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TO: LUGPA
FROM: ALEX WHALEN & LAWREN GEER
SUBJECT: W&M HEALTH HEARING – CHALLENGES FACING INDEPENDENT MEDICINE W/ LUGPA BOARD MEMBER DR. TIMOTHY RICHARDSON
DATE: MAY 23, 2024

Executive Summary

Today, the House Ways & Means Health Subcommittee held a hearing titled "The Collapse of Private Practice: Examining the Challenges Facing Independent Medicine" with several independent physicians and experts representing primary care and multiple specialties including **LUGPA Board Member and Wichita Urology physician Dr. Timonthy Richardson!** Throughout the entirety of the hearing, there was overwhelming bipartisan support and recognition of the urgent challenges facing independent physician practices due to a multitude of factors including consolidation, private equity, lack of predictable physician fee schedule updates, staffing challenges, administrative and regulatory burden from prior authorization and Medicare Advantage, site-of-service payment disparities, failure of MACRA and MIPS, and more.

Members on both sides of the aisle discussed and agreed with the witnesses regarding the unviable market forces plaguing independent physician practices and expressed genuine concern at the future of independent medicine if the status quo remains constant. They recognized that independent physicians need a much more predictable, if not permanent, reimbursement structure tied to inflation that allows them to compete with hospitals and health systems. Additionally, solutions discussed included site neutral payments, allowing hospital physician ownership, restructuring of MACRA/termination of MIPS, and fixing the prior authorization process particularly in Medicare Advantage.

There was specific focus on the impact of consolidation and private equity on independent physicians and patients in rural communities.

Opening Statements

Sub. Chair Buchanan (R-FL): Americans are hurt by inflation, which especially hurts small businesses, and physicians are no different. Nearly 90% of medical groups reported increased operating costs last year, according to the Medical Group Management Association, and physician's costs increased by over 63% from 2013 to 2022. Making it harder to run a practice. During this same time frame Medicare reimbursement for physicians has increased by only 1.7%, in fact when adjusted for inflation it actually plummeted by 29% over the last 20 years. How can we get doctors to stay in private practice when practice costs are rising, and reimbursement continues to get cut? Physicians are often forced to sell their practice or consolidate with a larger system to stay afloat. Selling a practice should be the choice of a physician based on what works best for them, their family, their patients, and their practice. They should not be forced. According to the American Medical Association, between 2012 and 2022 the share of physicians working in private practice fell by 13%. A thriving health care ecosystem needs a balance of larger health care system and

small, local practices. Medical school prices have also contributed to physicians going to work for larger systems where they can collect a steady paycheck and not have to worry about the administrative burdens of private practice. The rising amount of lawsuits for physicians is also a concern, as medical liability premiums have nearly doubled since 2018.

Sub. Ranking Member Doggett (D-TX): My father was a solo practice dentist for over 30 years and I know people he worked on who appreciated and valued the personalized care he was able to provide. Over 70% of physicians who are employed by a health care system are a corporate entity. This consolidation is creating greater obstacles for the few remaining independent practitioners who are struggling to compete and also has implications for taxpayers and patients. While I agree that physicians are sometimes over-regulated, the regulator that seems to be interfering the most for many comes from the private Medicare Advantage (MA) plans. MA plans continue to interfere with the provider-patient relationship through prior authorization, step therapy, and other management tools. These tools often lead to delays and denial of necessary medical care. One study found that 82% of denials that were appealed were ultimately overturned and found to be necessary and appropriate, but a small independent practice often can't afford to go through with the appeal. Physicians face inadequate payment and we know that the physician fee schedule is a source of stress we hear about every year. Private MA plans frequently provide lower payments than traditional Medicare, which is hard to believe. At the same time, MA is being dramatically overpaid $84 billion in taxpayer money this year alone and at the same time, they aren't being required to reimburse doctors at least at traditional Medicare rates. The Medicare Payment Advisory Commission (MedPAC) says that approval of an inflation update is very important, and we must find an acceptable way to pay for that. I don't think it's the complete answer though. We need to strike a balance to protect the long-term solvency of the Medicare Trust Fund while also holding MA plans accountable. Payment tweaks alone will not address what is already a broken market. Private equity and vertical consolidation that use their resources to consolidate and push providers out of network are problematic. Private equity can be viewed as a savior and it's easy to understand the allure of these buyouts, but often they only benefit the more senior physicians who are about to retire. Junior providers and staff are often fired and patients suffer.

