New certified IDR entity selected for your dispute

IDR Dispute Status: New certified IDR entity selected for dispute
IDR Reference Number: DISP-1226440

The previous certified Independent Dispute Resolution (IDR) entity selected for **DISP-1226440** was not agreed upon by both parties. **Keystone Peer Review Organization, Inc.** has been selected as the alternative preferred certified IDR entity for this dispute.

Next step:

Please provide the following information by completing the IDR Entity Reselection Response form:

1. **Do you have a conflict of interest (COI)** with the selected certified IDR entity?
2. **Do you agree to the certified IDR entity selected** by the other party to handle this dispute?
3. **If you have a COI or don't agree** with the selected certified IDR entity, review the list of certified IDR entities and **select an alternative preferred certified IDR entity**. Do not select a certified IDR Entity with which you have a COI.

Important: If we don't receive a response from you by **4/11/2024**, we'll proceed with assigning the preferred certified IDR entity selected by **United Healthcare** for this dispute unless the certified IDR entity is unable to attest that it has no COI. **Be advised the above IDR Entity Reselection Response form link will expire at 11:59 PM ET on the day your response is due.**

Resources

- For guidance related to your role in the Federal IDR process, please see the Federal IDR Guidance for Disputing Parties.
- Visit the No Surprises website for additional IDR resources.

Contact information

For questions, contact us at FederalIDRQuestions@cms.hhs.gov. Please reference your IDR reference number above.

Thank you,
IDR Review Team

Statement for the Record

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

Thank you for holding this hearing and for the opportunity to submit the following Statement for the Record. I am John Gallagher, MD, a private practice physician in Bucks County, Pennsylvania and a member of Congressman Brian Fitzpatrick's Physicians Advisory Board.

It is essential for Congress to focus on the urgent issues that jeopardize access to care for seniors. Private practices are small businesses, drivers of the local economy that provide high quality care at lower cost. Yet, for many years, private practice physicians have expressed alarm with the shortfall in Medicare physician payment. The absence of an inflation-based update puts patients' access to care at risk. It threatens the ability of independent physicians to keep the lights on, pay rent and taxes, retain staff, or afford necessary equipment. The COVID pandemic further pushed these practices to an even more precarious position.

The "playing field" is severely out of balance. Smaller practices are unable to negotiate with market dominant insurers for fair payment. Physicians, unlike other Medicare providers, do not receive an automatic yearly inflation-based update. Adjusted for inflation in practice costs, Medicare physician payment rates plummeted 29 percent from 2001 to 2024. Meanwhile, hospitals among others receive an inflation-based update; with these enhanced resources, hospitals are positioned to acquire physician practices. This decreases patient choice.

The flawed statutory budget neutrality requirements within the Medicare Physician Fee Schedule require immediate reform. Congress should (1) increase the outdated $20 million threshold that triggers budget neutrality adjustments, was set in 1989, and unadjusted for inflation, to $53 million to reflect current economic realities; and (2) authorize CMS to implement a look-back period to adjust for past misestimates and ensure a fairer and more accurate payment system.

In addition, prior authorization requirements imposed by health insurers places significant administrative and time burdens on health care staff and physicians. Prior authorization increases overhead and profoundly hampers practices' ability to operate efficiently. This opaque and overused process delays diagnosis and treatment, and diverts critical resources and time that could be better spent on direct patient care. Delays caused by prior authorization can harm patients, including causing prolonged suffering and progression of disease.

As a result of this unsustainable situation, independent physicians who have had longstanding patient-physician relationships have increasingly retired early or left their practice to join a large hospital or health system. As examples from Bucks County, a local gastroenterologist joined a hospital while another retired; a cardiologist joined a health system; and a hematology oncology practice's sale to a large health system increased the cost of care to patients. Due to the adverse practice environment, our own practice had a steep challenge recruiting a new physician member.

An AMA analysis shows that by far, the most cited reasons that independent physicians sell their practices to hospitals or health systems had to do with inadequate payment, followed by the need to better manage payers' regulatory and administrative requirements.

Congress should do more than listen to the stories of the loss of private practice. The Ways and Means Committee has jurisdiction over remedies. The Committee must act and advance solutions. Three such measures are (1) H.R. 2474, the "Strengthening Medicare for Patients and Providers Act," which provides a permanent annual update equal to the increase in the MEI, foundational to meaningful reform and stability of physician practices; (2) H.R. 6371, the "Provider Reimbursement Stability Act," that would repair the flawed budget neutrality system; and (3) Improving Seniors' Timely Access to Care Act, twice thankfully reported out of the Committee, to improve the prior authorization process. Immediate and decisive action would be appreciated.

Challenges Facing a New Spine Care Private Practice

Our private practice, consisting of two orthopedic spinal surgeons and one physiatrist, has faced tremendous pressures and difficulties to stay viable since it opened its doors in February 2021, in the middle of the COVID-19 pandemic.

Reimbursement Challenges

It has been extremely difficult to fight back against commercial insurance companies that erect numerous barriers to obtaining prompt reimbursement for healthcare services rendered. Every claim must be appealed, and the majority of services rendered are challenged as being "not medically necessary," requiring months of appeals. Our private practice has had to employ additional billing expertise and staff to fight these denials, impacting our ability to stay viable.

We are also very concerned about the downward pressure on Medicare reimbursement rates, which currently make it impossible to break even on services rendered to Medicare patients. Medicare rates continue to be cut year after year for physician professional fees, while inflation has raised the cost of labor and medical supplies. We continue to accept Medicare patients out of duty to our community, writing this component of our practice off as a financial loss.

Failed Implementation of the Federal Independent Dispute Resolution (IDR) Process

In 2020, Congress passed the No Surprises Act (NSA), which removed patients from payment disputes between health insurance companies and out-of-network providers. The NSA banned physicians from "balance billing" and instead created a quick and fair independent dispute resolution (IDR) process to resolve payment disputes. This IDR process is critical for our practice to obtain fair payments from private insurers. Unfortunately, federal departments have failed to implement the IDR as called for by the NSA, and our practice has faced continued problems with the IDR process. One egregious issue is insurers refusing to make payments even after a certified IDR entity determines a payment in our favor.

CMS cannot continue to allow private insurers to sabotage the IDR process to add to their unprecedented profits. The IDR process must adhere to the short timelines outlined in the law and be implemented fairly and simply. It should be clear from the time the explanation of benefits (EOB) is received whether the case is IDR eligible and in what venue. There should be a straightforward and non-duplicative method for requesting data from physicians, and IDR entities should make decisions promptly. Furthermore, insurers must be required to make payments within the required 30-day period after an IDR loss or face stiff penalties. These fixes would help alleviate the reimbursement challenges we face from commercial insurers.

Healthcare Consolidation

Corporate entities owning and running physician practices have severely challenged our ability to stay viable. Insurer-owned physician practices (e.g., Optum owned by UHC) and non-profit

health systems have unfair advantages that prevent fair competition in the healthcare marketplace.

Insurer-owned physician practices and non-profit health systems have purchased the majority of private practice primary care physicians in our marketplace, drying up independent practice specialist referral sources. Insurer-owned practices typically do not face the burdensome billing audits that UHC and other commercial insurers impose on independent practices, which exemplifies concerning anti-competitive behavior by consolidated entities.

Non-profit health systems, although directly competing with independent practices, enjoy significant advantages not accessible to our practice. These include tax benefits and lack of site-neutrality, where the same services we perform in our office are paid multiples more by Medicare and commercial insurers when performed at an outpatient facility owned by a health system. There are no tax credits allotted to private practices for charity care. Non-profit health systems use their tax advantages to capture further market share, making it difficult for our private practice to compete. It is not uncommon to see non-profit health systems in our marketplace spend heavily on marketing campaigns, such as sponsorship of a professional sporting venue or a Super Bowl ad, which is cost prohibitive for private practices. Corporate entities have also steadily increased labor costs in our marketplace, where we have seen health systems spend more than $30/hour on clerical staff in hospitals, which would be extremely difficult for our practice to afford, especially given the downward pressures on Medicare reimbursement rates.

Stark Law Restrictions

Stark Law imposes inconsistent restrictions on physician self-referral without placing any limitations on hospital system self-referral practices, with many health systems requiring self-referral. Physicians who self-refer face thousands of dollars in fines, exclusion from Medicare and Medicaid, and possible jail time, creating an unfair competitive landscape within the healthcare industry. The unequal restriction on self-referral has contributed to consolidation and vertical integration, including hospitals' and payers' acquisition of clinics, ambulatory surgery centers (ASCs), and similar entities, exacerbating rising healthcare costs while degrading the quality of patient care.

Optimal performance of integrated care delivery platforms, both high-quality and cost-effective, depends on aligning incentives for physicians and allowing them to compete with health systems and payer-providers. However, current Stark Law effectively prohibits physicians from competing with these vertically integrated healthcare entities, further demonstrating the need to balance the benefits of integration with preserving a fair and competitive environment for physicians. The prohibition of self-referral perpetuates challenges that hinder patient access to care by shifting the burden of quality assessment onto patients who may lack the necessary information to make informed decisions. The restriction on self-referral for Medicare and Medicaid patients may compel physicians to refer patients to providers without sufficient knowledge of their quality or capabilities, impacting patient outcomes.

Private practice sustainability requires Congress to pass comprehensive Stark Law reform to rectify disparities by ending the blanket ban on self-referral practices. Congress needs to pass equitable and balanced Stark Law reform that fosters fair competition, incentivizes innovation, and facilitates the delivery of high-quality, patient-centered care across the healthcare industry.

Viability of Independent Practice is at a Breaking Point

Our practice continually evaluates our financial sustainability, with significant concern that we may not remain viable given the increasing consolidation in the marketplace. Every month, we hear of private practice colleagues who remained independent for decades "seeking shelter" by seeking sale or acquisition by a health system or other corporate entity. If Congress does not act immediately to halt healthcare consolidation and reverse regulations adversely impacting private practice sustainability, our healthcare system will suffer from less choice, reduced access, and increased costs of care as private practice becomes extinct in this country.

