

# HEALTHCARE REALIGNMENT AND REGULATION: THE DEMISE OF SMALL AND SOLO PRACTICES?

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## HEARING

BEFORE THE

SUBCOMMITTEE ON INVESTIGATIONS, OVERSIGHT,  
AND REGULATION

COMMITTEE ON SMALL BUSINESS

UNITED STATES

HOUSE OF REPRESENTATIVES

ONE HUNDRED TWELFTH CONGRESS

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## HEALTH CARE REALIGNMENT AND REGULATION: THE DEMISE OF SMALL AND SOLO MEDICAL PRACTICES?

THURSDAY, JULY 19, 2012

HOUSE OF REPRESENTATIVES  
COMMITTEE ON SMALL BUSINESS,  
SUBCOMMITTEE ON INVESTIGATIONS,  
OVERSIGHT AND REGULATIONS  
*Washington, D.C.*

The Subcommittee met, pursuant to call, at 10:00 a.m., in Room 2360, Rayburn House Office Building. Hon. Mike Coffman (chairman of the subcommittee) presiding.

Present: Representatives Coffman, Tipton, Schrader, and Hahn.

Chairman COFFMAN. Good morning. The meeting is called to order. I want to thank our witness list for being here today. We look forward to your testimony.

Today, we meet to examine the changing landscape of small and sole position practices. For many years, newly-licensed physicians typically joined a private practice or open one of their own. According to Merritt Hawkins, a national physicians' recruiting firm, whose president is testifying today, only 1 percent of its searches in 2011 were for independent practices, the lowest in the firm's 28-year history and down from 22 percent in 2004. Many people believe that small and solo practices in order to survive, they will look very different than the medical practices in past years. These shifts appear to be rooted in the increasing economic pressures, younger physicians, they want freedom from the long hours and administrative burdens of owning a private practice and they need financial help with student loans, medical liability insurance, and health information technology. Established physicians have cited declining reimbursements and increasing regulations such as the reporting requirements for health information technology and the push towards accountable care organizations as reasons small and solo practices have become economically unsustainable.

In a recent Wall Street Journal op-ed, Daniel Henninger described practicing medicine as a health care law's biggest loser. We are interested in learning how all of these factors, including the requirement of the health care law which was upheld by the United States Supreme Court may affect small practices.

We have an exceptional panel of witnesses to help us understand these issues. Welcome, we look forward to your testimony.

Dr. Schrader, do you have any opening—

Mr. SCHRADER. I will just submit mine for the record, Mr. Chairman. Thank you.

Chairman COFFMAN. Thank you.

The subcommittee members have an opening statement prepared and that is within the Senate for the record. I would like to take a moment to explain the timing lights to you.

You will each have five minutes to deliver your testimony. The light will start off as green. When you have one minute remaining, the light will turn yellow. And, finally, it will turn red at the end of your five minutes. I ask that you try to adhere to the time limit.

Our first witness today is Mark Smith, president of Merritt Hawkins in Irving, Texas, a leading physicians' recruiting firm for small, independent practices, group practices, and hospitals. Mr. Smith has over 21 years of experience with Merritt Hawkins and is an expert in medical staff planning and physician staffing. He is a graduate of Oregon State University. Welcome. You have five minutes to present your testimony.

**STATEMENTS OF MARK SMITH, PRESIDENT, MERRITT HAWKINS; LOUIS F. MCINTYRE, M.D., WESTCHESTER ORTHOPEDIC ASSOCIATES, WHITE PLAINS HOSPITAL PHYSICIANS; JOSEPH M. YASSO, JR, D.O., HERITAGE PHYSICIANS GROUP; JERRY D. KENNETT, M.D., F.A.C.C., SENIOR PARTNER, MISSOURI CARDIOVASCULAR SPECIALISTS, VICE PRESIDENT AND CHIEF MEDICAL OFFICER, BOONE HOSPITAL CENTER**

**STATEMENT OF MARK SMITH**

Mr. SMITH. Thank you. Mr. Chairman and distinguished subcommittee members, good morning. My name is Mark Smith and I am president of Merritt Hawkins Associates, the largest physician search consulting firm in the nation and a member of the AMN Health Care.

In the course of my 22 years at Merritt Hawkins, I consulted with thousands of physician practices and my company has produced numerous white papers, surveys and books concerning physician practice pattern related topics.

I appreciate the opportunity today to address the subcommittee on the decline of solo and small physician practices.

For those who remember the "Marcus Welby, M.D." nightly TV show, we still have an image in the mind of a physician as a small business owner running their own practice. This classic model of an independent physician practice still exists today, but is rapidly becoming a relic of a bygone era.

Today, physicians are more likely to be employees than they are to be medical practice owners. This is particularly true of medical residents completing their training. In the 2011 survey of final-year medical residents by Merritt Hawkins, only 1 percent chose to be a solo private practice physician. By contrast, 60 percent said they would prefer to be either a hospital employee or work for another entity. In short, virtually no one wants to be a Marcus Welby anymore. This represents a fundamental transformation and structure of physician practices away from the classic private practice model and towards employment and an increasing number of other practice options.

The five primary reasons for this transformation taking place: flat or decline in reimbursement, growing regulatory and administrative burden, malpractice costs, information technology implementation, and the effects of health reform, both the legislative and evolutionary.

First reimbursement. For today's Marcus Welby, both Medicare and private insurers typically pay physicians for usual and customary charges. Physicians generally were paid for services invoiced in an amount above the cost of doing business. This system has been repeatedly modified in an effort to reduce cost and to manage care. Physician reimbursement in some cases has been cut or has not yet faced with inflation.

As a result today, physicians see little connection between their costs and the amount to which they are reimbursed. This is a difficult business model to sustain. Some small private practices are having trouble keeping their doors open. There have even been reports in recent months of a growing number of practices going out of business, something I have not seen in my 24 years with this organization.

By contrast, employment provides physicians safe harbor from today's challenges and from the uncertainties that lie ahead. Regulatory burdens, virtually all businesses are subject to regulatory compliance of some kind. Medical practices are no different. As a small business owner, physicians must abide by Equal Opportunity and worker safety laws, state and local ordinances, and many other rules and regulations. Adding a layer of complexity, physicians must work in the most highly of all regulated professions, having to comply with HIPAA, stark laws, Medicare, and many other regulations. It is concerning to me that a survey conducted by Merritt Hawkins stated that physicians spend 26 percent of their time doing paperwork. Many physicians see employment as a way to escape the rising tide of risk and regulation and allow them to focus on patient care.

