



**Statement of the
American College of Physicians
to the U.S. House Ways and Means Health Subcommittee Hearing
on
The Collapse of Private Practice: Examining the Challenges Facing Independent Medicine
May 23, 2024**

The American College of Physicians (ACP) is pleased to provide comments in response to the House Ways and Means Health Subcommittee hearing on “The Collapse of Private Practice: Examining the Challenges Facing Independent Medicine.” We thank Chairman Buchanan and Ranking Member Doggett for holding this hearing to examine why independent practices are challenged to remain open and care for patients.

There are several obstacles to the viability ‘of primary care and internal medicine physicians’ independent practices. Reform of the Medicare and Medicaid payment system is vitally needed. Action is also needed to address the existing and growing primary care physician workforce shortage through expansion of federal programs and federal student loan incentives. In addition, the administrative burden of increased paperwork and prior approvals has adversely affected physicians in independent practices more than those working in corporate and hospital settings. Finally, consolidation of practices has reduced the number of practices operating independently where more transparency and oversight are needed.

ACP members include 161,000 internal medicine physicians, related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge, clinical expertise, and compassion to the preventive, diagnostic, and therapeutic care of adults across the spectrum from health to complex illness.

Payment Reforms Are Needed to Ensure Stable Access to Quality Healthcare by Independent Practices

Physicians' payment is one of the only parts of Medicare that does not have an annual update based on inflation. As a result, when accounting for inflation, Medicare physician payments have declined 29 percent from 2001 to 2024. The Medicare Access and CHIP Reauthorization Act (MACRA) must be viewed within the broader context of the physician payment system. While physician services represent a very modest portion of the overall growth in health care costs, they are primary targets for cuts when policymakers seek to tackle spending. For years physicians have struggled with a broken Medicare payment system that does not allow them to keep up with practice expenses and rising

inflation. That has made it much harder for physician practices to manage sharp increases in practice expenses, staffing and supply shortages.

The modest statutory updates previously included in MACRA have ended, and physicians are in a six-year period with no updates. The result is real reductions to payments due to inflation and budget neutrality requirements. ACP [urges](#) Congress to pass H.R. 2474, the Strengthening Medicare for Patients and Providers Act, to provide an annual Medicare physician payment update tied to inflation, as measured by the Medicare Economic Index (MEI). It would allow physicians to make needed investments in their practices to help ensure that they are able to deliver high quality care to their patients.

Medicare Physician Fee Schedule (MPFS) Cuts

The current structure of the physician fee schedule does not provide sustainable, reliable and consistent payment rates for physicians who see Medicare beneficiaries. Patients and physicians who care for them are left to deal with the uncertainty of the Centers for Medicare and Medicaid Services (CMS) cuts to payment rates each year. These cuts, especially when practice expense costs have markedly increased, further strain our nation's doctors, limiting patient access to care. Each year, physicians routinely face harmful payment cuts making it increasingly difficult to remain in practice and accept Medicare patients.

Unless Congress acts, a continuing statutory freeze in annual physician payments is scheduled to last until 2026, when updates would resume at a rate of .25 percent per year, well below inflation rates. Some physician services in the fee schedule, such as evaluation and management services, have been increased. The problem is that any increases in the fee schedule must be paid for by across the board payment cuts to all services in the fee schedule. This policy, known as budget neutrality (BN), has caused annual cuts to physician payments over the past several years. Although Congress has passed legislation to mitigate the impact of these cuts – patchwork measures by Congress do not provide a stable, predictable payment structure for physicians in Medicare.

We urge Congress to act this year to pass H.R. 6371, Provider Reimbursement Stability Act, which aims to give CMS more flexibility in setting payment rates, updating average costs doctors incur in calculating reimbursement and making payments more predictable. The bill would require CMS to conduct a look-back period, to reconcile overestimates and underestimates in utilizations. We support this approach as it would allow for a more accurate calculation of the Medicare conversion factor based on actual utilization data and claims. Further, it would raise the BN threshold to \$53 million from \$20 million and would use cumulative increases in the MEI to update the threshold every five years afterwards. The \$20 million threshold was established in 1992 and has not been updated since. Raising the budget-neutrality threshold would allow for greater flexibility in determining pricing adjustments for services without triggering across-the-board cuts in Medicare physician pay. We believe that this is

a practical approach, which would help account for inflation. Congress should, at a minimum, pass H.R. 6475, the Physician Update and Improvements Act, that would raise the threshold for implementing budget neutral payment cuts from \$20 million to \$53 million and would provide an increased update to the threshold every five years afterwards based on the MEI.

MACRA Reform Hearings

ACP urges the Committee to convene one or more hearings on the implementation of physician payment policies within the MACRA, which sought to end the antiquated, burdensome and misaligned sustainable growth rate (SGR) payment formula, requiring annual Congressional fixes. We request these [hearings](#) to focus upon whether the current system achieves the Congressional intent to move towards value-based care and to consider the long-term viability of the current Medicare physician payment system, providing annual updates, meaningful quality measures and predictable outcomes. We have members who are willing to testify as internal medicine represents 24 percent of the physician workforce.