Daniel E. Choi, M.D.
Spine Medicine and Surgery of Long Island
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Ronkonkoma, NY 11779
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The collapse of Private Practice: Examining challenges facing Independent Medicine

Embarking on the journey of a private medical practice is driven by the noble aspiration to deliver dignified, autonomous patient care. It's about nurturing deep connections with patients, offering personalized attention, and making medical decisions that transcend mere numbers. This pursuit of excellence and freedom is the cornerstone of a patient-centered approach, yet it is met with formidable challenges imposed by insurance carriers, which often feel like running a relentless gauntlet.

Private practice is a bastion of personalized medicine, where the sanctity of patient-physician relationships flourishes. Here, the luxury of time allows for meaningful interactions, enabling physicians to treat individuals, not just symptoms. This environment transforms healthcare from a sterile necessity to a warm, welcoming community where patients are treated by familiar faces dedicated to their well-being. Moreover, the camaraderie among staff, bound by shared values and goals, creates a familial atmosphere that not only supports but also enriches the practice, making each challenge a shared endeavor and each success a collective triumph.

Authorizations and payments are quickly becoming a provider's biggest adversary. The authorization process is an ever changing, time consuming, delay of care that is demeaning to a physician and their medical decision making. There is no clear, fair process for authorization. It is a relentless task that devours manpower. It is common to spend 45 minutes on hold, be transferred, disconnected, and forced to decipher a language invented by insurance carriers. A response of “no authorization required” translates to nonpayment for a procedure that is not a covered service. There is no transparency from the mouths of an insurance company or the third-party authorization groups they use. These groups are responsible for some CPT codes or certain places of service but not all. It is up to office staff to know to whom the request should be placed, and it can result in multiple submissions, wasting more time and delaying care. One example is an authorization placed for a 53-year-old male with multiple myeloma and three debilitating vertebral compression fractures needing treatment with kyphoplasty. An authorization was placed with the insurance carrier only to be met with the response that they are not responsible for the given CPT codes. A number was given for a third-party authorization group. A second authorization was submitted to the third party and office staff were told they also are not responsible for auth as the place of service was not under their authority. A suggestion for resubmission with the host plan was given. This back and

forth “I am not responsible” response continued for 4 weeks. It took dozens of man hours, emails, multiple 3-way calls, sitting on hold and being disconnected just to find out who is accountable for authorization. Throughout those four weeks the patient spent all his time in a bed or recliner, unable to walk or work and transferring only to use the bathroom. At his post procedure two week follow up he walked through our front doors. Even when the responsible party for auth is known there is no guarantee of a prompt authorization or an approved authorization period.
An auth request placed for a 67-year-old male with gangrene of the foot and arterial occlusions needing revascularization took two weeks for approval. Prior to approval, the patient developed sepsis, was hospitalized and underwent an amputation. Another authorization for a 77-year-old female with osteoporotic compression fractures and worsening pain needing vertebral augmentation was denied after two weeks stating the request is not medically necessary. A second attempt at auth was submitted and immediately denied noting “administrative void for duplicate of a previously denied request.”

The fight for authorization is only part of the payment process. Once procedure is performed and claims are submitted, we are daunted with countless requests for records, denials, post payment reviews and notifications to take back payment. All of these require administrative man hours, delay in payment, increase of AR and loss of money for the practice. A claim for a procedure done on a 63-year-old male took four months for payment requiring all procedure notes be sent multiple times via fax and mail. Once payment was made a letter of post payment review was received asking for all notes to be sent yet again. A notification stating the payment would be taken back was given 3 months post. Despite compliancy of requests, several phone calls, and appeals this claim was never fully paid.

Another such instance is a claim submitted to carrier for a 95-year-old male. Before payment, the payor asked for all procedure-related notes. These notes were uploaded directly to insurance carrier online portal with a receipt of attachment. This claim was still denied stating procedure notes were never received. After speaking with a representative, the claim was sent for reprocessing along with another attachment of all procedure notes only to be denied again. A reconsideration was requested and denied. This claim is still in appeal process and was originally submitted 7 months ago.

We need urgent transparency and electronic simplification to preauthorization process. We need to limit their ability to delay payments for frivolous reasons without accountability. Provider relations representatives should be assigned, readily available and accessible to private practice offices and their staff. Private practices cannot afford to

provide services and wait without certainty of payment. There should be a limit on claw back of payments without reason, as happens now. **The increase in administrative work to beg an insurance carrier to approve care only to turn around and fight for payment of care provided from those same carriers is a burden private practices should not have to carry alone.**

Healthcare at a private practice is no longer just about a passion to help others and to make lives better. It requires grit, fortitude, and a strong resolution to run the gauntlet laid by insurance carriers. It is also about knowing that every small victory will be met with a bigger challenge, that there is no help coming, and that the opponent has no accountability.

We want your help to bring accountability and reason from powerful insurance carriers so that patients can continue to be helped by compassionate, small private practices.

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

An address to the U. S. House Ways and Means Health Subcommittee

Dear Mr. Chairman and Subcommittee Members:

I am a solo independent family physician practicing in a small town in Northwest Ohio and completing my 45th year in the practice of primary care. I am speaking for myself, but in a larger sense as a member of the Ohio State Medical Association, a member of the American Medical Association, and a former member of the AMA House of Delegates who represented Ohio's Physicians, I also am speaking for thousands of physicians in Ohio and tens of thousands of physicians across this great country, to inform you of the dire straits that I and my many colleagues are experiencing in attempting to run an independent medical practice.

To cut to the chase, Medicare payments have simply not kept up with the costs incurred in running a medical practice, and this in turn has led to an astounding attrition in the loss of independent practice in our country. Greater than half of physicians were employed in independent practice fewer than 15 years ago to about 20% today. In the last 20 years, while inflationary costs have risen about 30%, adjustments in fee for service payments have increase just 7%. Practice costs are simply not being compensated adequately, and physicians are being squeezed to the bone. Unable to make ends meet, physicians are retiring early, selling their practices to hospitals or insurers, becoming employed, or just plain quitting and closing the doors to their offices. This in turn has led to a dramatic loss of availability of service to our patients in a private setting, and has generated higher system costs due to the seeking of care by many patients in expensive hospital-based venues. By-the -way, hospitals have received a 60% increase in payments in the last 20 years, physicians just 7%. Studies have shown that our total health care expenditures are as much as 34% higher than they should be because of an inadequately funded primary care system in our country and an over-dependence of the delivery of specialty care in expensive hospital settings.

Instead of integrated hospital systems that employ large numbers of physicians, delivering economies of scale, large integrated systems deliver dis-economies of scale and end up driving prices higher than they otherwise would be, and by as much as 34% higher.

How did we get here?
Well, the intent of Congressional funding of Medicare through the years was to help our health care system deliver high-quality care at reasonable costs, by favoring hospital payments over physician payments. Somehow primary care payments were left out of the equation, and thus primary care has been chronically underfunded. We now have a worse, much worse system of misplaced resources than we should have had, had primary care been adequately funded all along.

How do we get out of this conundrum?
Thought leaders in the field largely agree that independently practicing physicians hold the key to improvements in access to care in a least expensive venue for our patients. To do this, independent physicians and primary care need markedly improved funding. We currently spend about 6-7% of healthcare costs on primary care, this should be 12-15% of total healthcare expenditures. Payments to physicians need to be improved immediately, and annual cost of living adjustments must be part of the payment structure to assure the survival and prosperity of independent medical practice. As commercial insurers follow Medicare reimbursement rates, Medicare rates to physicians need an immediate adjustment of 20% to help compensate for long-term inadequate payment rates, and *realistic annual* inflation cost adjustments must be built into any payment scheme enacted by our Congress.

Thanks for listening,

God Bless America.

TEXAS MEDICAL ASSOCIATION
Physicians Caring for Texans

June 6, 2024

Chair Jason Smith (R-Mo.)
Ways and Means Health Subcommittee
1139 Longworth House Office Building
Washington, D.C. 20515

Chair Vern Buchanan (R-Fla.)
Ways and Means Health Subcommittee
1139 Longworth House Office Building
Washington, D.C. 20515

Submitted via email WMSubmission@mail.house.gov

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

Dear Chairs Smith and Buchanan:

On behalf of the Texas Medical Association (TMA) and our more than 57,000 physician and medical student members, I write in response to the May 23, 2024, hearing held by the U.S. House Ways and Means Subcommittee on Health titled, "The Collapse of Private Practice: Examining the Challenges Facing Independent Medicine." TMA House of Delegates policy defines "independent physician practice" as comprising "one or more physicians with decision-making authority and responsibility for the viability of the medical practice in which they own a controlling interest." Independent practices operate on the thinnest of margins compared with larger, integrated, delivery systems. The health care marketplace is increasingly hostile to solo, small, and independent practices through factors such as low payment rates that fail to keep up with inflation, increasing administrative burdens, the inability to find and retain staff, and exclusion from health plan networks due to market consolidation and vertical integration. These factors can result in decreased patient access to physician services.

It is crucial for Congress to understand the displacement of independent physician practices by health care systems results in diminished patient autonomy and reduced accessibility of patient care. More concerning, studies show the transition from independent physician practice to hospital-owned clinics often leads to staggering surges in service costs as high as 14%, with no supplementary advantages for patients.

The challenges facing independent physician practices are of such concern that the TMA House of Delegates in May of 2024 approved a standing Committee on Independent Physician Practice with highest priority, reporting directly to our TMA Board of Trustees.

Physicians have an ethical duty to their patients, whereas corporate boards of directors and officers have fiduciary duties to shareholders and the corporation itself. Often corporate entities consider independent physician practices to be competition, rather than partners in providing health care in their community. As such, TMA sincerely appreciates congressional leaders examining the financial and regulatory burdens facing independent medical providers and how continued challenges result in consolidated health care systems and barriers to patient care.

Research on Independent Practice Physicians
The burdens that independent physicians experience are all too real, and financial pressures are increasing. TMA is concerned with a report published by Physicians Advocacy Institute (PAI) and Avalere Health in April 2024. Unfortunately, key findings from this long-term research project (2019-23) demonstrate an ongoing physician exodus from independent practice. Specifically, the report indicates nearly four out of five (77.6%) physicians are now employed in hospital or corporate-owned practice settings.