Witness Statements

- **Dr. Jennifer Gholson, MD,** *Family Practitioner, Summit, MS*
- **Dr. Timothy Richardson, MD,** *Independent Physician, Wichita Urology, LUGPA Board*
- **Ms. Chris Kean,** *COO, The San Antonio Orthopedic Group*
- **Dr. Seemal Desai, MD,** *Founder, Innovative Dermatology*
- **Dr. Ashish Jha, MD,** *Dean, Brown School of Public Health*

Dr. Gholson: I represent the members of the American Academy of Family Physicians and former solo practice owner. Over the last few decades, we have propped up a health care system with misaligned incentives that reward consolidation and underinvest in primary care. In 2011 I opened my own family medicine practice in my rural community. Plans provided no transparency on the contracted rates, meaning I didn't know what I would be paid until I signed on the dotted line, and many plans closed their networks completely and would not contract with me. I was an early participant in value-based care and joined an accountable care organization (ACO), and there was at least one year that the shared savings from the ACO helped keep my practice doors open. We were able to effectively use telehealth during the pandemic. During 2021 prior authorization started increasing while payments started shrinking, as physician practices already get paid 2-3 times less than hospitals for the same services. It is hard for us to compete with hospitals for staff as they are

able to offer higher salaries and benefits, and I lost most of my staff. Health plans also started clawing back payments they already gave me because of minor billing mistakes instead of allowing me to resubmit claims. The presence of my practice in my small town drew in other providers such as a pharmacy and urgent care, but ultimately, I had to close my practice in 2022. Congress must advance policies that improve payment for primary care, address misaligned incentives, such as facility fees, that encourage consolidation, and minimize the administrative building that independent practices face.

Dr. Richardson: My practice is no stranger to the mounting pressures independent practices face such as the double whammy of increasing regulatory and administrative burdens alongside declining reimbursement. Physicians have responded by working harder and more, leading to burnout and early retirement, thereby compounding the shortages and onus on those who remain in practice. I am reminded of what occurred to a colleague's practice in Shreveport Louisiana, which peaked at 20 urologists but over time dwindled to 8, as hospitals recruited their doctors who could be relieved essentially of 100 percent of administrative, practice management and regulatory burdens overnight alongside RVU pay schedules that substantially reduce their patient care obligations. Pay differentials, presumably subsidized by site-of-service disparities, made it impossible to meet or compete with salaries offered to nursing and professional staff, leaving remaining staff overtaxed and driving up practice costs. Eventually this practice collapsed and patient access to care was reduced. This is a trend as hospital-employed physicians increased by more than 70% from 2012 to 2018 and another 5.1% between 2022 and 2023. More than half of physicians are now employed by hospitals! Hospitals have focused on acquiring physician practices because that strategy simultaneously quashes competition in the local market for services such as outpatient surgery and captures downstream revenue from ancillary services such as radiation therapy, imaging, and physician-administered drugs (often 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 Merrit survey found urologists generate $2.1 million while receiving an average salary of $386,000. Similar returns on investment applied for acquisition of other specialists. Studies have shown that Medicare could save over $150 billion by equalizing payment disparities between hospitals and physician offices, yet simply cutting the hospitals does not assist physician practices. We would suggest an approach that modestly reduces HOPD payments and modestly increases physician payments, to protect patient access. The lack of available alternative payment models (APMs), the failure of the MIPS program, and Stark laws remain an impediment to value-based care delivery and opportunities for physician entrepreneurs to bring competition and improved patient choice.

Ms. Kean: I represent a fiercely independent, 100% owned group. Our physicians built this group to help navigate an often-confusing health care system with as much physician-directed care as possible under a seamless umbrella. Patients are able to receive x-rays or MRIs, physical therapy, CS after hours, preventive bone health care, and outpatient ambulatory surgery from our practice. Inpatient services will also be directed by our physicians at one of three community-based hospitals in the region. Creating an entity like this is rare and requires physicians to be focused on all aspects of the patient's care and treatment plan, as the physician is solely responsible for the liability of every patient. Meanwhile, they are also responsible for the 600 professional team members they employ. There are three main challenges facing independent medicine: (1) the source of revenue to maintaining this environment is fixed, decreasing, and largely not in our control; (2) expenses have increased dramatically; and (3) relationships with insurance carriers and others have become at times hostile and not conducive to keeping the healthy balance required in health care delivery today.