Medicaid Payment Reform

While [84 million](#) Americans receive Medicaid benefits, lower Medicaid payment rates can contribute to [negative health outcomes](#), especially for people of color, and make it harder to access care. Comparatively lower Medicaid payment rates are a substantial factor affecting physician participation in the program. Medicaid payments for services are significantly lower than Medicare payments for the same services.¹²In response, Congress took decisive action and raised Medicaid primary care payment rates to Medicare levels for 2013 and 2014, with the federal government paying the full cost of the increase for the states. Unfortunately, lawmakers failed to reauthorize the payment increase after 2014. The evidence clearly demonstrates that physician participation in Medicaid is tied to reimbursement rates.

ACP supports the Kids' Access to Primary Care Act of 2023, H.R. 952, which addresses Medicaid-Medicare pay parity. Internal medicine physicians commit themselves to a long-term relationship with all their patients, including Medicaid beneficiaries, and furnish first-contact, preventive services and long-term care for complex and chronic conditions that minimizes hospital admissions and other high costs to the health care system. However, increasingly inadequate Medicaid payments impede internal medicine physicians and other clinicians from accepting more Medicaid patients, particularly among small practices, and threatens the viability of practices serving areas with a higher proportion of Medicaid coverage.

Increasing the Primary Care Physician Workforce Leads to a Healthier Population

Even before the COVID-19 pandemic, the Association of American Medical Colleges (AAMC), estimated that there would be [a shortage of 17,800 to 48,000 primary care physicians by 2034](#). A [report](#) by the National Academy of Sciences, Engineering and Medicine calls on policymakers to increase

our investment in primary care as evidence shows that it is critical for achieving health care's quadruple aim (enhancing patient experience, improving population, reducing costs, and improving the health care team experience). Now, with the closure of many physician practices and physicians nearing retirement not returning to the workforce after the COVID-19 pandemic, it is even more imperative to assist those clinicians serving on the frontlines and increase the number of future physicians in the pipeline.

Evidence clearly shows that increasing the number of primary care physicians (PCPs) helps reduce mortality. A [recent study](#) appearing in the *Annals of Internal Medicine* showed that in counties with fewer primary care physicians (PCP) per population, increases in PCP density would be expected to substantially improve life expectancy. People living in counties with only one PCP per 3,500 persons have a life expectancy almost a year less than those individuals living in counties above that level. To reach the one PCP per 3,500 persons ratio in those counties (the Health Resources and Services Administration's (HRSA) threshold of a Health Professional Shortage Areas (HPSA)) would require an additional 17,651 PCPs, about 15 more physicians per county. To reach a more optimal one PCP per 1,500 people ratio as recommended by the Negotiated Rulemaking Committee convened by HRSA in 2010 would require 95,754 more PCPs or about 36 additional physicians in each of these counties.

Accordingly, Congress should enact policies that will not only increase the overall number of PCPs, but also ensure that these additional PCPs are located in the communities where they are most needed in order to furnish primary care. ACP encourages efforts by federal and state governments, relevant training programs and continuing education providers to ensure an adequate workforce to provide primary care to patients and those continuing to be affected by the pandemic. Funding should be maintained and increased for programs and initiatives that increase the number of physicians and other health care professionals providing care for all communities, including for racial and ethnic communities historically underserved and disenfranchised.

Funding Initiatives to Help Grow Number of Physicians in Independent Practices

ACP [supports](#) federal programs and student loan incentives to address physician workforce shortages. Immediate action is needed to address the existing and growing physician workforce shortage through expansion of federal programs such as Medicare supported graduate medical education (GME), the National Health Service Corps (NHSC), Community Health Centers (CHCs) and Teaching Health Centers Graduate Medical Education (THCGME) programs. We appreciate H.R. 5378, the Lower Costs, More Transparency Act, reauthorizing and increasing funding for these programs. This legislation should serve as the floor for funding of these programs through fiscal years 2024 to 2029.

The NHSC awards scholarships and loan repayment to health care professionals to help expand the country's primary care workforce and meet the health care needs of underserved communities across the country. In FY2023, with a projected field strength of 20,000 clinicians including over 2,600

physicians, NHSC members are providing culturally competent care to a target of over 15 million patients at over 18,000 NHSC-approved health care sites in urban, rural, and frontier areas. These funds will help maintain NHSC's field strength helping to address the health professionals' workforce shortage and growing maldistribution.

ACP strongly supports Community Health Centers and has continuously advocated that Congress reauthorize the program's mandatory funding as well as include robust funding in annual appropriations bills. Congress should provide sufficient and continuing financial support for these essential public health facilities that serve underserved populations that otherwise lack the financial means to pay for their health care. For the reauthorization of the CHC program for FY2024 and beyond, Congress should continue its investment and increase funding for CHCs.