Malpractice. Among the greatest cost of doing business, small business owners must pay for their own malpractice insurance, the cost of which could be debilitating.

For example, the annual premium for malpractice in some parts of Florida for an obstetrician can exceed \$160,000 a year. As malpractice rates remain high, the former becomes an attractive option to physicians, as employers typically pay for this benefit.

For a variety of reasons, physicians are obliged to incorporate a growing level of information technology into their practice, particularly EMR or Electronic Medical Records.

While the federal government has provided reimbursement funds for physicians to implement EMR, many still find it difficult due to a lack of time and available expertise. EMR implementation is the key example of resources, expertise, and time a small medical practice are being taxed in today's increasingly complex medical environment. A growing number of physicians are embracing employment again as potential refuge from these challenging concerns.

Health reform is a driver of a number of health care trends, including the decline of small, private practices. Health reform encourages the consolidation of physicians into larger entities to be economies of scale.

In addition, health reform promotes the formation of new delivery models such as Accountable Care Organizations or ACOs which depend upon hospital and physician alignment in the use of advanced information technology. ACOs are also risk-bearing entities and as such require a high level of administrative and business expertise and it is difficult for a solo and all practice physicians to participate in these models, which naturally lend themselves hospital employment for physicians.

Combined, these factors with others have created conditions in which small, private practice is increasingly untenable. This model is only likely to survive in small, rural areas, where there are few physicians and even in these segments, physicians will need to affiliate with larger entities. Otherwise, physicians are likely to be employed by multi-physician groups like hospitals and the era of Marcus Welby will rapidly disappear into our rearview mirror.

Thank you for the opportunity to address the subcommittee for examining the challenges facing America's solo and small practice physician.

Chairman COFFMAN. Thank you for your testimony.

At this time, our next witness is Louis F. McIntyre, a medical doctor, a board-certified orthopedic surgeon practicing in White Plains, New York. Dr. McIntyre and his partners had operated a small practice since 1994, but in the fall of 2011, they sold their partnership to a hospital group and joined the hospital's employees. He earned his medical degree from the New York Medical College at Valhalla. How do you say it?

Mr. MCINTYRE. Valhalla.

Chairman COFFMAN. Valhalla.

Mr. MCINTYRE. Land of the gods.

Chairman COFFMAN. Okay. Dr. McIntyre is a member of the American Association of Orthopedic Surgeons and is testifying today on their behalf.

Welcome. You have five minutes to present your testimony.

#### **STATEMENT OF LOUIS F. MCINTYRE**

Mr. MCINTYRE. Thank you, Mr. Chairman and members of the committee to allow me to testify today and tell my little small practice story.

I joined Westchester Orthopedics in 1994. The practice resided in a small office and we had a few employees and we wanted to grow the practice and improve the quality of care that we delivered. So, in 1995, we moved to a much larger office space, hired more physicians, free parking. Patients love free parking, and added more docs.

The late 1990s brought two challenging trends: decreasing reimbursement and increasing business cost. We needed more employees to handle the clerical demands and by managed care and yearly malpractice premiums went from \$40,000 to \$110,000 per doctor from 1994 to 2011. As a small practice, we were unable to negotiate favorable rates because we did not have market share. We formed a network of orthopedic surgeons to try to change that, but we were unable to affect rates because of anti-trust concerns.

To remain viable, we added more doctors in ancillary services and implemented an electronic medical record. Our total cost for

the EMR implementation was about \$500,000, which represents about \$100,000 per doctor. Initially, we saved some money with EMR, but over time, that was negated by the need to upgrade the system and hire data entry personnel. We built an ambulatory surgery center and acquired additional office space to build a physical therapy center to standardize the quality of the physical therapy that our patients received.

When completely configured, we had just under 50 employees. All had health insurance, all had a generous profit-sharing plan, all had paid vacation and leave and sick leave. Patients appreciated the convenience of being able to receive all their musculoskeletal care in one coordinated and contiguous setting.

The negative pressure on reimbursement, however, continued. The American Academy of Orthopedic Surgeons estimates that orthopedic surgeons with Medicare reimbursement revenue decreased 28 percent in the last decade alone. Reimbursement from private payers has also fallen and practice costs, unfortunately, continue to rise.

Laws recently passed by Congress have further stressed private practice. The American Recovery and Reinvestment Act mandated the adoption of EMR for all physicians serving Medicare patients. Even though we had previously implemented an EMR, the meaningful use criteria accompanying the regulations still represented a significant cost burden for us in terms of data collection and quality reporting rules.

The Patient Protection and Affordable Care Act proposes new, complex risk-sharing methodologies that many small practices, if not most, will not be able to comply with. The combination of decreased reimbursement, increased reporting requirements, huge outlays for technological improvements, and uncertainty about future potential earnings are driving physicians to seek employed positions. Doctors know that they cannot meet all the demands placed upon them now and see patients at the same time. According to the AAOS, the employment of orthopedic surgeons by hospitals has increased 300 percent in the last 5 years.

Last year, we decided to become hospital employees. This year, the other orthopedic group in our town also is going to become employees of the same hospital. The multi-specialty group next use, WESTMED, has 225 employee positions. Clearly, the employee model is winning in Westchester County.

There are advantages for employee positions. Doctors have more financial security with a salary, they do not have to worry about losing money taking care of uninsured patients, they are free from dealing with some of the troublesome human resources and IT issues, but employment, however, significantly decreases physicians' autonomy and infecting the care environment. Physicians are in a unique position to interact with patients on a daily basis and identify deficiencies in care. Physicians' ability to advocate for patients is diminished by employment because they no longer manage the care environment.

As more physicians seek employee positions, there will be a generation of physicians who will never experience private practice and the business of taking care of medicine. They will be unaware of the costs and management issues of providing care.

There is concern that an employed position will see less of a need to join medical specialty societies that have added great value to patient care. How these concerns will affect the profession is unknown at this time.

In the future, I fear that physicians may unionize to protect their economic interest. I believe this would herald the end of medicine as a profession and the start of medicine as trade associations.

It is rarely mentioned, but private practice employs people and pays taxes. A recent study conducted by the Medical Society for the State of New York showed that the private practice of medicine was the fifth largest employer in Westchester County, second in business establishments, third in personal income taxes paid, and seventh in corporate sales taxes paid.

As a hospital employee, our practice is now tax-exempt. The loss of employment and tax revenue resulting from private practice physicians migrating to hospital employment may be significant and worthy of further study.

