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

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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.

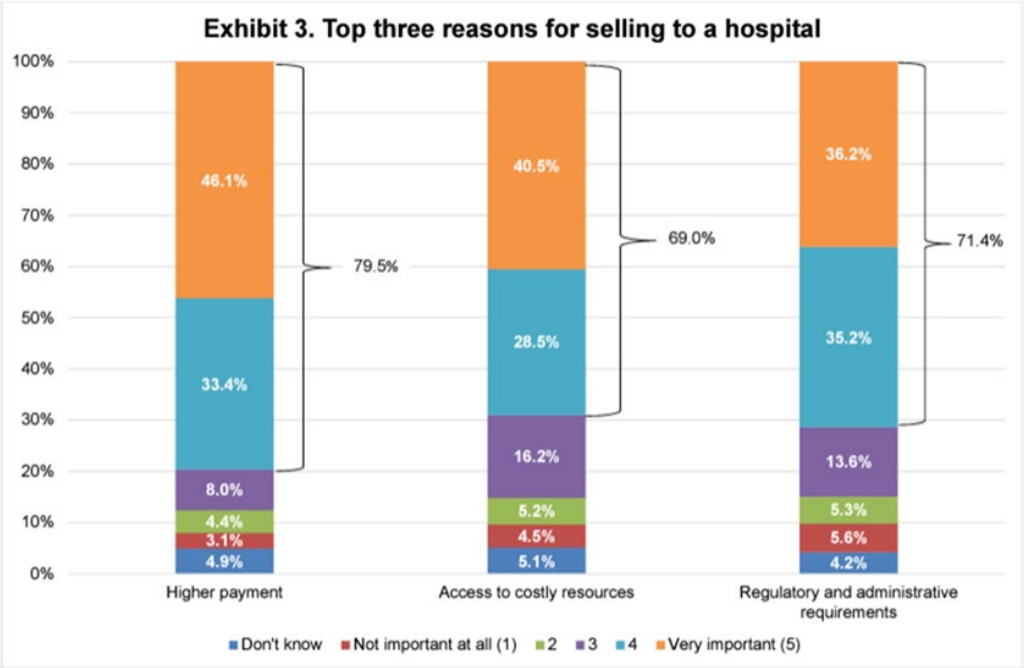
In its 2024 annual report, the Medicare Trustees warned that the program faces "challenges," notably that physician payments are not based on underlying economic conditions – such as inflation – and are not

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.