Dr. Desai: I am the President of the American Academy of Dermatology Association representing 17,000 physicians nationwide. I saw in my own, personal experience the importance of having access to a high-quality specialist and I was inspired to go into medicine. The threats facing small practices have grown immensely in the last decade and the end is nowhere in sight. The greatest challenge facing practices and patients is the failure of the PFS for keeping up with inflation, especially when physicians are the only Medicare provider that do not receive any inflationary updates. Since 2001, the price of keeping up a physician's practice has increased by nearly 50% and when adjusted for inflation, Medicare physician rates declined by 30%. What business can survive under these circumstances? This has ultimately led to fewer health care options for patients. Congress must adopt a permanent Medicare payment update that fully acknowledges the inflation of health care costs while working towards long-term reform. The Academy urges Congress to adopt a positive annual payment adjustment and to increase the budget neutrality threshold by passing H.R. 2474 and H.R. 6371. Additionally, too much time and resources are spent on prior authorization for medications that will keep patients out of the hospital.

Dr. Jha: I have watched American medicine change and have seen so many colleagues and friends leave private practice. Today a primary care physician caring for a complex, sick population must coordinate care across dozens of specialists and manage a dizzying array of tests and procedures. Providing care in an independent small practice has gotten harder for sure, but on top of that there is an array of sources driving the demise of independent practices. Hospitals and health systems have been on a buying spree. While some of these purchased may have been helpful, many have not as the only thing that changes are hospitals being able to charge higher prices due to facility fees. The access and quality aren't any better, but these fees make private practices a target for acquisition. Large corporations, such as Optum, have gotten involved in this game. Optum now owns or manages one in ten practicing physicians in America. MA has also made life more complicated for physicians as MA payments usually don't even match what traditional Medicare pays, and prior authorization is implemented. Initial denials of care authorization have grown substantially in recent years. Finally, there is private equity. A colleague recently sold his practice to private equity and found himself changing the way he practiced. PE firms are spending hundreds of billions of dollars buying up health care sites, which usually increases costs, decreases access, and even can harm patient safety. Congress should take action on site neutral payments, transparency around ownership, enforcement of existing anti-trust laws, and addressing physician reimbursement.

Q&A

Sub. Chair Buchanan (R-FL): You had to close your practice after 20 years. In hindsight, could you have done anything differently?
Dr. Gholson: In my community, the local hospital considered me competition instead of a community partner. If one of my patients ended up in their ER, they wouldn't list me as the primary care physician because I wasn't employed by the hospital. 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.

Sub. Chair Buchanan (R-FL): Can you expand on the increasing administrative burden?
Dr. Richardson: A lot of it revolves around MIPS. I have 3 staff that are constantly having to deal with the reporting associated with MIPS, often half their day is spent on this. Practice costs are going up every year and we have to keep adding administrative employees for that. Coupled with decreasing reimbursement so we're constantly pressured to add new service lines of treatment for patients to try and maintain revenue. There's increased costs and increased need to try and employ

more staff coupled with the competition to employ those staff with competing hospitals in town who offer more money.

Sub. Chair Buchanan (R-FL): Biggest challenges you face?
Ms. Kean: Aside from the payment issues, prior authorization has been an absolute disaster and doesn't do anything to improve care and only allows insurance carriers to deny care.

Sub. Chair Buchanan (R-FL): Effects of private equity?
Dr. Desai: Must be very careful when evaluating models – it's not a one-size-fits-all approach.
Dr. Jha: It's hard to know how much private equity is in health care because there's no real transparency. Their general strategy is buying up a lot of practices, gaining a lot of market power, and then leveraging high prices against the carrier. Patients and consumers end up footing those higher prices. We need to begin with transparency and vigorous antitrust enforcement.

Sub. Ranking Member Doggett (D-TX): Studies show private equity owned medical practices charge 20% more per claim than independent practices and 80% of PE owned physician practices significantly increased prices just after the takeover. Estimates show PE has invested more than $1T in healthcare. Is it fair to say PE's strategy is to increase prices to both insurers and to the Medicare system and to decrease the quality of care?
Dr. Jha: We all agree physicians need to be reimbursed more – that's not what PE is doing. They are getting higher reimbursements but PE is pocketing that difference and physicians are not better off. We're seeing a lot of physicians leaving those practices. One study showed that when PE took over hospitals, medical errors and adverse events went up. Doctors and patients are worse off.