Finally, there will not be employed positions for all the doctors in Westchester County or the United States. There is and will continue to be an increased need for physicians, especially with the implementation of PPACA in 2014. If private practice disappears, patient access to care, local employment, and tax revenue will suffer. We need to strengthen private practice as well as other models of health care delivery to ensure patient access to quality of care. Thank you for the opportunity to share these thoughts.

Chairman COFFMAN. Thank you, Dr. McIntyre.

Our next witness is Joseph Yasso, junior doctor of—

Mr. YASSO. Osteopathic medicine.

Chairman COFFMAN. Osteopathic medicine, I am sorry. A board-certified family physician, medical physician, and medical director of the Heritage Physicians Group in Independence, Missouri. He is a member of the American Osteopathic Association and is testifying today on their behalf.

Welcome. You have five minutes to present your testimony.

#### **STATEMENT OF JOSEPH YASSO**

Mr. YASSO. Thank you. Chairman Coffman, Ranking Member Schrader, and members of the subcommittee, on behalf of the American Osteopathic Association, thank you for the opportunity to testify today.

As a board-certified osteopathic family physician, I proudly treated patients for over 30 years. My current practice is comprised of three physicians, including myself and a family nurse practitioner. We are owned by the Hospital Corporation of America.

Today, I am pleased to share with you my personal experience of how impactful health care realignment and regulations are upon decisions made by new and established physicians alike.

After leaving the Army in 1980, I entered a small practice with two other physicians that we ultimately chose to sell in 1992, due to multiple financial and regulatory concerns similar to those my colleagues in practice are facing today. Today, physician practices face new demands as required by statute and regulation. These include the adoption of electronic health records and electronic prescribing systems, preparation for coding under ICD-10, implemen-

tation of quality measures, and adjusting to other changes in the health care delivery system. These additional policies and procedures are important and are primarily beneficial to efficiency as well as to providing improved patient care. However, each new requirement can be quite costly to the physician practice operating as a small business.

The burden on small practices is particularly disproportionate, detracting from the time available for patient care. In addition, the looming physician payment cuts under the SGR for small practices with limited revenues and narrow margins to make difficult decisions about whether to lay off staff, reduce the Medicare patient population, defer investments, opt for early retirement, or sell their practice. My first small practice of three buckled to these concerns and we opted to sell.

Today's medical school graduates are faced with difficult decisions after completing their education and training. The average osteopathic medical school graduate has a debt nearing \$200,000. As you can imagine, this makes the prospect of opening a small practice extremely daunting.

This spring, the American College of Osteopathic Family Physicians conducted a survey of its membership, including questions related to practice types and settings. The survey found that 60 percent of family physicians are employees with no ownership stake in the practice. Often, the overwhelming collective burdens I mentioned today are cost prohibitive and outweigh a physician's desire to enter or remain in a small or solo practice. There are also physicians who wholeheartedly embrace the choice of becoming an employee physician. Physicians should not be forced to enter an employed situation out of pure necessity. They should retain their option to choose their ideal practice type absent undue financial considerations and regulatory burdens.

Medical homes and ACOs provide opportunities for physicians to continue managing patient care while still being able to operate as a small or solo practitioner. Either model requires a physician to be employed by a hospital or large health system in order to be successful. Appropriately aligned, incentives can serve to foster success regardless of practice type. Regulators should be cautious in creating additional financial burdens on physicians that would inhibit their ability to choose a practice setting that is most appropriate.

In closing, the transformation of the practice of medicine has undoubtedly impacted the ability of physicians to thrive in a small practice or as solo practitioners. However, physicians are adapting to the changing practice of medicine by becoming patient-centered medical homes and participating in shared savings programs. As we work to improve the health care delivery system for patients, physicians must be provided appropriate payment and incentive to practice effectively in the setting of their choice. Patients deserve this level of access.

I would again like to thank you and the members of the committee for affording me the opportunity to share my experiences and the AOA's perspective regarding this important topic affecting osteopathic physicians and our patients. We appreciate the work that you do to promote policies that enable physicians to success-

fully operate as small business absent undue regulatory and financial burdens. We look forward to working with you in the weeks and months ahead to ensure that congressional action fosters rather than impedes the physician-patient relationship.

Chairman COFFMAN. The Chair now yields to Dr. Schrader for the introduction of our next guest.

Mr. SCHRADER. Thank you, Mr. Chairman. It is my pleasure to introduce Dr. Jerry Kennett. Dr. Kennett has practiced interventional cardiology in Missouri for the last 30 years as a senior partner of Missouri Cardiovascular Specialists and vice president and chief medical officer of the Boone Hospital Center. He has maintained a busy clinical schedule while also participating in a lot of clinical research in education. He is testifying today on behalf of American Academy of Cardiology. The college has 40,000 members and he has dedicated to enhancing people's lives through cardiovascular treatment intervention. We welcome Dr. Kennett.

#### **STATEMENT OF JERRY KENNETT**

Mr. KENNETT. Good morning. Thank you, Member Schrader and Chairman Coffman and members of the subcommittee. We appreciate your inviting us to testify here today.

I am Jerry Kennett, chairman of the American College of Cardiology Advocacy Steering Committee. The ACC, as said, is a 40,000-member medical society serving the needs of both providers and patients.

I am a cardiologist with Missouri Cardiovascular Specialists, a 17-person cardiology and cardiovascular surgery practice in Columbia, Missouri.

My group was one of those typical office-based practices with over 100 employees. Our practice included a cardiac diagnostic center, where patients had easy access to echocardiograms, stress tests, and even an outpatient cardiac categorization laboratory.

A little more than a year ago, our group was an independent practice, but now we are integrated with Boone Hospital Center in what is termed a professional service agreement. According to the 2011 Lewin Group report on the economic impact of office-based physician practices, these small businesses, such as ours, account for 4 million jobs across the United States with \$833 billion in wages and benefits. These small businesses generate \$63 billion in state and local tax revenue.

Physician practices are different from almost any other small businesses. The payment for services performed is not controlled by free market dynamics, but instead payment is tightly regulated by Medicare and Medicaid and private payers who essentially follow the lead of the government with the recipient of the services or patient often paying only a fraction of the cost.

Recent events have had a dramatic effect on private practice cardiology. The ACC estimates that 60 to 70 percent of our current physician members have now integrated with hospitals.