Since Medicare payment rates for physician services continue to disregard inflationary increases in the cost of providing medical care, hospitals, health systems, and other corporate entities are provided a significant advantage over struggling independent physician practices. Private practices are breaking under the pressure of lack of adequate payment and increasing overhead. When this happens, physicians must look toward "partners" who can help navigate the financial crisis. This leads to increasing consolidation with potentially predatory partners primarily interested in profits. The PAI and Avalere Health report further indicates financial incentives linked with flawed government and private payer payment policies have contributed to nearly six out of ten (58.5%) physician practices being owned by hospitals/health systems and other corporate entities. This in turn forces patients to seek care from higher-cost care settings, leading to significantly higher costs to the entire system due to site-of-service payment disparities and higher patient copayment responsibilities.

The PAI/Avalere research further indicates more than 19,000 physicians became employees of hospitals or corporate entities – a 5.1% increase from 2022-23. Further, their research shows hospitals and other corporate entities acquired 8,100 additional physician practices over the past two years, representing a 6% increase in the number of hospital or corporate-owned practices since 2022.

Congress must adjust Medicare payment policies to account for the growing shortage of health care workers. Data show:

- About one in five health care workers have left medicine since the pandemic began.
- Since the pandemic started, 18% have quit, 12% have been laid off, and 31% have considered leaving.
- In 2022, nearly 1.7 million people quit their health care jobs – equivalent to almost 3% of the health care workforce.
- It is estimated that the cost to replace a health care employee averages the amount of a year's salary for that position.

Though the issues are complex and multifactorial, staffing issues create a significant burden on independent practices who compete with large health systems and hospitals for the same staff. These systems are able to offer more attractive benefits like signing bonuses and higher base salaries. These systems also already benefit from an array of staff and technology at their disposal to compete against small practices for the same workforce. While other service industries can raise their prices to accommodate the higher wages, the Medicare physician fee schedule does not increase.

TMA fully shares concerns expressed by PAI that, "Corporate entities are assuming control of physician practices and changing the face of medicine in the United States with little to no scrutiny from regulators." **To preserve the independent practice of physicians, TMA calls on Congress to take steps to keep physicians, not corporate interests, in charge of patients' medical care.**

Disruptive Cyberattacks

Change Healthcare – a health care technology company that is part of Optum and owned by UnitedHealth Group – experienced a cyberattack on Feb. 21, 2024 that disrupted payment and revenue cycle management operations for medical practices across the country. This cyberattack was an unfortunate, unforeseen, significant, and further damaging blow that disrupted continuing care for patients and strained struggling medical practices, in particular those in solo, small, and rural settings.

To date, Congress has not taken any meaningful steps to address future cyberattacks nor has the Administration asserted that physician practices, victims of the attack, would be held harmless from any possible release of protected health information, which causes further concerns for struggling independent practices.

Inadequate Payment Failing to Keep Pace with Inflation

The lack of any predictable, positive, and inflationary based payment update, despite the disruptive and costly COVID-19 pandemic and cyberattack challenges, is contributing to the collapse of independent practices. As you know, Congress was unable to avert the full 3.37% pay cut to Medicare participating physicians in 2024 though it

was mitigated to about 1.68% for services rendered on and after March 9. This latest cut especially stings after a full 2% cut occurred in 2023 Medicare physician payments. This is untenable in inflationary times.

TMA joined national and state medical societies in a Jan. 17, 2024 letter to Congressional leaders noting failure to reverse these cuts will harm the continued viability of physician practices and their ability to care for patients. The letter noted, "Cuts will be felt hardest by small, independent practices, like those in rural and underserved areas that continue to face significant health care access challenges. Continuing down this path is simply unsustainable."

The letter further spotlights, "Physicians are the only Medicare providers that did not receive an inflationary update this year. In fact, they are the only Medicare providers who have a payment cut in 2024." The House Ways and Means Committee should continue examining Medicare site payment differentials and pass reasonable, fair, and inflationary updates as advocated for by TMA and other physician organizations.

TMA implores you to stand for Texas patients and their physicians. Seek legislation that provides a positive, stable, and predictable Medicare physician payment system! TMA wholeheartedly endorses a bill currently introduced in Congress, the *Strengthening Medicare for Patients and Providers Act* (House Resolution 2474). We encourage Congress to pass this bipartisan bill, reform this broken system, and help ensure physicians receive inflationary updates, just like other Medicare providers receive.

Passage of this bill would be significant and needed progress toward a more viable Medicare Payment System as it provides independent physician practices with greater financial stability and predictability.

Physician Well-Being/ Burnout
Another significant challenge independent physicians increasingly face on a daily basis, and in increasing amounts, is work-related stress. As communicated in a Jan. 24, 2022 letter to the National Institute for Occupational Safety and Health, TMA maintains that even prior to the COVID-19 pandemic, a growing number of physicians reported suffering from professional "burnout," characterized by "emotional exhaustion, depersonalization, and a sense of reduced accomplishment in day-to-day work." As the pandemic entered its third year, physician morale declined even further, exacerbated by the multiple COVID surges, staffing shortages, and the public's unprecedented level of distrust in science, medicine, and clinical expertise.

TMA again aligned with the American Medical Association (AMA) to argue that while workplace stress and burnout display themselves in individual physicians, the root causes stem from the problems inherent in the health care system, public and private payer issues, and excessive and ever-growing administrative burdens. **Congress should therefore focus on interventions that address the problems of the health care environment, rather than on interventions designed to help an individual physician withstand a dysfunctional care environment.**

Shortage of Physicians
Texas has long lived with a shortage of physicians. Given the state's demographics and geography, there are longstanding, deeply rooted challenges to recruiting and preparing enough physicians for the state's needs. In order to increase the strength of private practices, we must address the trend in physician shortages.

On March 21, 2024, the Association of American Medical Colleges published a report concluding that the U.S. is expected to face a physician shortage of between 13,500 and 86,000 by the year 2036. The report states the continued need for more physicians is related to population growth and aging.

The TMA recognizes that on May 24, 2024, bipartisan members of the Senate Finance Committee released proposals to improve the Medicare Graduate Medical Education (GME) program. We appreciate their work and look forward to further efforts to increase our GME proposals.

Most residents of Texas' 177 rural counties experience medical underservice. This results from a variety of factors that include geographic characteristics such as single counties in West Texas that span 4,600 square miles to factors such as a lack of infrastructure to sustain a physician practice. The void of pharmacists, diagnostic labs, hospitals,

etc., present strong challenges. Practice in a rural, isolated community requires appropriate training. Family physicians who train in the heart of the Texas Medical Center in Houston – with ready referrals and access to every medical specialty, diagnostic test, or medical procedure and facility – cannot reasonably be expected to feel prepared for the role of the sole physician in a rural, isolated community.

It would be beneficial to identify ways for private health care systems to partner as residency training rotations to extend training responsibility beyond public institutions and to allow a portion of the Medicare GME payment to the hospital to follow the resident.

TMA supports congressional legislation such as the REDI Act, House Resolution 1202 by Rep. Brian Babin, (R-Texas), which would help reduce education-related debt for physicians by allowing for the deferral of interest on education loans until a physician completes their residency training. Reducing education debt will allow physicians to go into private practice with less financial risk. This legislation would reduce physician debt and serve as an incentive for more talented young Americans to pursue medical careers.

Administrative Burdens
A major contribution to physician burnout across the board is the excessive, ever-changing, and overly burdensome paperwork requirements imposed by public and private payers. TMA thanked the Centers for Medicare & Medicaid Services (CMS) in a March 13, 2023 letter in response to a proposed rule titled, "Advancing Interoperability and Improving Prior Authorization Processes" for Medicare Advantage organizations, Medicaid managed care plans, and others. In the regulation, CMS recognized the ongoing and increasing burden of prior authorization on physicians. TMA found the regulatory changes set forth in the proposal are a needed and critical step forward in improving the prior authorization process. **TMA urged CMS, and we likewise now also encourage Congress, to evaluate prior authorization burdens further and make additional modernizations to ensure patients receive physician-directed medically necessary care.**

In response to CMS' proposed rule on Advancing Interoperability and Improving Prior Authorization Processes, TMA calls for CMS to finalize regulations that:

- Make information about prior authorization requests and decisions available to patients;
- Require payers to provide a specific reason for prior authorization denials and to include clear and actionable next steps;
- Require payers to publicly post on their websites aggregated prior authorization data;
- Allow for a gold-carding program to reduce prior authorization requirements for physicians who demonstrate a consistent pattern of prior authorization approvals;
- Specify that Certified Electronic Health Record Technology (CEHRT) vendors be required to update their technology to support adopted electronic prior authorization standards; and
- Allow CMS to establish an oversight and enforcement process to ensure payer compliance with regulatory requirements processes that allow patients and physicians to report noncompliant payers.

Physicians continued to be overburdened by additional work created by use of the EHR. When CMS incentivized physician adoption of EHRs it came with the promise of practice efficiencies, better care quality, patient safety and lower cost of care.

Unfortunately, EHRs have significantly increased the workload on physicians. One example is the amount of work created by the EHR inbox. A 2023 National Institutes of Health article, "Burnout Related to Electronic Health Record Use in Primary Care," cited the number of electronic messages in the EHR inbox as a significant predictor of burnout. The publication cited a study of primary care practices in which those with "more than 307 messages per clinical full-time equivalent (FTE) per week (highest quartile in study) were six times more likely to have exhaustion compared to those with less than 147 messages (lowest quartile in study)." The high number of messages in the inbox requiring physician time has "become nearly the equivalent of a second set of patients to be treated beyond scheduled patients. … Unlike effort spent in care of scheduled patients, the added burden of care given through electronic messaging is also typically unmeasured productivity and not reimbursable."

The Journal of General Internal Medicine published "The Electronic Health Record Inbox: Recommendations for Relief" in 2022. The first sentence of the article states, "The inbox has become unbearable." There is recognition that some administrative paperwork is expected but that the electronic inbox has grown "dramatically and insidiously." The article says that "at one large integrated healthcare delivery system, family physicians and general internists addressed an average of 100 inbox messages daily during working hours and another 50 each weekday evening." It is also insightful to note that the "number of patient messages increased by 157% at the onset of the pandemic and have remained at this 'new normal' level since." This is simply unsustainable.