We also support expansion of the Medicare Graduate Medical Education (GME) program. ACP was greatly encouraged that bipartisan Congressional leaders worked together to provide 1,000 new Medicare-supported GME positions in the Consolidated Appropriations Act (CAA), 2021, H.R. 133, the first increase of its kind in nearly 25 years, and that some of those new slots have been prioritized for hospitals that serve HPSAs. We encourage Congress to now pass H.R. 2389/S. 1302, the Resident Physician Shortage Reduction Act of 2023, which authorizes 2,000 new GME positions per year for seven years. With an aging population with higher incidences of chronic diseases, it is especially important that patients have access to physicians trained in comprehensive primary and team-based care for adults—a hallmark of internal medicine GME training. It is worth noting that the federal government is the largest explicit provider of GME funding (over \$15 billion annually), with most of the support coming from Medicare.

Reducing Administrative Burden

Administrative requirements force physicians to divert time and focus away from patient care and can prevent patients from receiving timely and appropriate treatment. They are also a financial burden and contribute significantly to the burnout epidemic among physicians. A 2022 [survey](#) of more than 500 doctors from group practices found that 89 percent believe that regulatory burdens increased in the past year, and 82 percent responded that the prior authorization process in particular is very or extremely burdensome.

ACP recommends three ways Congress can help reduce the administrative burden for patients and their physicians. Congress should:

- Support Section 301 of H.R. 4822, the Health Care Price Transparency Act. The provision includes the Improving Seniors' Timely Access to Care Act, which would require that Medicare Advantage (MA) plans establish an electronic prior authorization process to make it easier for physicians to determine if a prescribed procedure, service, or medication is covered. ACP also supports streamlining prior authorization for other group health plans.

- Support H.R. 2630/S. 652, the Safe Step Act of 2023, a bipartisan bill that would ensure patient access to appropriate treatments based on clinical decision-making and medical necessity rather than arbitrary step therapy protocols. The bill would require group health plans to provide a transparent exception process for any medication step therapy protocol.
- Support legislation that facilitates electronic health record (EHR) standardization and the adoption of new standards in medical practices that would reduce burdensome administrative tasks.

Protecting Viable Independent Primary Care Practices During Consolidation

It is important that Congress offer ways to ensure independent practices remain a viable option in a highly consolidated health marketplace. In our [paper](#) entitled “Financial Profit in Medicine: A Position Paper From the American College of Physicians,” ACP considers the effect of mergers, integration, private equity investment, nonprofit hospital requirements, and conversions from nonprofit to for-profit status on patients, physicians, and the health care system. For physician practices, private equity investment and management could alleviate administrative burdens, provide financial stability, and accelerate adoption of health information technology.³ Research is needed to better understand the effect of private equity investment in health care.

ACP [recommends](#) longitudinal research on the effect of private equity investment on physicians' clinical decision making, health care prices, access and patient care, including the characteristics of models that may have adverse or positive effects on the quality and cost of care and the patient–physician relationship. We believe passage of H.R. 5378, Lower Costs, More Transparency Act, is a good start at examining the effects of consolidation on independent practices. While the bill does not include private equity, it does require the Department of Health and Human Services to collect data on how its regulations affect consolidation.

ACP supports transparency regarding corporate and private equity investment in the health care industry. Policymakers, stakeholders and regulators should provide oversight of private equity activity to prevent practices like unwarranted self-referral, overreliance on nonphysician health care professionals, or consolidation that results in uncompetitive markets. While greater transparency and data collection of vertical integration activity is an important first step, ACP recommends that lawmakers and regulators scrutinize in advance and regularly evaluate after approval all mergers, acquisitions, and buyouts involving health care entities, including insurers, pharmacy chains, large physician groups, and hospitals. The appropriate public representative (for example, federal or state attorney general, trade regulator, or insurance commissioner) should evaluate the potential effect on the communities served, competition, health care prices, insurance premiums, innovation, and access to physicians.⁴⁵

Physician–hospital consolidation into vertically integrated health systems has accelerated in recent years, with for-profit and church-affiliated systems growing especially large in size.⁶ Market concentration among primary care physician organizations has increased as well.⁷ Consolidation, which could conceivably increase efficiency and value-based payment initiatives⁸⁹ may also lead to higher prices.¹⁰

ACP has expressed concern about potential unintended consequences of market concentration and system consolidation, calling for health care organizations to provide detailed claims data so that public agencies and private researchers can assess the full effect on costs and quality of care.¹¹ Antitrust enforcement agencies need to have the necessary data to effectively weigh the tradeoff between desirable outcomes, like more coordination, and undesirable outcomes, like less competition, when examining the effect of mergers on health care markets.¹² At the same time, oversight activities should be implemented in a way that does not unduly burden physicians, particularly those in small and independent practices with limited financial and legal resources that may also be most prone to vertical consolidation.

Conclusion

We commend you for working in a bipartisan fashion to identify solutions to the declining number of independent practices in the U.S. Thank you for working to ensure that the nation’s health care workforce needs are met. If you have any further questions or if you need additional information from ACP, please contact George Lyons at (202) 261-4531 or glyons@acponline.org.

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