Why has this happened? There are a variety of factors that have contributed to this evolution. The prominent reasons relate to Medicare physician payment not keeping up with actual practice costs, direct cuts in Medicare physician reimbursement, and increased administrative and regulatory burdens. All these add up to

tremendous uncertainty among physicians as to what the future holds and so many physician practices such as mine see hospital integration as their only choice.

Every year since 2002, physician practices have been threatened with significant cuts in Medicare reimbursement, the so-called SGR. This uncertainty stifles physician practices from making real investments in improving coordination, reducing the current fragmentation of care, and reducing waste.

Another major turning point for cardiology occurred in 2010 with the Medicare Physician Fee Schedule, which reduced payments to cardiology practices or some in-office procedures as much as 35 percent. How many small businesses could survive a 35 percent cut in payment for the exact same service? Our practice, like many others, could not.

There are also a significant number of regulatory and administrative burdens that contribute to the uncertainty for physician practices and hinder their ability to grow. A few examples are audits. While physician claims for services are generally subject to contractor medical review, greater scrutiny in recent years has increased costs and uncertainty. Physician claims must comply with multiple edits, as well as recovery audit contractors.

ICD-10. The Center for Medicare and Medicaid Services will soon implement ICD-10, a diagnostic coding system that will increase the number of diagnosis a physician has to choose from 15,000 to over 87,000.

Multiple Medicare penalties. Starting in 2011, Medicare began to penalize physicians for not meeting the requirements of certain incentive programs. In the coming years, physicians will be penalized for not prescribing electronically, not participating in meaningful use of an electronic medical record, and not submitting quality data through the Physician Quality Reporting System, as well as a yet-identified value-based modifier.

Finally, physicians have significant anxiety regarding the future of Medicare payment reform, as you have heard. The new payment methodologies, such as ACOs, bundled payments at medical homes will require additional staffing with no assurance they will produce any shared savings. Physicians are afraid of being left out.

In conclusion, the financial pressures associated with declining reimbursements and rising operational costs on private cardiology practices have resulted in the rapid migration of practices to hospital affiliation. Continued cuts in Medicare reimbursement combined with increasing overhead costs, increased regulation, unfunded mandates, a micromanaged payment system, and an uncertain future are making it difficult for practices to remain viable. We believe that a well-functioning Medicare payment system could provide opportunities for physicians to practice both independently or as employees of a hospital. Increased payments should come from increased quality and demonstrate appropriate utilization and physicians should be appropriately paid for the increasing expectations associated with the practice of medicine.

Thank you for the opportunity to share my views and look forward to any questions.

Chairman COFFMAN. Thank you so much for your testimony. I really appreciate all of you taking the time to be here. Let me just

open it up with a few questions and then I will defer to my colleagues on the subcommittee.

All of you had mentioned rising administrative costs as a factor in hurting solo and small practices. Back home in my district, I was just talking to a woman who is starting a new concept to help child care providers by simply doing their administrative work to back office work to allow them to focus on child care and her entity then focused on the administrative compliance.

Is there any movement to assist small practices with these third party organizations? I know they have existed in say Medicaid, Medicare, but just in overall administrative work and all the compliance things that you have to do to—are there such entities emerging to relieve some of the cost pressures on small and solo practices?

Mr. SMITH. There are businesses that have evolved to fill that need that exists with physicians, I mean, more of these administrative burdens placed on their shoulders and some can work quite well. In the new legislation, that intensifies greatly the changes, as mentioned, are very significant, but even if you are able to outsource that, it comes at a cost and it comes at a cost when you are looking at your revenues either being flat invests or declining. So, again, it opens up that option to make employment seem much more attractive as to transferring that burden to someone else.

We mentioned in the survey that Merritt Hawkins had that 26 percent of a physician's time was in paperwork. And, so, in essence, you have a hidden army of about 200,000 physicians out there that are doing something other than they were trained. So, anything that we can do to relieve that burden outside of just the pure employment option that will allow them to focus on patients which I am sure that folks sitting at the table would much prefer to do than to do paperwork would be of great assistance.

Chairman COFFMAN. Dr. McIntyre.

Mr. MCINTYRE. My experience in our practice was that there were many entities that could help us with individual things. Billing. We outsourced billing. IT. We could outsource a lot of stuff to IT, but there was not any umbrella organization that would come in and say we will do it all for you. It sounds like a great business, actually.

So, the hospital assumes all those tasks for you. I think that is what makes it attractive to many physicians who are just looking for a way out so that they can concentrate on patient care instead of regulatory burdens.

Mr. YASSO. When we sold our practice in 1992, of course, we did not have the IT piece to worry about back I those days, but we were doing our own billing and managing the practice ourselves and doing quite well.

When we sold to TriSource, they right away started charging us a \$7,000 a month management fee and a \$7,000 a month billing fee. That was \$14,000 a month of overhead that we did not have before. So, all of a sudden, the practice that was in the black was now in the red because we had such a tight margin. And, so, if you do those kinds of things, that is the cost that you have to bear to get those things done.

Mr. KENNETT. In private practice, there are always consultants and companies that want to come in and do things for you. They say they can do it more efficient and better and usually that does not have to be the case, that usually the costs are as great as before.

As you might imagine in these small businesses, the physician practices, they are so regulated and so many things we have to deal with that your overhead sometimes in small practices can be as much as 80 percent. So, it becomes overwhelming and that is one of the reasons that as mentioned they tend toward employment.

Chairman COFFMAN. Most of you mentioned medical malpractice as an issue and the small or solo practice dissolving and moving into as employees or into a larger physicians' group or employees of a hospital. But those costs do not change. Is it that just as a function of cash flow, as you got a small practice and there is a bump in cash flow and you have got this big overhead issue like paying your premiums on a medical malpractice policy, is that essentially the problem because I do not see where the costs are changing. They are very high, obviously, higher than they ought to be, but I do not see them materially changing from the individual from the small practice to a larger practice or as to employees of a hospital.

Mr. MCINTYRE. Well, personally, my malpractice went from \$40,000 a year in 1994 to \$110,000 in 2010. We paid that and at one time, we had 7 orthopedic surgeons, almost a million dollars in malpractice premiums per year. That was a big number.

Human resources, obviously, was the single most expensive item in our budget, but right below that was malpractice and it really became a burden to pay the malpractice, so much so that we shifted from doing it in quarterly payments to shifting to monthly payments. It was really a cash flow burden for us.

Going to the hospital, the hospital assumes that cost. We do not see that cost at all and many of the hospitals are self-insured in regards to malpractice.