Sub. Ranking Member Doggett (D-TX): What impact will the FTC's recent action on non-compete clauses and other enforcement mechanisms have?
Dr. Gholson: Positive impact. At the heart of the issue should be relationship between patient and physician and nothing should come between that. One of the things that concerns me about the FTC ruling is that it doesn't include non-profits and we do have hospitals that would fall under that purview. I'd urge that non-profits should come under that ruling as well.

Sub. Ranking Member Doggett (D-TX): Estimates show we're paying about $1,500 more per Medicare recipient a year out of the Medicare Trust Fund to MA plans than traditional Medicare. Yet, some of these won't pay the MA provider as much as traditional Medicare. Recommendations?
Dr. Jha: MA has taken off in the last 10 years. We're overpaying for MA and it's not translating into better care for patients or better reimbursement for physicians. Policy solutions could be risk adjustment, how you do regional benchmarking, and more but we need to implement them. Just paying more to insurance companies when they're not generating more value for consumers, patients, or taxpayers doesn't make a lot of sense.

Rep. Smith (R-NE): Recommendations we should pursue to address workforce shortages?
Dr. Gholson: In Mississippi, we've increased the number of residencies with the belief that where people train they will stay so would encourage more GME funding.

Rep. Sewell (D-AL): 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: First of all, we need to look at reimbursements for primary care more broadly. Policy ideas I've talked about with MA and site neutral payments are going to be helpful everywhere but particularly for the rural provider who's much more vulnerable to these issues.

Dr. Gholson: Paying primary care is vital to being able to sustain primary care independent practices in rural America. The budget neutrality issue is also something that needs to be addressed. Prior authorization and administrative burden are also key to address.

Rep. Chu (D-CA): Every year at the end of the year, physician group after physician group comes into my office pleading for their reimbursement to not be cut. What do you recommend we do to upgrade how Medicare pays physicians in a way that improves value without breaking the bank?
Dr. Jha: We have a long tradition of not fixing things for the long run and doing this band aid fix every year. We need a long-term fix for inflation adjustment for PFS. I've not encountered someone who doesn't agree with that. Where the disagreement is exactly how we do that. Do we use MEI? What proportion of that? Over what time? MedPAC has laid out a strategy approach that is pretty reasonable. The bottom line is having to do this every year creates uncertainty, wastes time, and creates hardship and more susceptible to selling out.

Rep. Chu (D-CA): Elaborate on rampant use of unvetted AI tools by MA insurers creating unnecessary burdens for physicians and contributes to harmful outcomes for patients? Additional measures to enforce to ensure private insurers aren't leveraging these AI tools to unlawfully deny care for seniors on MA?
Dr. Jha: Cigna spends 1.5 seconds per claim on denials. This is not a physician carefully reviewing the circumstances and claims and making a clinical determination. Insurers strategy is assuming that busy physicians will give up after they deny the first authorization. I think there are instances where prior authorization can make sense: if you're doing something experimental, extraordinarily expensive, or extremely unusual, going through an extra hurdle can make sense. For more routine things, we need to have actual physicians involved in the decision making, transparency around preauthorization rates and denial rates. I'd love to see long term fixes on these because MA is here to stay and we've got to make sure we solve these problems for the long run.

Rep. Hern (R-OK): 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: Absolutely. We have a very comprehensive one-stop-shop practice where we offer radiation therapy, diagnostic therapy, surgical therapy, medication therapy, and clinical trials. We do treatments and diagnosis throughout the gamut. If we sold to a hospital system and changed absolutely nothing, it'd cost 2-3x more overnight for any of the insurance companies or Medicare and the patients OOP as well. So, it absolutely makes a big difference when you're billing under a hospital code instead of an outpatient clinic code. The price skyrockets and it has nothing to do with quality of care and access to care. In fact, most of the time it would actually decrease access because all of a sudden we're not motivated to work as much because we're getting paid substantial rates on RVUs because the hospital can afford to do it because of their site of service benefits and advantages.

Rep. Hern (R-OK): 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. Do you think allowing physicians to own hospitals would create more competition and what type of benefits would patients see?
Ms. Kean: We're a 100% physician owned practice and own/manage 2 ASCs. I don't see a reason why a physician can't own a hospital. I understand there's regulatory requirements as far as a referral relationship and where that patient goes but the physician knows where the best place is for the patient to receive care. We need to let them do that.