While great strides have been made to make disparate EHRs interoperable so that patient information can be easily shared among physicians providing care to a patient, there is still much work to be done. Patient information should move seamlessly and securely across vendors, physician practices, and health systems without extra effort from the physician.

Reexamine Burdensome MIPS Requirements
Independent physicians also face challenges complying with burdensome requirements associated with the Merit-based Incentive Payment System (MIPS). TMA member physicians report finding it expensive and time-consuming with little to no impact on patient health care outcomes.

Although some progress has been made, lack of alignment across CMS' quality programs has contributed to challenges for clinicians, facilities, and health insurers when it comes to prioritizing outcomes that are meaningful for patients. It is imperative to recognize that the continuous changes to participation and reporting requirements, program terminology, and other aspects have proven to pose significant impacts on patient-physician interaction. This further hinders the ability of physicians to develop practice goals and better measure/improve their own performance. Physician burnout is also a serious consequence for physicians who operate small businesses and must comply with myriad regulations. Physicians' primary mission is to help, treat, and heal their patients who are sick and suffering, not to check boxes and chase down paperwork.

TMA maintains the position articulated to CMS in our Sept. 8, 2023 comments on the 2024 proposed Medicare physician fee schedule. TMA expressed concern that annual and incessant proposed changes to MIPS significantly contribute to physician administrative burdens and regulatory compliance challenges that result in physician burnout. TMA pleaded with the agency to alter MIPS requirements only as needed or when doing so significantly reduces the burdens physicians bear while navigating the MIPS program. While TMA understands CMS is encouraging continued improvements in physician performance each year, TMA cannot understand the need to continuously change the program before participants have a chance to master the changes implemented the previous year.

Unfortunately, according to the most recent CMS Quality Payment Program data released by the agency, independent practices across the country continue to struggle with this complicated and convoluted program. TMA asserts that the Congressional intent behind the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015, which generally called for MIPS participation until alternative payment models were developed and offered to physicians, has not been realized. TMA believes that MIPS requirements established by Congress must be revisited. Congress should work with physician associations to implement policy recommendations developed and prioritized by AMA's MIPS workgroup. Three of the key components of the proposal include:

- Mitigating steep MIPS penalties that disproportionately harm small, rural, independent practices and practices that care for the underserved.
- Holding CMS accountable for timely and actionable MIPS and claims data, as is required under MACRA.
- Making MIPS more clinically relevant and less burdensome.

Ending Predatory EFT Fees
Yet another erosion of physician payment, practice sustainability, and patient access to care are the practices related to mandatory, percentage-based electronic fund transfer (EFT) fees.

According to a Medical Group Management System survey conducted in April 2023 of nearly 150 medical group practices, "over two-thirds of practices reported that over 75% of their practice's annual revenue is paid via EFT." A similar majority (two-thirds) reported "insurers are charging them fees they did not agree to when sending payments via EFT."

Most concerning, this MGMA data reveals that medical practices reported estimated fees of up to $1,000,000 annually, although a majority reported $100,000 or less. This is an inefficient use of precious health care funds that does nothing to improve patient care or access.

TMA strongly urges Congress and CMS to address payers' excessive EFT fees charged when paying physicians what they have earned. **TMA calls on the Ways and Means Committee to support immediate passage of the bipartisan No Fees for EFTs Act (House Resolution 6487), which would prohibit payers from imposing such fees.**

Consequences of Inaction
As Congress further explores challenges that threaten the independent practice of medicine, TMA asks you to consider the consequences of payment reductions, administrative complexities, and the impact of the health insurance market and hospital consolidation on small, solo, and often rural practices. TMA asserts that inaction will accelerate the decrease in independent physician practice across the United States, ultimately reducing care and increasing costs for patients.

Congress could address these fundamental issues by fully addressing Medicare payment policies, reducing administrative burdens, and allowing more physician autonomy over their business from interferences by payers, government, or perverse incentives by large systems to acquire independent physician practices.

TMA implores you to stand for patients and their physicians. If you have questions, please contact Robert Bennett, TMA vice president of medical economics, at robert.bennett@texmed.org or Teri Deabler, CMPE, COE, director of practice services at teri.deabler@texmed.org.

Sincerely,

G. Ray Callas, MD
President
Texas Medical Association

CC
Michelle A. Berger, MD, Chair, Texas Medical Association Committee on Independent Physician Practice
Amy Townsend, MD, Vice-Chair, Texas Medical Association Committee on Independent Physician Practice

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Unsustainability of Private Medical Practice

Private Practices are unable to adjust to economic changes in a timely way to ensure financial solvency as in other industries due to governance by CMS and constraints by private insurance. Unlike all other industries, healthcare is unable to share out rising costs of materials and labor to our customers. Extreme regulation of healthcare industry, increased costs and demands on physicians and their practices make running of private practices untenable. The rate of reimbursement is not keeping par with the increased costs. The reimbursement model has not kept pace with the myriad changes in healthcare system and our national economy.

Labor related issues:

- Labor shortage
- Cost of living impact on staff (childcare, food, fuel, etc.)
- Recruitment costs are a larger portion of our budget because of perpetual recruitment in a competitive market. Prospective hires that we recruit for, and existing staff are poached by healthcare conglomerates with larger budgets and more attractive benefits packages than private practices are able to offer.
- Baseline salaries all went up when the minimum wage went up.
- Health insurance costs for staff are increasing significantly annually, contributing to the record gains being reported by private insurance companies. (The last two years reflect a two-digit percentage increase in our region)
- More costs (time, money, and morale) in training resulting from having to hire inexperienced people.
- Teaching: Off-setting workloads with student interns who require a large investment of time for training and oversight.
- **Specifically for a primary care practice** in a value-based environment:
    - More staff are required to run a medical business than in the past. We have 35 staff for 5,500 patients for 2 MD's.

The last generation of MD's needed 2 staff plus themselves.
    - Higher Administrative costs (we have a 5-person administrative team for a modestly sized Practice) to manage an interdisciplinary team and answer the demands of value-based payment structures.
    - More sophisticated skills are necessary for staff to do their work in a Value-Based model of Care. Skills are less task-based today and require more nuanced abilities to think critically, communicate effectively with patients and colleagues in other disciplines and facilitate patient health-related behavior change. Higher costs are in hiring more highly trained people or training people who are less well trained.
- Constant disruption in healthcare precipitates staff morale problems which are associated in higher administrative costs due to turnover.

Delivery of Care:

- Virtual Care was much needed and finally reimbursed during the pandemic, but Insurance Companies are no longer reimbursing for these visits. They are an essential part of increasing access (particularly for older adults) and allowing us to deliver care as efficiently and cost-effectively as possible.
- A growing awareness of the influence of mental health and social complexity on health outcomes within the medical community represents a shift in resources to integrate experts in behavioral health. However, the lack of parity in reimbursement for said services, has left private practices to absorb these additional costs while managing tight budgets.
- In the US, heavy dependence on medications necessitates costly resources such as medication management and collaboration with pharmacists.
    - Aggressive marketing campaigns by the pharmaceutical industry precipitate high patient demand for costly and sometimes unnecessary medications, and subsequently

time-intensive and often contentious conversations with physicians and their patients.
- A persistently fragmented care delivery system frequently results in polypharmacy, poor outcome contributing to high healthcare costs that private practices are financially penalized for.

Medical Business:

1. Information Technology:
   - Cybertechnology didn't exist in health care in our community when we began 20 years ago. Since our initial investment in an EHR these costs have risen steadily.
   - Cyber insurance has risen from $2,800 in 2021 to $3,800 in 2022 and in 2023 jumped to $4,400 per year.
   - In 2023 we were required by our carrier to add multi-factor authentication and encryption to our system this year which was an additional $20,000.
   - In 2023 we also absorbed a several thousand-dollar costs for a server migration and an additional cost to make our system cloud-based.
   - Maintenance IT costs have risen by 50% since the pandemic.
   - Additional ancillary IT costs that are a cumulative budget line include:
     - Airconditioning to keep the server room cool enough to prevent equipment damage.
     - Security monitoring
     - Laptop upgrades for staff
     - Switching from desktops to laptops to give more staff flexibility necessary to do their work
     - Additional docking stations for the additional laptops
     - Privacy screens
     - Payouts on Phishing scams when our staff is targeted
     - Cyber Security and HIPAA training for staff

2. Legal:
   - Standard business agreements are obsolete in the current environment. Constant industry change necessitates a high level of innovation in care delivery, medical business, and medical partnerships. Such initiatives require legal agreements to protect these relationships, driving increasing reliance on attorneys.
   - Standard legal fees have increased by approximately 50% (for our private practice they increased from $350 -$500/hr in 2021 to $750/hr in 2022)
   - Malpractice insurance costs are rising, and legislators continue to pass bills threatening small practices with unsustainable levels of risk, e.g. the Wrongful Death bill being proposed in NYS.

3. Vendors:
   - All Vendor costs have risen sharply:
     - Cleaning
     - Plumbing
     - Printer Services
     - Postage
     - Office supplies
     - Medical supplies

Systemic issues:

- Currently there is no mechanism of reimbursement for the rapidly rising time demand of documentation associated with healthcare reform. This temporal expectation is approximately 20 hours of work outside of normal working hours, during weekdays, weekends and even time off.
- Available data bears out an alarming trend of increasing incidence of mental health problems, burnout, and suicide among

physicians. Physicians in primary care may be particularly susceptible to burnout in the absence of the support available in larger systems.

- Increased complexity of care (more staff; more training)
- Private insurance prior authorizations are ubiquitous and drive unnecessary costs for constant billing resubmission.
- Large medical conglomerates negotiate rates of reimbursement, value-based contracts, and more timely access to resources (e.g. vaccines) that are favorable to their sustainability than private practices are able to.
- Market vulnerability drives private practices into risky business collaborations with more powerful entities like DCEs and private equity firms. These David and Goliath collaborations result in a loss of autonomy and even exploitation of private practices.
- As the healthcare industry moves towards greater efficiency and productivity in traditional business models, their performance is being measured in non-standardized ways that often yield either useless information for future decision-making, or harm to their practices. (e.g. In the ACO REACH framework that dominates the WNY market, practices are being measured against themselves each year rather than against standardized benchmarks.