Chairman COFFMAN. Okay.

Mr. MCINTYRE. So, that may affect the rates, but my personal experience, my hospital now is paying my malpractice premium for the policy that I have. Now, I would imagine at some point in time, that is going to be subsumed by their own malpractice policy.

Chairman COFFMAN. Okay. Does anybody else have any—

Mr. SMITH. Well, just keep in mind that with these physicians, since Dr. McIntyre joined the hospital-based practice, the hospital loses money. There is not a true savings that occurs from him coming over. They typically lose money on these practices, but the hospital has to have physicians in the community. They really have no choice but to bear that potential loss.

Chairman COFFMAN. But is it cheaper if a larger entity can be self-insured and manage its own liability or do these hospitals still carry third party insurance?

Mr. YASSO. Well, Hospital Corporation of America in the metropolitan area of Kansas City employs over 250 physicians. I would think they get a bit of the economy of scale—

Chairman COFFMAN. Okay.

Mr. YASSO [continuing]. To some degree if they stick with one insurer and probably get a rate break to some degree.

Chairman COFFMAN. In looking at the new health care law, the Affordable Care Act, there is a movement I think borne of that to accountable care organizations. So, there has been a trend prior certainly to the Health Care Act, a movement away as you all have tried from the solo practice, the small physicians' group to larger practices and to employees at hospitals. How has the current health care law or has it accelerated by that process?

Mr. SMITH. There is no question it has accelerated that process. It had the fear of the unknown and I think a lot of wait and see, see what would happen from the Supreme Court's decision. It has picked up the pace quite a bit. I would say as ACOs come closer, hospitals realize there is bundle payments looking for partners. At the same time, you see insurance companies not wanting to be left out as you have seen with Highmark in Pennsylvania buying hospital systems. So, there is a bit of a race for that finish line and physicians might experience running for cover because of the intensity of the penalties within the system.

Some information we could provide is there is so much more regulation and the penalties are so great, I find physicians very fearful that they will make an honest mistake and being held accountable financially.

Mr. KENNETT. Speaking from my administrative side, I would say that probably the health care law has accelerated more on the part of the hospitals probably more so than physicians because of the fact of the Accountable Care Organizations, the bundle payments, and measures in there that the hospitals want to be sure they have enough primary care physicians particularly as well as specialists that they can have in their Accountable Care Organizations to being able to participate. I think it has brought about some acceleration on the part of physicians just because of uncertainty, but as you mentioned, so many of these things we talked about actually predated the Affordable Care Act.

Chairman COFFMAN. Sure. I am going to ask one more question and then defer to Dr. Schrader and but then I will come back probably and we will go back and forth. Oh, and I am sorry, Ms. Hahn, as well, from California. And that is that you talked about the patient-doctor relationship being compromised, if you will, through the movement of the solo or small group practice to the larger group practice or to employees of a hospital. I wonder if you could all elaborate on that and please be specific in terms of examples of how you think that changes the patient-doctor relationship, this movement.

Mr. YASSO. I think that one of the ways it change that, when you become an employed physician for particularly those physicians that come directly out of residency and become employed physicians and have never practiced in solo practice or owned their own business, it is more of a business now and it is I work for X number of dollars and I work X number of hours a week and that is all I do. I may not stay a little longer to say Ms. Jones, let us work her in or see that extra patient because they want to be seen, they need to be seen that day and do that. And you hear stories about that all the time about how physicians tend to cut it off and say

well, I used to see 30 a day. Well, now I see 26 a day or I see 22 a day and those types of things and it is a problem, I think.

Mr. MCINTYRE. My practice is two miles from my house, and, so, I take care of the people that live in my community. My reputation is predicated upon how I do that. So, not only was I very concerned about being a good physician, but running a good small business in my community. And what I said before in the testimony was that I had great ability to affect the atmosphere and the business that was there because I ran it. So, if things were brought to my attention by patients or staff or whatever, that we were deficient in that area, well, you can be sure that we changed that. Now, I am really not responsible for the policies of the practice; the hospital is. So, I am a little bit hamstrung in my ability to affect those policies.

Yesterday, a patient came in. Supposedly, one of our doctors was not on the insurance panel because the hospital had not gotten us all on the various insurance plans yet and the patient was told well, you cannot see the doctor that you have seen for 10 years. If I were running the practice we would just have seen the patient and dealt with the insurance issues later. So, I think that when you are vested in your practice as a physician and also as a business man or woman, that lends a whole different color to the way you approach it.

Mr. KENNETT. I might differ slightly because of the fact that I do not think being employed has changed my physician-patient relationship. I think I feel the same about my patients as I always have in the past 30 years. There is a lot of regulatory and reimbursement issues that have affected relationships because we cannot provide the services we used to provide. That is a real concern. And, quite honestly, there is an evolution in medicine that is going to change physician-patient relationships in the fact that we now have intensivists, we have hospitalists, we have an nocturnist, we have shift medicine, and that is what the younger physicians like in many instances. And, so, that is changing the physician-patient relationship.

Mr. SMITH. I would add quickly the difference to me, the patient is access. Today, we have a shortage of physicians in many parts of the country and surveys I have read had shown that employed physicians, the risk off the table, they are no longer business owners, see about 7 percent fewer patients and this is at a time we already have a shortage and we are looking to add 30 million people for this process. To me, that is a great concern.

Chairman COFFMAN. Dr. Schrader.

Mr. SCHRADER. Thank you, Mr. Chairman. Well, thank the panel as I guess retired, small business. Been a practitioner for 35 years, started my own business from scratch when you could do that sort of thing. My humble opinion, much as had been stated here, I mean, that is almost impossible to do. I do not care what sort of medical practice you are into. I mean, the tax law has gotten byzantine. I actually did my own tax returns when I started my practice. It was actually doable and I felt like I was not committing—and the regulatory burden, and certainly those in the medical profession, with all the different regulatory frameworks come out, the SGR has been a sword of Damocles hanging over every physician's

head, I do not care who you are, for many years. Sometimes we treat it almost cavalierly here in D.C. because we “never let it happen,” but it is still there and it is still disrespectful, I think, of the hard work that folks put in. It makes it pretty tough. It makes it pretty tough.

The debt burden now that youngsters came out with, I mean, gosh, my tuition, I am embarrassed to say, graduated college a few years ago, like \$700. Students would kill themselves to do that now. I am a dinosaur, but not that much of a dinosaur.