Rep. Davis (D-IL): One thing we could do to preserve independent private practice of medicine?

Dr. Gholson: Get rid of prior authorizations completely and paying primary care their worth.
Dr. Richardson: Updating PFS so we can keep pace with cost of running a practice.
Ms. Kean: Returning medical record back in hands of physicians instead of AI tools/insurers.
Dr. Desai: Fix PFS by passing H.R. 2474 and H.R. 6371 to allow physicians to maintain practices.
Dr. Jha: Site neutral payments are the main reason we're seeing practices get bought out. Dealing with prior authorization in MA. Fixing PFS.

Rep. Miller (R-WV): Pressures that come with competing for workforce with the larger systems?
Dr. Gholson: I could not compete with what the local hospital was able to pay my nursing staff. The hospitals had an advantage because of the facility fees.

Rep. Miller (R-WV): Examples where Medicare regulations or reimbursement requirements have limited your practice's ability to provide high quality services to your rural patients?
Dr. Richardson: Everything is more difficult when treating patients in rural areas. Unless you actually have a provider in that area, from a specialist standpoint you're travelling. I mentioned earlier we have 13 clinics throughout the state – those are clinics where we actually get in our car, grab our staff, equipment, scopes, drugs and put them in our trunk to drive to a community and run a clinic. We sometimes do simple outpatient surgeries at that local hospital and then drive back. It's just an increased burden to your quality of life and burden to your practice at home. We've had the discussion of consolidating care and making patients drive to the Wichita Metro area because we are so overburdened, but we just haven't had the heart to do it because many of these patients cannot or wouldn't make the travel. They don't have the social support or resources to drive 3-4 hours. One of the good things that came from COVID was telemedicine. We've tried to take advantage of that when possible.

Rep. Fitzpatrick (R-PA): Impacts of pressing financial instability on physician practices including difficulty retaining staff, trouble keeping doors open, rising costs, admin burden?
Ms. Kean: Trying to retain our staff has been very difficult. It's not just hospitals we're competing against but also retail entities that can simply just raise their prices.

Rep. Fitzpatrick (R-PA): Explain how increased operating costs have impacted your practice and others like yours? How can Congress address?
Dr. Desai: The cost of seeing patients and providing care is astronomically different from when I started in practice. When you look at inflationary updates that Medicare hospitals and skilled nursing facilities receive that physicians have been excluded from it makes it difficult to see patients on a day-to-day basis. In my practice, we have to increase the volume of patients we have to see on a day-to-day basis to justify the increasing overhead costs that we have to pay for staff.

Rep. Beyer (D-VA): From your perspective, why is site neutrality so important?
Dr. Jha: Site neutrality is critical for all the reasons you've heard today. If the hospitals say they have to take care of a sicker, more indigent population then 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 or quality – all it does is allows Medicare and consumers to pay a lot more through private insurance. There's been progress on site neutrality – I don't want to say we've made no progress but there are still large issues that are still not addressed.

Rep. Teney (R-NY): Need to protect a merit-based system in terms of who gets to be a physician?
Dr. Gholson: I do. But the merits need to be transparent.
Dr. Richardson: Yes

Ms. Kean: Yes, need to cultivate the best and brightest minds to go into medicine.
Dr. Desai: Yes.

Rep. Teney (R-NY): 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? How's it impacted patient access in rural areas?
Dr. Gholson: It impacts it tremendously.
Dr. Richardson: Our employee overhead has gone up 30% in the last year and that's not the only line item in our business we're paying more for. Would venture to say MA plans actually decrease access. At least where I am, most of the specialists try not to participate in them.

Rep. Teney (R-NY): Outside of Congressional intervention to update PFS, what else can we do?
Dr. Richardson: Updates need to be tied to MEI.

Rep. Moore (R-UT): Estimates found physicians spend $12,800 annually to comply with MIPS quality reporting and devote approx. 53 hours per physician. This is a fundamental problem and should be low hanging fruit. Alternative ways to accurately reflect patient outcome and physician value provided?
Dr. Desai: Reporting is burdensome. MIPS hasn't improved anything and needs to be fixed.
Dr. Richardson: MIPS reporting is largely meaningless and most of the time has nothing to do with the care that the patient is there for. Especially for specialists. There's no tie to quality or value.
Dr. Jha: MIPs was a well-intended program at first. Some of us were hopeful that it'd actually work. It really has not. It doesn't improve quality – it just burdens physicians. Quality reporting is important, as a concept, but we should have smaller number of measures, automatically collected, focused on things that patients care about like outcomes.