- Specifically, Primary Care private practices has been selected to be the driving force in implementing CMS's quadruple-aim objective that resulted in an unsustainable burden of documentation resulting in high levels of burnout in PC. Where will the support come from to off-set this problem?
  - Value-based incentives only address clinical objectives but do not reflect the hidden costs embedded in the delivery of that care. Fee schedules must be adjusted accordingly.

Smaller practices can provide more meaningful relationships with patients and the community in which they serve. Private practices are highly motivated to innovate and are more readily adaptable to a dynamic industry. By contrast, larger healthcare corporations tend to be less

responsive to the needs of their patients and can afford to be less attentive to the importance of efficiency and cost containment, contributing to the rising healthcare spending in the US. Under the current conditions, private practice is clearly unsustainable. It is imperative that legislators step in to assist in saving this cornerstone of health delivery.

National Rural Health Association

Statement for the Record

National Rural Health Association
to the
United States House Ways and Means Committee

Health Subcommittee Hearing on *The Collapse of Private Practice: Examining the Challenges Facing Independent Medicine*

June 6, 2024

June 6, 2024

Submitted via email: WMSubmission@mail.house.gov

Chairman Jason Smith
House Ways and Means Committee
1139 Longworth House Office Building
Washington, DC 20515

Re: Statement for the Record on Hearing on ***The Collapse of Private Practice: Examining the Challenges Facing Independent Medicine.***

Dear Chairman Smith, Health Subcommittee Chairman Vern Buchanan, and Members of the Committee,

The National Rural Health Association (NRHA) thanks the Chairman and members of the Committee for the opportunity to submit a statement for the record on the financial and regulatory burdens facing independent rural medical providers and how continued challenges result in barriers to patient care. We appreciate the chance to provide information on how issues pertaining to independent medicine and private practice impacts rural health care and look forward to working together to increase access to quality care for rural residents.

NRHA is a non-profit membership organization with more than 21,000 members nationwide that provides leadership on rural health issues. Our membership includes nearly every component of rural America's health care, including rural community hospitals, critical access hospitals, doctors, nurses, and patients. NRHA works to improve rural America's health needs through government advocacy, communications, education, and research.

RuralHealth.US
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National Rural Health Association

NRHA recognizes the importance of prioritizing and modernizing the healthcare system to empower medical professionals to effectively serve patients in rural communities. Within this statement, we discuss the vulnerability of rural hospitals and independent rural health clinics, the administrative burden and challenges faced by rural hospitals and clinics from Medicare Advantage, and the need to support GME programs to build the rural workforce.

Rural Hospital Vulnerability

Since 2010, over 175 rural hospitals have closed their doors or discontinued inpatient services.[i] Nationally, 50% of rural hospitals are operating with negative margins and therefore vulnerable to closure.[ii] When a rural hospital closes, not only does the community lose access to vital health care, but a major employer and community lynchpin ends, affecting the larger community. Investing in a strong rural health infrastructure has massive impacts on health outcomes of rural residents, but also widespread effects on local economies as well.

The impacts of hospital mergers are mixed for rural facilities, providers, and their patients. Mergers and affiliations can affect the financial status of facilities, service costs (including out-of-pocket costs), access to high quality services, and community members' perspectives regarding healthcare delivery (including breadth of services available in their communities).

Quality of care for rural residents could be affected in multiple ways post-merger. For example, quality might improve with more direct access to specialty care through the system (both through telemedicine and rotating clinics) and more timely referrals.[iii] Additionally, acquisitions and mergers help reduce health care costs and create a fiscally sustainable environment for health care delivery for patients and communities. Affiliation may provide investment in local services, including some that were not previously sustainable, but it also may result in loss of local community services as a result of system decisions to consolidate services elsewhere. Quality could be adversely affected if a merger or consolidation results in closure of local services and loss of independent decision making. However, reports on the effects of hospital mergers or acquisitions consistently show higher prices for consumers/patients stemming both from price increases in merged hospitals as well as in competing hospitals.[iv]

Independent RHC and FQHC Vulnerability

Rural hospitals are primarily outpatient facilities. For example, the average critical access hospital derives 79.4% of patient revenue from outpatient services through provider-based Rural Health Clinics (RHCs)[v]. Further, in areas where a rural hospital has closed, some of the potential reductions in access to essential preventive and diagnostic services may be filled by Federally Qualified Health Centers (FQHCs) and RHCs[vi]. Independent RHCs and FQHCs that are not affiliated with a hospital system also serve as invaluable resources for rural communities, offering accessible, comprehensive, and patient-centered healthcare services. These clinics play a vital role in improving health outcomes, enhancing healthcare access, and strengthening the fabric of rural America[vii]. These clinics also help administer comprehensive services, provide patient-centered care, deliver cost-effective care, provide financial support, and establish community impact[viii]. As a result, NRHA encourages Congress to support legislation like S. 198, the RHC Burden Reduction Act. This is a piece of legislation that would make a significant difference on the day-to-day operations of RHCs by addressing outdated legislative barriers. This important bill would align RHC physician

supervision requirements with state scope of practice laws governing physician assistant and nurse practitioner practice, remove outdated laboratory requirements, allow RHCs to provide an increased amount of behavioral health services, among other technical tweaks.

Medicare Advantage Impact on Rural

The popularity of Medicare Advantage (MA) plans as an alternative to Traditional Medicare has grown significantly in recent years. Both rural and urban areas have seen MA enrollment become a larger fraction of total Medicare enrollment in the past decade, and rural beneficiaries have increasingly chosen MA plans over Traditional Medicare with the rate of MA growth in nonmetropolitan counties higher than metropolitan counties.[ix] About 45% of all rural beneficiaries are enrolled in an MA plan and current trends point to MA plans enrolling a majority of rural beneficiaries in two years.[x] NRHA members have increasingly voiced their frustrations and concerns with MA plans and how these issues affect beneficiaries' access to care. Rural beneficiaries already face access challenges given the unique characteristics of rural areas, and MA plan practices continue to compound such barriers to care. MA especially impacts rural independent medical clinics and private practices due to the strain of administrative burdens from prior authorization and quality reporting, restrictions to access of care for patients, and lack of physician reimbursement.

Administrative burdens: NRHA members have cited prior authorization as a major barrier to care for beneficiaries and an administrative burden to staff. Prior authorization is a common issue plaguing providers both rural and urban; however, NRHA members have raised administrative burden issues that are unique to rural. Rural providers do not have the staff needed to jump through MA plans' prior authorization hoops. Understaffed rural private practice physicians often are overwhelmed by these extra administrative burdens, which is time that they view should be spent on patient care instead. Additionally, extra duties with the few staff present in these rural private practices often drive rates of burnout as well as enable workforce loss to large hospitals instead.[xi] These challenges as a result of administrative burdens take away the opportunity to access quality patient care at private practices. Independent practices in rural areas enable the provider and clinical staff to develop meaningful and long-term relationships with patients, providing integrated services while practicing within the context of family and community. Access to a consistent and reliable independent primary care practice is associated with increased patient trust in the physician, more effective patient-provider communication, and an increased likelihood that patients will receive the care they [xii] Independent physicians who manage their own practices tend to have a closer connection with their patients and experience lower burnout rates.[xiii]

Physician Reimbursement Rates: NRHA members have voiced that payment-related challenges with MA plans have negatively impacted their patients, staff, and facilities. Payment challenges are heightened for providers with special rural designations and payment systems, like RHCs, because of their specific payment rates. NRHA members representing various facility types have raised concerns over payment timeliness, audits, negotiating power, and payment denials. As the proportion of MA beneficiaries compared to Traditional Medicare beneficiaries continues to grow, rural providers that are reimbursed on a different payment system are increasingly losing money. Growing MA enrollment in rural areas is diluting the original purpose of these rural designations and threatening their ability to support rural providers. RHCs are paid their specific all-inclusive rate (AIR)

through Traditional Medicare. Yet MA plans do not adhere to these Traditional Medicare payment rates and in turn RHCs receive worse reimbursement from the plans.

Medicare Physician Reimbursement Rates

Medicare physician payment is shrinking, dropping 29% since 2001, when adjusted for inflation, as practice costs have gone up by 54% at the same time.[xiv] The growing gap between the operational costs of independent practices and Medicare payments is tremendous in rural areas and affects the viability of these practices. Retention of staff is difficult in comparison to competing against local hospitals and retail entities raising prices. Practices find themselves caught between rising costs and declining reimbursement, and that gap has widened in the past two decades. Persistent inflation means higher expenses for staff, rent, and supplies. At the same time, Medicare rates have been flat or cut and MA and commercial health plans often squeeze payments as well.

To address this gap, reimbursement rates for primary care need to be looked at more in depth. Many private practice and independent rural physicians stress the importance of paying them for the excess work they do, especially primary care physicians that play a vital role in sustaining care in rural areas. The greatest challenge is that the Medicare physician fee schedule has not kept up with inflation, especially when physicians are only medical providers who do not get inflation increase. Costs increasing from inflation and Medicare reimbursement rates declining end up disproportionately affecting people who live in rural or low-income communities and leads to less healthcare options. Congress must adopt a permanent Medicare update while working toward long-term reform and increasing budget neutrality.