But the other thing I think the panel has alluded to a little bit that did not get brought out is there is a change in attitude among the young people. I do not care, and this is not just the medical profession, I see this in a lot of my other business friends and associates where the idea of starting a risk-based enterprise, well, there are lots of great entrepreneurs in our great country, thank goodness, and that is what is going to make and continue to make our country great. In some professions, they are a little less more risk diverse for a lot of the reasons you all have just enunciated here. It seems almost daunting for these people with the debt they come out with, the regulatory burden that is out there, the uncertainty, and I will grant that the ACA does create some uncertainty out there. It is one of many issues I think face our medical community.

I would like to get some thoughts about potential solutions going forward here. So, I guess one main question I would ask the panel here is of the many things you have talked about today from taxes to debt, SGR to other regulatory burdens, ICD-10 codes, some of the aspects of the ACA, what is the single most or one or top two burdens that we should talk about trying to eliminate or change and make less burdensome for you guys to get it back to the practice of medicine that we all do so well?

Mr. KENNETT. So, Congressman, I think that, to me, without a doubt, the biggest thing you can do is to eliminate the SGR and have a stable platform for physician payment that is fair for the appropriate service that they are providing going forward so that the physician is on a yearly, monthly sometimes basis, do not know what the payment is going to be next year and do not know if their claims are going to be held and they have to go borrow money to make payroll. So, taking care of the Medicare physician payment platform going forward would be a huge step forward.

Debt, I think, is a very big issue for these kids coming out of school today or residency. If we could find a way to either help them defer their debt for a while so they have the opportunity to go into private practice or if we could find a way, particularly if they go into underserved areas and take care of people that truly need help, to eliminate their debt so that they can stay in practice and stay in areas where people truly need their service.

Mr. SCHRADER. Very good. Thank you.

Dr. McIntyre.

Mr. MCINTYRE. I think as a philosophy, we might want to inject some market principles into the physician-patient relationship and have providers compete not only on quality issues, but also on price issues, which we have not done in decades. I think that might go a long way to decreasing costs and increasing quality. If we decide we do not want to do that, then I think to strengthen private prac-

tice, we need to allow private practitioners to band together to negotiate rates without owners' overhead structures so that they can compete with what is becoming monopsony. We have the big medicine, big insurance, and the government, and with consolidation, I do not think we are going to get the cost containment we need. I think we need more players in the market to do that and facilitating private practice's ability to negotiate, I think might go a long way to contain cost and increase quality.

Secondly, I think malpractice tort reform will go a long way to decreasing the costs not only of private practice, but of medicine in general.

And, lastly, especially with the SGR being such a problem and being so expensive and the problems in trying to eliminate it as well as deal with Medicare reimbursement cuts that are supposed to go through the ACA, perhaps, we might want to think about bringing back balanced billing to the Medicare equation that was part of the program for the first 20 years of its existence. And I think it could be done in a way that would not hurt seniors, but would allow private practice to continue to serve Medicare patients.

Mr. SCHRADER. Mr. Smith.

Mr. SMITH. Oh, I agree with all three topics mentioned: SGR, medical debt, something we hear on a daily basis from the folks that we are talking to, and tort reform. I would add to tort reform that the impact goes beyond the malpractice. The cost of defensive medicine is something that has been calculated in incredible numbers, where physicians are forced, they feel, to protect themselves by doing additional tests under normal circumstances they might not do. So, that cost is significant.

The other thing I would mention is to relax some of the regulations that are in Stark II as it implies to recruiting physicians in the community. Being a solo practitioner is near impossible. If you can get a partner or two partners, you have a chance. Unfortunately, stipulations in Stark II make it difficult because you cannot share any of your costs. You have to bear that burden of the cost that exists to bring a new associate in and most physicians cannot go through that year process to wait for that new person to contribute to their overhead to be able to afford to bring them in. So, that would be a real benefit.

Mr. SCHRADER. Very good. Very good.

Dr. Yasso, you talked about medical home, and I thought about this myself, as maybe being a way to get back to where the physician is ultimately in control, one of the things that is in the ACA that maybe needs to be fleshed out more. There was some loan forgiveness over a period of time for new students and that we tried to give a little better deal for primary care docs that actually opted to go into some sort of—in particular will do that, but primary care.

But I thought that maybe the medical home, and everyone has alluded to this. I mean, the doctors have to be in charge of decision-making, not the hospital, not the insurance company, not the outfit you would hire to run all your books and stuff and can you elaborate a little bit about what would you be looking for, how would you be talking to CMS about how to organize this so the docs are in control?

Mr. YASSO. Well, I think the PCMH is set up in such a fashion that it is under the control of the physician. It is a collaborative approach to medicine and a team approach where everybody is involved in the care of the patient. That includes the medical assistants in your office, your nursing staff, even the front office staff for that matter. Everybody is involved in the care of that patient rather than—an even footing to a degree and things are done for the patient by everyone, not just the physician, not just the nurse, but everybody gets involved in the care. That is the whole idea behind the patient-centered medical home. And then you develop relationships as a primary care physician, you develop relationships with specialists that you know are going to provide quality care for your patients and you deal with those people and you discuss the care so that you know what kind of care that individual is receiving that is the best possible care that they can get.

If you take that a step further and you look at the Accountable Care Organizations, I was talking to a physician yesterday who practices in the Phoenix area and they have been very successful in setting up an ACO down there that is driven by primary care. It is not driven by the hospital, it is not driven by the specialist, it is driven by primary care, which seems to be very cost effective and providing good, quality care.

So, I think two things. We need to keep in mind when we talk about ACOs in particular is they need to be driven by physicians, not the hospital. My concern when I first started hearing about ACOs was that they were something akin to the old PHOs, Physician Hospital Organizations, which for all intents and purposes was driven by the hospitals and that is what we really need to avoid because the care, the rubber that meets the road is where the patient sees the doctor and that is where the care is delivered. It is not by the hospital per se on a daily basis. So, the physicians really need to be in control of that.

Mr. SCHRADER. Dr. Kennett.

Mr. KENNETT. Just would like to make just two additional comments about medical homes. The first is medical homes, as Dr. Yasso said, requires some additional resources within your office. People teaching dieticians. So, we have to be sure that they are reimbursed adequately that they are going to be able to provide those additional resources.

And the second is that the medical home needs to be assigned to whoever actually should be in control of that patient's care on a regular basis. If that is a patient that is on dialysis, then really the nephrologist probably ought to be their medical home, it is the patient that has got chronic congestive heart failure, then probably a cardiologist. There is a huge majority that should be in the hands of the primary care physicians, but it needs to encompass all these other specialties, as well.