Rep. Steel (R-CA): What do market consolidation trends mean for patients & independent doctors?
Dr. Jha: Horizontal and vertical consolidation evidence is quite clear. This is a trend not focused on integration and improving care but rather results in higher costs, worse patient and physician experience. Everyone is worse off except the organization that can make more money. To fix, we've discussed site neutrality, dealing with MA, and vigorous enforcement of antitrust.

Rep. Van Duyne (R-TX): Reforms to encourage higher quality of care while reducing burdens?
Dr. Desai: H.R. 2474 and H.R. 6371 would allow us to at least start making sure those of us in private practice, academic practice, large groups can continue to practice and keep the doors open.

Rep. Van Duyne (R-TX): Many Democrats look at PE as a villain but I've heard from many physicians that are starting to look at PE as an investment, so they don't have to consolidate. What are the positive impacts of PE investment in medical practice?
Dr. Desai: Competition and access are a good thing. When you only have one or two players in town – that's a problem. When we encourage competition broadly in the best interest of the highest patient quality care that's where we need to land.
Van Duyne: And you're seeing PE as something that actually helps increase competition?
Dr. Desai: I'd frame it in a way that not all PE is bad, not every academic medical center is great, not every hospital system is great. We can't label it a one-size-fits-all approach.

Rep. Estes (R-KS): 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 impacts the

rural parts of our state the most. Elaborate on how your private practice has remained open to these rural areas and how that's not often an option for physician groups that have been acquired?
Dr. Richardson: We're not unique as a specialty that does these outreach clinics. Gastroenterology, cardiology, rheumatology and more do these rural outreach clinics throughout KS because they know those patients can't drive 3-4 hours. Speaking on consolidation, there's a hospital system that has specialists that do no outreach. Independent physicians are reaching out, doing telemedicine, driving, doing clinics to reach rural patients while the consolidated hospital system is not and instead making those patients drive to them. The rising costs and inflation is the only reason we've considered consolidating ourselves back to Wichita and taking our staff out of those outreach clinics. It's not because we don't enjoy seeing those patients in the rural areas or because they don't need it, it's because we almost can't afford it with the difficulty in hiring nurses/NAs. We've talked about consolidating because of these costs. We've not had the heart to do it and I don't think we will but that's the only reason we've had that conversation.

Rep. Estes (R-KS): Provide details on how site neutral policies can be managed without necessarily reducing payments to hospitals?
Dr. Richardson: I don't think the right thing is to just decrease payments to hospitals. That doesn't necessarily help physician practices stay in business or help patient access. However, right now it's an unfair playing field and we're competing with those systems for doctors and staff. Site neutrality is one of the most important ways to keep independent physicians in practice. We are simply competing against someone we can't beat. A more reasonable solution would be to have a modest decrease in the HOPD payment and a modest increase in the physician payment.

Sub. Chair Buchanan (R-FL): I'm curious how tort reform and frivolous lawsuits impact your businesses, premiums, and preventive medicine?
Dr. Gholson: We had state level tort reform in Mississippi in the early 2000s which made a huge impact on our ability to be able to practice medicine.
Dr. Richardson: Tort reform is never going to be turned down by physicians and is a very important thing to discuss. It's very specialty and state specific. There are some specialties where tort reform is absolutely crucial to allow them to stay in business. In others it's not as crucial. It pales in comparison to moving the needle to site neutrality and PFS updates.
Ms. Kean: Texas passed tort reform over 20 years ago and it absolutely impacted the malpractice rates our physicians were paying and decreased it substantially. It's working well in TX.
Dr. Desai: According to AMA study, in 2022, over 30% of physicians reported being sued. That's a staggering number and exactly why there's so much concern for physicians to go into medicine or continue practicing and doing procedures well within scope but out of fear they could be sued depending on state law. We certainly support broad medical liability system reform but we need common sense limits into these medical liability regulations.
Dr. Jha: This is one part of the bigger picture we've been talking about today. We need to deal with all the other stuff – site neutrality, MA, PFS updates. If we do all that and make this part of the solution, we can get to a better place.