GME Programming to Support Rural Workforce

One solution to address the workforce shortages in rural areas is an investment in rural GME programming and increasing residency slots to continue practicing in rural communities. Only 2% of residency training occurs in rural areas, despite research showing that training physicians in rural areas increases their likelihood of practicing in a rural community.[xv]

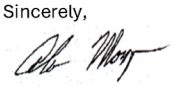
To increase rural physician training in the short term, Congress must authorize the Rural Residency Planning and Development Program (RRPD). RRPD has shown incredible results as a pilot program by increasing the number of rural residency programs, standing up 44 new accredited programs and 563 additional residency positions since 2018[xvi]. It is essential that this very successful program is formally authorized in order to support rural residency capacity as outlined in H.R. 7855, the Rural Residency Planning and Development Act of 2024. Additionally, to correct these discrepancies in rural areas and genuinely support rural healthcare, the Committee should consider a companion bill to H.R. 8235, the Rural Physician Workforce Preservation Act. This bill would exclude reclassified hospitals from receiving the 10% of slots allocated to rural hospitals unless the hospital reclassified because they are in a rural Census tract of a metropolitan statistical area or are located in an area considered rural by state law or regulation. Further, NRHA supports H.R. 834/S. 230, the Rural Physician Workforce Production Act, which tackles the geographic maldistribution of physicians in rural areas stemming from the current structure of Medicare-funded GME. The bill would lift GME caps, remove Medicare limits on rural resident training growth, extend equitable federal funding to rural hospitals, and establish an elective per resident payment initiative. We also welcome state-level GME initiatives such as the establishment of the Office of Mississippi Workforce that assists

National Rural Health Association

with startup costs for residency and starting DO programs in Mississippi discussed during the hearing.

Thank you for the opportunity to weigh in on this important issue. Please contact Alexa McKinley (amckinley@ruralhealth.us) with any questions or for more detail on any of the information above. NRHA would welcome a meeting with the Committee to discuss our response and put forth viable policy solutions to improve rural health care for patients and providers.

Sincerely,



Alan Morgan
Chief Executive Officer
National Rural Health Association

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[i] https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/
[ii]https://www.chartis.com/sites/default/files/documents/chartis_rural_study_pressure_pushes_rural_safety_net_crisis_into_uncharted_territory_feb_15_2024_fnl.pdf
[iii]https://rupri.org/wp-content/uploads/Health-System-Affiliation-Landscape.Finalversion.April-2024.pdf
[iv] https://rupri.org/wp-content/uploads/Health-System-Affiliation-Landscape.Finalversion.April-2024.pdf
[v] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8522564/
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[viii] https://orchardmedicalmgt.com/understanding-independent-rural-health-clinics-eligibility-and-benefits/
[ix] Edmer Lazaro, Fred Ullrich, & Keith Mueller, Medicare Advantage Enrollment Update 2023, RUPRI Center for Rural Health Policy Analysis, University of Iowa, 2, November 2023, https://rupri.public-health.uiowa.edu/publications/policybriefs/2023/Medicare%20Advantage%20Enrollment%20Update%202023.pdf.
[x] Id. at 3.
[xi] https://www.medicaleconomics.com/view/rural-health-care-falling-behind-nationally-and-action-is-needed-now-ama-president-elect-says
[xii] https://www.elationhealth.com/resources/blogs/the-importance-of-independent-practices-in-rural-areas
[xiii] https://www.elationhealth.com/resources/blogs/what-are-the-benefits-of-independent-physicians-and-practices
[xiv] https://www.medicaleconomics.com/view/rural-health-care-falling-behind-nationally-and-action-is-needed-now-ama-president-elect-says
[xv] https://www.hrsa.gov/rural-health/grants/rural-health-research-policy/rrpd#:~:text=Only%20two%20percent%20of%20residency%20training%20occurs%20in%20rural%20areas.&text=We%20partner%20with%20the%20Bureau,practicing%20in%20a%20rural%20community
[xvi] https://www.hrsa.gov/rural-health/grants/rural-health-research-policy/rrpd

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May 23, 2024

The Honorable Vern Buchanan
Chairman
Committee on Ways and Means
Subcommittee on Health
U.S. House of Representatives
1100 Longworth HOB
Washington, DC 20215

The Honorable Lloyd Doggett
Ranking Member
Committee on Ways and Means
Subcommittee on Health
U.S. House of Representatives
1100 Longworth HOB
Washington, DC 20215

Re: MGMA Statement for the Record — House Committee on Ways and Means Subcommittee on Health Hearing, "The Collapse of Private Practice: Examining the Challenges Facing Independent Medicine"

Dear Chairman Buchanan and Ranking Member Doggett:

On behalf of our member medical group practices, the Medical Group Management Association (MGMA) would like to thank the Subcommittee for holding this important hearing on the challenges facing independent medicine. Numerous policies and extraneous factors coalesce to undermine the ability of independent medical groups to remain financially viable — cuts to Medicare reimbursement, staffing shortages across clinical and nonclinical positions, substantial administrative burden, inflation, and more. We appreciate the Subcommittee for examining policies that can help bolster independent practices who remain a bedrock of our healthcare system.

With a membership of more than 60,000 medical practice administrators, executives, and leaders, MGMA represents more than 15,000 medical group practices ranging from small private medical practices to large national health systems representing more than 350,000 physicians. MGMA's diverse membership uniquely situates us to offer the following policy recommendations.

Independent practices are vital to the communities they serve yet are rapidly becoming extinct. Over the past decade, physicians fed up with government overregulation, payer red-tape, and declining reimbursement have sold their practices to health systems, hospitals, insurers, and private equity firms at an alarming rate. They cannot survive as small businesses. Health systems can maintain reserves to weather the next economic storm. Most independent practices can't carry cash reserves year-over-year or they would face double taxation. It's common for hospital systems to run medical practices as a loss-leader, often at yearly losses in excess of $200,000 or more per FTE physician. They subsidize the shortfalls with more lucrative revenue from inpatient services, health insurance plans, and ancillary referrals. If many of these system-owned physician practices were run independent from non-ambulatory subsidies, they would quickly go out of business. This environment illustrates a broken system that forces independent practices to make difficult decisions about their ownership structure and erodes their ability to stay in operation.

Exacerbating these concerns are the effects of multiple significant events over the past several years. The COVID-19 Public Health Emergency (PHE) had a seismic impact, not only on the nation's health system, but especially on independent physician groups. Even with the flexibilities and financial relief programs implemented by multiple administrations, independent physician groups that were already operating on razor thin margins were particularly affected by the reduced patient volume and increased costs resulting from the pandemic.

Further amplifying these impacts is the ongoing fallout from the massive Change Healthcare cyberattack. Change Healthcare provides a multitude of services to the industry, touching one in three patient records and processing 15 billion healthcare transactions annually.[1] MGMA members felt numerous negative impacts following the cyberattack, including: severe billing and cash flow disruptions, inability to submit claims, limited or no electronic remittance advice (ERA) from health plans, electronic prescriptions could not be transmitted, lack of connectivity to data infrastructure, health information technology disruptions, and much more.[2] To even get paid, physician practices had to institute workarounds for various processes to remain operational, which required significant labor costs and time to institute, diverting critical resources from patient care. The impacts are still being felt and affecting independent practices' ability to keep their doors open. Smaller, independent practices were far more vulnerable than their larger corporate brethren.

Taken together, these major events illuminate the precarity underlying independent physician practices. In addition, MGMA surveys our members annually for our regulatory burden report, and 75% of respondents to our 2023 report were independent practices. Throughout our testimony we highlight these burdens and offer policy solutions to support independent practices' ability to thrive and provide high-quality care to their communities.

Key Recommendations

- **Provide an annual inflation-based physician payment update based on the Medicare Economic Index (MEI) and modernize the budget neutrality aspect of Medicare payment.** Congress should pass the *Strengthening Medicare for Patients and Providers Act of 2023*, which would provide a long-needed annual Medicare physician payment update tied to inflation, as measured by the MEI. Congress needs to also mitigate the negative impact of the antiquated budget neutrality requirements of the Medicare Physician Fee Schedule (PFS) by enacting the *Provider Reimbursement Stability Act of 2023*.
- **Make commonsense changes to the Merit-based Incentive Payment System (MIPS)** such as alleviating the program's reporting burden, and extending the Small, Underserved, and Rural Support (SURS) program that expired in 2022.
- **Reduce administrative burden by implementing prior authorization reform.** Prior authorization burden is particularly felt by independent practices that have less resources to devote to onerous administrative processes than larger health systems. Congress should enact an updated version of the *Improving Seniors' Timely Access to Care Act* to alleviate prior authorization burden, which has historically been the number one regulatory burden facing

[1] Department of Health and Human Services, Letter to Health Care Leaders on Cyberattack on Change Healthcare, March 10, 2024.
[2] MGMA Statement for the Record – Senate Committee on Finance Hearing, "Hacking America's Health Care: Assessing the Change Healthcare Cyber Attack and What's Next," May 1, 2024.

medical groups. The *GOLD CARD Act* and the *Reducing Medically Unnecessary Delays in Care Act* would make additional needed reforms to the prior authorization process if passed into law.

- **Work to address the physician shortage** by properly funding Graduate Medical Education (GME) programs and increasing Medicare-supported medical residency positions.
- **Provide positive financial incentives to support independent practices transitioning into value-based care.** Congress should extend the Alternative Payment Model (APM) incentive bonus at 5%, provide resources to assist practices with the transition into APMs, and allow the Centers for Medicare & Medicaid Services (CMS) the ability to set the qualifying participant threshold at an appropriate level that does not discourage APM participation. Numerous provisions in the *Value in Health Care Act of 2023* would help address these concerns.
- **Support the development of physician-led, value-based care models** designed to help independent medical groups succeed.
- **Examine further authorities and flexibilities** that should be granted to federal agencies so they can rapidly respond to future cyberattacks and significant events to support independent physician practices' ability to keep their doors open.

Stabilizing Medicare Payment

The *Medicare Access and CHIP Reauthorization Act of 2015* (MACRA) replaced the sustainable growth rate formula with the Quality Payment Program (QPP). This was intended to stabilize payment rates in the Medicare fee-for-service (FFS) system and incentivize physicians to transition into value-based payment models. The QPP created two reporting pathways to facilitate the transition to value-based care: the Merit- based Incentive Payment System (MIPS) and advanced alternative payment models (APMs).

In addition to no annual positive payment update, independent medical groups also experience annual reimbursement cuts stemming from 2021 PFS changes and correlating budget neutrality requirements. CMS finalized a 3.37% cut to the Medicare conversion factor in its 2024 Medicare PFS; from Jan. 1 to March 8 of this year, medical groups absorbed a 3.37% reduction to reimbursement. Following congressional action to partially mitigate 1.68% of the cut in the *Consolidated Appropriations Act of 2024* (CAA, 2024), physician practices are left with a 1.69% reduction for the rest of the year.