Mr. SCHRADER. Just a final comment then, Mr. Chairman. I really appreciate this panel and the topic we are discussing. It is near and dear to my heart and very concerned about the future of medicine from all walks of life.

As a little, old, country veterinarian, I enjoy the opportunity to get to know my patients, see them from birth to their passing. It is a beautiful thing. But I rely on the specialists. I think we have

got a great relationship in the veterinary world where we are not afraid to send it out. In the old days, it used to be keep everything pretty close and the medicine has changed. Hopefully, physicians, veterinarians, and other practitioners of all sorts have come to that realization and we will work through that.

I guess my last point would be that I hope each and every one of you are active in making sure that whatever comes out of health care evolution, whether it is related to ACA or anything else, that some of us are pushing to reform the SGR, this bill out there I am cosponsoring with Allyson Schwartz and others to get rid of the SGR and get to a smarter level playing field. She is actually like a part of the solution and not just a part of the whipping child that is out there at the end of the day. But, hopefully, it will be a good process, a better process at least going forward and I appreciate the Chair bringing this issue to Small Business' attention. Thank you, sir.

Chairman COFFMAN. Thank you, Dr. Schrader.

Ms. Hahn from California, and I will relax the five-minute rule.

Ms. HAHN. Thank you, Chairman Coffman, Ranking Member, Dr. Schrader.

I want to thank the Chairman for holding this hearing. Really appreciate the witnesses that are here today, all of you who are involved in some aspect of health care and getting folks healthy. We really do appreciate what you are doing.

It is interesting because, I mean, I know the more Affordable Care Act is implemented and this lifestyle, I think a lot of the issues as I understand that you brought up today are actually addressed in this new law.

Loan repayments. There is a lot about helping students repay their loans or forgive their loans, particularly if they serve in areas that have seen a shortage, talked about, Mr. Smith, the shortage of physicians. There is actually a lot in the health care act about providing incentives and scholarships to encourage more doctors, physician assistants, folks to go into this field.

I agree with Dr. Schrader, there are many of us who want to have a permanent doc fix and I hope we do that in Congress with the SGR.

This is a small business committee, so, it is really interesting to hear your views as it relates to being a small business person. I am wondering how much training did you get, how much are students in medical school actually getting business training, would be partnering with business schools and medical schools. And, again, I am always trying to figure out what our Small Business Administration is doing to help small businesses. Is there a better role? Is there any role? What is Small Business Administration doing as it particularly relates to physicians who are attempting to run a small business and what can we do better to help that aspect so that—it sounds like we would like to ultimately see more doctors continue to be in the role of being a small business owner.

Mr. MCINTYRE. Training would be zero. On-the-job training would be zero. We learned it on the fly. And many of my colleagues who I interact with in the regulatory arena have gone on to get MBAs. I know a boatload of orthopedic surgeons, MBAs. So, there

are a number of people who are doing that. But in terms of the Joe lunch bucket doctor, I think that the training is pretty much zero.

Ms. HAHN. So, in medical school, there is no sense that it could be an important part of your success as a doctor who wants to be also a small business man?

Mr. YASSO. Some of the schools, my alma mater being one, offers an MBA degree, but not to everybody. They keep it to a very small number of students that can get involved in that. So, there is some, but as far as any kind of formal training for everybody else or even just basic business courses, no. There really is not.

As far as what can you all do, promote some of the things we talked about, I guess, and some of the things that you mentioned that are in the Affordable Care Act that might be helpful to make sure that those things come to fruition. If they are unfunded mandates, they do not do us any good. So, that is really the key to see that some of those things come out and really give us what we need to promote people to at least consider going into solo practice or small practices.

Mr. KENNETT. Congresswoman, I would say that certainly going forward is what these small businesses need and that relates to what we said. Reimbursement, knowing what you are going to get paid down the road, and reducing the regulatory burden, which is huge. If you could help those two, they would have a lot more businesses staying in practice.

Ms. HAHN. I am going to follow-up because the Affordable Care law also aims to reduce paperwork and administrative costs by standardizing billing, and between 2013 and 2016, the rules will be implemented to standardize health insurance processing requirements.

Mr. SMITH, you worked on this Merritt Hawkins whitepaper where "Physician practices should benefit from improved revenue cycles and save time and money tracking claims." So, I am thinking since these rules are not finalized yet, maybe this is an opportunity. Your whitepaper suggests that this is a potential cost savings. So, while we are considering these rules, what should we be keeping in mind to maximize these potential cost savings within this particular realm?

Mr. SMITH. Well, anything we can do to keep it as simple as possible would be a plus, which obviously we solve the depth and the weight of Affordable Care Act to just pay for a loan and people are just really digesting all the areas and attempting to refine some of those areas. And to lessen the penalties in certain areas where things are unknown. There is an example of which if there is a whistleblower situation, the Medicare can suspend payment to the physician for that whistleblower act if verified. So, in essence, you could have a disgruntled employee who makes a claim, Medicare suspends payment to the physician, and it's over. And I would bet that three physicians on this panel, if you had zero Medicare revenue from guilty to proven innocent could crush any of their practices and several examples like that, again, unintended consequences.

Ms. HAHN. Thank you very much.

Mr. MCINTYRE. I think that to standardize the billing process as you alluded to in the ACA would go a long way. For example, Medi-

care is about 23 percent of our business, but was our most prompt payer. We could anticipate Medicare reimbursement within 18 days of the bill being sent out as long as it was a clean claim.

Managed care companies on the other hand, had an average AR timeframe of 45 days. And we got much more runaround and hassle from the managed care companies in regards to them saying a claim was not clean, them wanting more information.

So, a standardization of that process, I think, would go a long way to help the private practice.

Mr. KENNETT. Congresswoman, I can give you one quick example of one of the regulatory things that happened to physicians that make no sense. So, the rack auditors, which I am sure you are probably familiar with that can go in and take money back from hospitals for whether the patient inpatient or outpatient. So, now, a patient can be in the hospital and just because there are some regulations of you tell them that they are inpatient or you call it inpatient or outpatient, same exact service is provided in the hospital, but then the rack auditor comes in and says no, they should have been called outpatient. They can take back the physician's reimbursement any services that are provided during that hospitalization. It really makes no sense.

Ms. HAHN. Thank you.