These ongoing cuts are untenable for practices and must be averted to ensure the financial viability of independent medical groups. The 2024 Medicare Board of Trustees' annual report outlines the inadequacy of Medicare payment and its potential impact on Medicare participation: "While the physician payment system put in place by MACRA avoided the significant short-range physician payment issues resulting from the SGR system approach, it nevertheless raises important long-range concerns that will almost certainly need to be addressed by future legislation … Absent a change in the delivery system or level of update by subsequent legislation, the Trustees expect access to Medicare-participating physicians to become a significant issue in the long term."[3] This echoes what medical groups are saying, with 87% of groups reporting reimbursement not keeping up with inflation impacts current and future Medicare patient access.[4]

In the face of ongoing Medicare cuts, the cost of running a medical practice continues to rise — according to MGMA data, physician practices saw total operating cost per FTE physician increase by over 63%

[3]2024 Medicare Board of Trustees Annual Report, May 6, 2024.
[4] MGMA, 2023 Annual Regulatory Burden Report, Nov. 2023.

from 2013–2022, while the Medicare conversion factor increased by only 1.7% over the same timeframe. Eighty-nine percent of medical groups reported an increase in operating costs in 2023.[5]

An annual inflation-based physician payment update tied to inflation, as measured by the MEI, is needed to prevent further damage to independent medical groups' ability to continue operating. Congress should pass the *Strengthening Medicare for Patients and Providers Act of 2023* — this bipartisan bill introduced by congressional doctors currently has 142 cosponsors and is essential to ensuring independent groups are reimbursed fairly to prevent them from shutting down.

Further, MGMA recommends the Committee work to mitigate the harmful impact of Medicare's budget neutrality requirements. The *Provider Reimbursement Stability Act of 2023* would modernize many aspects of Medicare budget neutrality and would make significant changes to alleviate the adverse effects practices are experiencing. The legislation would increase the triggering threshold from $20 million to $53 million (while adding an update to keep pace with inflation), institute new utilization review requirements to better reflect the reality of providers using certain services compared to CMS' estimates, and more.

MGMA urges Congress to make changes to budget neutrality in unison with the long-needed annual inflationary update. The current policies work in concert to undercut the financial viability of medical practices, as independent medical groups will be facing another cut in 2025 absent congressional intervention.

Reducing burden in the Quality Payment Program

MIPS Reform

MACRA instituted the Quality Payment Program (QPP) that includes MIPS which was intended to be an on-ramp in the transition to value-based care for medical groups to join APMs. Unfortunately, the program has been beset with issues. Physician practices cannot continue to divert financial and staff resources away from patient care to comply with duplicative MIPS requirements. A study found that in 2019, physicians spent more than 53 hours per year on MIPS-related activities and MIPS cost practices $12,811 per physician to participate.[6] Aside from onerous reporting requirements that do not drive meaningful clinical improvements and unfairly penalize clinicians, the $500 million funding for the MIPS exceptional performance bonus expired at the end of 2022. MGMA urges Congress to extend the exceptional performance bonus, which will support physician practices as they work to comply with MIPS requirements.

Rural, small, and medically underserved independent practices can be disproportionally disadvantaged under MIPS. The SURS program provided direct support for these practices, but funding appropriated under MACRA expired in February 2022. MGMA encourages Congress to extend this critical program by passing the *SURS Extension Act*, as it is needed to assist practices in rural and underserved areas understand the continuously changing policies in MIPS and succeed in the program.

There are many factors contributing to increased administrative burden under MIPS for independent practices. The MIPS program requires clinicians to report on quality measures that are not clinically

[5] MGMA Stat Poll, July 12, 2023.
[6] Dhruv Khullar, Amelia Bond, Eloise May O'Donnell, *Time and Financial Costs for Physician Practices to Participate in the Medicare Merit-based Incentive Payment System*, Jama Network, May 14, 2021.

relevant to them. The cost reporting measure holds clinicians accountable for costs outside of their control. It is a time-consuming and laborious process to comply with these requirements. Compounding these issues is the lack of adequate and timely feedback by CMS on measure performance. Without receiving appropriate feedback about which patients are assigned to them and what costs outside of their practice they must account for, physicians are unable to correct issues and improve compliance.

A study from the Weill Cornell Medical College found that MIPS scores inconsistently relate to performance on process and outcome measures.[7] The study found that physicians treating more medically complex patients were more likely to receive low MIPS scores despite providing high-quality care. Medical groups report that MIPS reporting requirements detract from patient care efforts due to significant program compliance costs that could be more efficiently allocated to clinical priorities. The QPP reporting burden is substantial — 67.19% of MGMA members surveyed for the 2023 annual regulatory burden report found QPP reporting to be extremely or very burdensome.[8]

Small independent practices are disproportionately impacted by MIPS policies as they often do not have the same resources, staff, and capital as large systems. In 2022, the Small, Underserved, and Rural Support (SURS) technical assistance program ended due to a lack of congressional funding. This program was vital in assisting small practices' compliance with the constantly evolving policies in MIPS, and its expiration further exacerbates small practices' ability to meet program requirements. The *SURS Extension Act* would help rectify this problem by reinstating the program.

CMS proposed to increase the MIPS performance threshold from 75 points in 2023 to 82 points in the 2024 proposed Medicare Physician Fee Schedule (PFS). While we are thankful the agency maintained the current threshold at 75 points, this number is already too high, and a further increase of the threshold would result in even more physician practices receiving a negative adjustment.

Supporting innovative value-based care models

APM Development

Value-based care (VBC) models must be designed to address the challenges facing independent practices if CMS wants to meet its goal of having every Medicare beneficiary in an accountable care arrangement by 2030. There are numerous barriers preventing independent groups from both joining and successfully participating in VBC arrangements due to application requirements and parameters around many of the CMS Innovation Center (CMMI) models. Seventy-eight percent of medical groups reported that Medicare does not offer an Advanced APM that is clinically relevant to their practice, with 56% of members being interested in participating in a clinically relevant model if one were to exist.[9] The Congressional Budget Office found that accountable care organizations (ACOs) led by independent physician groups were

[7] Amelia M. Bond, PhD; William L. Schpero, PhD; Lawrence P. Casalino, MD, PhD, Association Between Individual Primary Care Physician Merit-based Incentive Payment System Score and Measures of Process and Patient Outcomes, JAMA Network, Dec. 6, 2022.
[8] *Supra* note 4.
[9] *Supra* note 4.

associated with greater savings, thereby demonstrating the value of expanding access to these arrangements.[10]

CMMI and private sector entities under the Physician-Focused Payment Model Technical Advisory Committee (PTAC) can develop APMs. Unfortunately, CMMI, who possess the sole responsibility to test and implement the APM, has yet to test any of the models PTAC has recommended.

In conjunction with a shortage of APMs, 94% of MGMA members reported that moving to value-based care initiatives has not lessened the regulatory burden on their practices.[11] This is exemplified by recently finalized changes in the 2024 PFS that added burdensome Promoting Interoperability reporting requirements in the Medicare Shared Savings Program (MSSP), as well as certified health information technology utilization requirements that are set to take effect in 2025. One of the main benefits of joining an APM is the reduced MIPS reporting burden — these policies undermine the success of groups joining value-based care arrangements.

APM Incentive Payment and Qualifying Participant Threshold

Shifting program requirements and financial incentives instituted under MACRA do not align with enabling independent practices to successfully participate in APMs. Congress recently extended the APM incentive payment at 1.88% for 2024 — a decrease from 3.5% in 2023, and 5% in 2022. MGMA strongly urges Congress to reinstate the full 5% as this payment is necessary to cover costs, support investments, and safeguard the financial viability of medical groups in the program.

Further, the qualifying participation (QP) threshold to participate in an APM is unreasonably high. Participants need to meet this threshold to qualify for the APM incentive bonus and to avoid reporting under MIPS; it was set to increase this year, but Congress intervened by freezing the threshold in the *Consolidated Appropriations Act of 2023.* Practices should not be subject to an excessively high threshold that fosters uncertainty and hinders their ability to participate — MGMA supports giving CMS the flexibility to adjust the QP threshold so that it is not set arbitrarily high. The *Value in Health Care Act of 2023* would work to address the APM incentive payment and QP threshold problems facing practices.

Reducing prior authorization burden

Prior authorization requirements are routinely identified by medical groups as the most challenging and burdensome obstacle to running a practice and delivering high-quality care. Increasing prior authorization requirements are detrimental to both practices and the patients they treat. Prior authorization requests disrupt workflow, increase practice costs, and result in dangerous denials and delays in care. In 2018, MGMA partnered with several provider groups and health plans to publish a *Consensus Statement on Improving the Prior Authorization Process*.[12] Our organizations agreed that selective application of prior authorization, volume adjustment, greater transparency and communication, and automation were areas of opportunity to improve upon. However, since the time this consensus statement was released, medical groups have reported little progress in any of these areas.

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[10] Congressional Budget Office, Medicare Accountable Care Organizations: Past Performance and Future Directions, April 16, 2024.
[11] *Supra* note 4.
[12] MGMA, AHA, AHIP, AMA, APhA, BlueCross BlueShield Association, *Consensus Statement on Improving the Prior Authorization Process*, Jan. 1, 2018.

MGMA is increasingly alarmed by reports of rising prior authorization requirements — 89% of medical groups assert that prior authorization requirements are very or extremely burdensome.[13] Ninety-two percent of physician practices reported having to hire or redistribute staff to work on prior authorizations due to the increase in requests. Sixty percent of groups reported that there were at least three different employees involved in completing a single prior authorization request.[14] Physician practices are already facing significant workforce shortage issues — this situation is simply untenable.

Despite feedback from MGMA to multiple administrations and Congress over the years regarding the unnecessary administrative burden, cost, and delay of treatment associated with prior authorization, CMS has only recently begun to finalize regulations to mitigate some of these harms. While the agency's actions are a good first step, there is still more work to be done as these requirements disproportionally impact small businesses and medical groups who do not have the resources, infrastructure, and personnel to process these prior authorization requests.

The *Improving Seniors' Timely Access to Care Act*, which we anticipate will soon be reintroduced, would make welcomed changes to ease this burden. Previous iterations of this legislation had widespread bipartisan, bicameral support with over 53 Senators and 327 Representatives cosponsoring the bill in 2022. We strongly urge Congress to pass this long-needed legislation, as well as the *GOLD CARD Act*, the *Reducing Medically Unnecessary Delays in Care Act* as these bills would make additional critical reforms.

Improving the healthcare workforce

MGMA has been a longtime champion of increased funding and reasonable improvements to the GME program as the U.S. healthcare system will face a shortage of up to 86,000 physicians by 2036.[15] We appreciate the progress Congress has made over the past few years adding Medicare-funded GME slots through the *Consolidated Appropriations Acts of 2021 and 2023,* but there is still a critical need for more doctors to treat our nation's aging population.

The *Resident Physician Shortage Reduction Act of 2023* is bipartisan legislation that would help address the physician shortage facing the nation, which is especially pronounced in rural communities. This bill would increase Medicare-supported medical residency positions by 14,000 over the course of seven years. These slots are a lifeline to ensuring patients have access to care and we urge the Committee to support its passage.

There are additional critical workforce challenges as staffing shortages across clinical and nonclinical positions remain a concern for medical group practices. Fifty-six percent of medical groups reported staffing as their biggest productivity roadblock in an April 18, 2023, MGMA *Stat* poll.[16] As Congress continues to examine ways to bolster the healthcare workforce, MGMA hopes the Committee will take a comprehensive view of the staffing concerns facing medical groups to better strengthen the workforce programs under its purview.

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[13] *Supra* note 4.
[14] MGMA, Spotlight: Prior Authorization in Medicare Advantage, May 2023.
[15] Association of American Medical Colleges, The Complexities of Physician Supply and Demand: Projections from 2021 to 2036, Mar. 2024.
[16] MGMA *Stat* poll, Apr. 20, 2023.

A major contributor to the healthcare workforce shortage is the worsening problem of physician and staff burnout, with 65% of physicians having reported experiencing burnout in 2022.[17] Many of the issues discussed in this letter compound to increase burnout — when you add prior authorization requirements that MGMA members consistently rank as their number one regulatory burden on top of these issues, it only hastens staff resignations and employee turnover. Practices are already facing significant workforce shortage issues — this situation is simply unsustainable.

Conclusion

MGMA thanks the Subcommittee for its leadership in examining the issues undermining independent medical groups. We look forward to working with you to craft commonsense policies that will allow independent physician practices to continue providing high-quality patient care. If you have any questions, please contact James Haynes, Associate Director of Government Affairs, at jhaynes@mgma.org or 202-293-3450.

Sincerely,

/s/

Anders Gilberg
Senior Vice President, Government Affairs

[17] Jackson Physician Search and MGMA, Back from Burnout: Confronting the Post-Pandemic Physician Turnover Crisis, Oct. 7, 2022.

To: U.S. House of Representatives; Committee on Ways and Means - Health Subcommittee:

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

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Date: June 6, 2024

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

Introduction

The landscape of private practice in healthcare has undergone significant changes, resulting in the collapse of many independent practices. This memo outlines the market conditions contributing to this decline and the role of the federal Independent Dispute Resolution (IDR) process in exacerbating these challenges.

Ultimately, the collapse of independent practices results in decreased access for many underserved patients, decrease quality of care given the large monolithic systems that replace independent practices, and decreased affordability.

Market Conditions Affecting Private Practice

1. *Consolidation of Healthcare Systems*
   - *Rise of Large Hospital Systems*: Over the past decade, there has been a marked increase in the consolidation of hospitals and healthcare systems. Large entities are acquiring smaller practices, reducing competition, and creating an environment where independent practices struggle to compete.

   - *Economic Pressures*: The bargaining power of large healthcare systems with insurance companies leads to more favorable reimbursement rates for them, while private practices face lower rates and higher administrative burdens.

   - *Large health Systems have an unfair competitive advantage*; given the 'nonprofit' status of large health systems, private practices are frequently at a significant disadvantage as they are reimbursed less and taxed on that revenue.

2. *Increasing Administrative and Regulatory Burdens*
   - *Complex Regulatory Environment*: Private practices face a growing number of regulations, including those related to electronic health records (EHR), patient privacy (HIPAA), and quality reporting (MACRA/MIPS). Compliance requires significant time and financial resources.
   - *Administrative Costs*: Managing billing, coding, and insurance negotiations requires dedicated staff and resources, which are more easily absorbed by larger entities but can overwhelm smaller practices.

3. *Insurance Reimbursement Challenges*
   - *Declining Reimbursement Rates*: Insurers often reimburse private practices at lower rates compared to hospital-owned practices. This

discrepancy places financial strain on independent practices, making it difficult to sustain operations.

- *Payment Delays and Denials*: The frequency of delayed or denied claims creates cash flow issues for private practices, further destabilizing their financial viability.

Impact of the Federal Independent Dispute Resolution (IDR) Process

1. *Background of IDR Process*

- The federal IDR process was established to resolve payment disputes between insurers and out-of-network providers, particularly for emergency services and non-emergency services provided by out-of-network providers at in-network facilities.

2. *Implementation Challenges*

- *Complexity and Costs*: The IDR process is complex and can be costly for providers. The administrative burden of initiating and navigating the IDR process discourages many small practices from pursuing fair compensation.

- *Bias Toward Insurers*: There is a perception that the IDR process favors insurers, as it often uses median in-network rates as a benchmark. This benchmark can be lower than what out-of-network providers need to cover their costs, leading to unfavorable outcomes for private practices.

- *Delays in Resolution*: The time-consuming nature of the IDR process means that providers face extended periods without resolution, exacerbating financial instability.

Conclusion

The collapse of private practice in healthcare is driven by several interrelated market conditions, including the consolidation of healthcare systems, increasing administrative burdens, and challenging insurance reimbursement environments. The federal IDR process, while intended to resolve disputes, has further strained private practices due to its complexity, perceived insurer bias, and slow resolution times. Addressing these issues requires comprehensive policy interventions aimed at leveling the playing field for private practices, simplifying regulatory compliance, and ensuring a more balanced and efficient IDR process.

Recommendations

1. *Policy Reforms:* Introduce policies that support the financial viability of private practices, such as fair reimbursement rates and streamlined regulatory requirements.
2. *IDR Process Improvements*: Simplify the IDR process and ensure it is equitable for all parties involved, possibly by incorporating alternative

benchmarks such as "Fair Health" pricing data vs. QPA/Medicare based pricing or establishing more transparent criteria.
3. *Support for Small Practices*: Provide targeted financial and administrative support to help private practices navigate the complex healthcare environment and remain competitive.

By addressing these critical issues, we can help preserve the essential role of private practices in providing high-quality, accessible healthcare to our communities.

Warm Regards,

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Subject: **The Collapse of Private Practice: Examing the Challenges Facing Independent Medicine**

House Ways and Means Committee:

I left an employed neurological surgery position in the Pacific Northwest in February of 2023 to start up a private, solo neurosurgery practice after having numerous contract disputes with my former employer, a major employer of healthcare workers in the region with over 3,200 employed physicians. I applied for credentials at three (3) different hospitals and at each facility, the bylaws were used punitively to block me from obtaining credentialing. The identical excuse provided from the credentialing office was that a solo, private practitioner can not provide adequate backup call coverage and is thus unsafe to practice at their facilities. At my last three employed positions, I was essentially on call solo with little to no backup which meant I was forced to cover hospitals 24-7-365 for many years–a prescription for burnout and a breach of my contract terms at all three institutions. The hospitals' approach to the on-call issue while I was employed was "take it or leave it. We can replace you."

So in 2023, I set out to start my own independent neurosurgical practice with my own means of addressing the call issues and quality issues I had encountered. The solution I envisioned was starting my own private practice as a solo practitioner and eventually grow to a call group of partners that could have autonomy, provide quality care for patients, and support quality of life efforts for the physicians and staff of the practice. After spending over $60,000 in startup costs, I have now learned that all of the hospitals have blocked me completely from practicing neurosurgery in the region using the inadequate call coverage issue as the reasoning. This has cost me the tremendously in terms of these startup costs but also lost referrals, and lost income for the past 18 months as I battle legally with these large organizations for my right to practice and compete.

Their denial of me to practice due to lack of call coverage is contrary to the facts in that at two of the three institutions, the employed surgeons of my exact specialty have absolutely no backup call support because they too are solo, only solo employed instead of solo private. In essence, these large systems are exempting their own employed physicians from call backup requirements and blocking out same specialty, private competition with no rational justification except to retain in-network control of care and to exclude private, independent physicians from working. This practice is illegal, anti-competitive, anti-American, violates Stark law and anti-kickback statutes by providing highly costly exemptions to employed physicians in exchange for in-network referrals for

services. This barrier is prohibitive for anyone seeking to enter into the private, independent practice of medicine and is being used to eliminate private small groups and solo practitioners that already have substantial disadvantages. We don't have access to nearly unlimited capital. We have to maintain our own offices, our own EMR, and our own staff. We don't have in-house counsel to battle and the delays caused by legal battles take forever to resolve and are onerous to prove. All of these factors harm patients waiting for quality care that the large institutions struggle.to provide as they burn out their physicians and constantly replace them.

I ask that the House Ways and Means Committee look seriously into these illegal and anti-competitive business practices and if it would be valuable, I would be happy to provide further testimony and evidence of these practices that I have been the victim of personally and that my many patients have been the victim of because I can not provide them my much needed services. People are being harmed. Practices are faltering and new ones can not start up. The bylaws are being used to harm patients and these organizations use their employed physician network to block out any competition. They own the facilities, the employees, the medical staff offices in charge of credentialing, and the medical staff leadership throughout direct employment. If action is not taken, there will be no private surgical groups left and loss of access to quality care will be the result. Again, please take this matter seriously. Lives depend on it.