Mr. McINTYRE. So, there is one additional program, too, the Medicare Administrative Contractors, which is also retroactively denying services for lack of paperwork. For example, in orthopedics, the MAC are denying payment for total joint replacements unless there is documentation of unsuccessful treatment with physical therapy for three months prior to the procedure. Not only is this very costly but there is nothing in the literature that supports that such treatment is efficacious. In addition, the rules of these programs are unknown and they are enacted retroactively, making them impossible to comply with. This really will affect patient care negatively.

Chairman COFFMAN. Thank you, Ms. Hahn.

The Chair recognizes Mr. Tipton of Colorado.

Mr. TIPTON. Thank you, Mr. Chairman, and I apologize for being late. We had a natural resources meeting, as well. So, I sent your regards to that meeting. I know you could not be there because of here.

I would like to thank our panel for being here. Incredibly important issue, particularly for districts like mine, rural Colorado, 54,000 square miles, and as I have traveled through those 54,000 square miles, just held a town hall meeting with senior citizens in Pueblo, Colorado, last week, they are worried about the president's health care mandate and how it is going to impact them. I have got senior citizens in Del Norte, Mono Vista, Alamosa, Cortez, Crawford, Hodgkiss, Edgar, some towns a lot of people have not even heard of, they cannot find a doctor that is willing to take Medicare.

So, I guess, Mr. Smith, I would like to be able to start with you. With a number of small business and a lot of our doctors are small business people, solo practices, what effects will the president's health care mandate have on rural Americans, rural citizens' access to health care in your perception?

Mr. SMITH. My perception, the impact I look at first is of the patient. As you mentioned, very difficult as a patient. A new patient, physician practice, could be seen if you have Medicare, especially if you have Medicare without any kind of gap insurance. A physician has to limit the amount of Medicare that they see in their practice to be financially viable. If you have pure financial to procure practice, it is not viable. The reimbursements are too low to be able to do that.

Most physicians that I work with, we conduct about 3,000 searches a year around the country so we have an excellent of information will tell me that Medicare rates, they generally break even as a cost of doing business. So, you have to keep that to one-third of your practice.

Some specialists, such as internal medicine, you might get it to half, but you cannot have that happen. You see physicians as they get older, their patients get older, and more and more Medicare and you can look at their financials and they slowly dwindle until such a day that the decision is I am working for free, I have to get out of practice.

So, now, as we look at this, we have patients that could come onto the system, was going to pay Medicaid rates and we are elevating them to Medicare, thinking that is going to be a driver for physicians to see them. One, that is a temporary rate. Two, it is not a factor and those patients, 30 million people we are adding to the system, will have a card that gives them insurance or a version thereof. What they will not have is access.

The second expense, the legislation does address some areas of need, attracting people to the system. The shifting of unfilled primary care spots, that really is resulting in a few hundred positions, but the issue is we can add as many people as we want to the medical schools, but we have not added a single dollar as it comes to residency. And, so, all you will be doing is shifting foreign positions out of the system and replacing them with American-trained physicians, but at the end of the day, there is the same number of physicians coming out of the machine and in places like Russia and Trinidad and Serbia will still not be able to find a doctor because there will be more attractive options in large states.

Mr. TIPTON. If we could, Mr. Smith, I would like to explore that a little bit because you were focusing a little bit on the economic—

Mr. SMITH. Okay.

Mr. TIPTON. From the doctor's perspective—the majority of doctors I know actually went into health care because they truly care about people. They are going to limit the number of patients that they can see simply because they want to be able to provide quality health care. If you are trying to run them through like an assembly line, is that going to reduce the quality of health care?

Mr. SMITH. Well, there is no doubt. I mean, the physician-patient relationship is the most critical thing we can talk about and the colleagues here, I am sure, would completely agree with that. But the only choice is to do more and I would bet that each of these physicians here see a few more patients each year to be able to make their practice viable. Not so much as just financial reward, but just to make it a viable business that employees will be able

to count on and you want income, but the patient will be left on the sideline.

Mr. TIPTON. You just mentioned doctor-patient relationship. We should not be getting between that, but if there is going to be a medical decision that is to be made, let us have the family patient doctor do that in the doctor's office. Do you have some concern about the IPAB Board?

Mr. SMITH. Well, yes, to answer your question. We have seen this in other countries. We have seen some of the impact it has had. I saw recently in Europe where epidural injections were taken off the list of care to be provided, other decisions that are being made, but in each of these decisions that you see along the way, the majority of these decisions are made without physicians involved. We speak to thousands of physicians on a monthly basis, and I have yet to find any of the ones that had the lab coat that were on the front line during these conversations. But anything we can do, it has to come down to the physician-patient relationship.

Mr. TIPTON. Dr. Yasso, I saw your head nodding. Would you like to make a comment on that?

Mr. YASSO. I would agree and the American Osteopathic Association adamantly opposes the IPAB. We think that is just wrong-headed for no other way to say it.

The other thing that is concerning to me in regards to Medicare, as Mr. Smith said, you are almost getting to a point where you are just barely breaking even as far as reimbursement is concerned. What happens in the next 10 years when they cut \$500 billion out of Medicare because of ACA? Does anybody know? I mean, obviously, reimbursement is going to take a hit. It has to take a hit. I do not see how else you are going to reach that number.

Mr. TIPTON. Excellent point, and Dr. McIntyre, maybe you would like to jump in a little bit on this because I think Mr. Smith said it very well. We can insure everyone in the country, but there is a quantitative difference between insure and health care. Two completely different things. And if we are wanting to be able to get at health care, are you seeing a real problem with the president's health care mandate when it gets down to actual delivery of health care?

And I am speaking primarily for rural America, rural Colorado. I know some of our metropolitan areas have an abundance of doctors and specialties, but let us talk about rural America.

Mr. MCINTYRE. I do not know that a mandate in itself creates an access issue. I think the access issue is really driven more by reimbursement level. So, if your reimbursement level falls below the level of your ability to deliver the care—

Mr. TIPTON. But the reimbursement level is actually via the mandate. That is part of the program.

Mr. MCINTYRE. Well, my understanding of the ACA is that it does cut \$500 billion out of Medicare—

Mr. TIPTON. Five hundred seventy-five billion.

Mr. MCINTYRE. Over 10 years and does fail to correct the SGR, which is another \$300 billion. So, I think that is the access issue. I think I certainly have a philosophical and constitutional issue with the mandate myself personally, but, perhaps, I am not sophisticated enough to realize how it will impact access other than the

issues we spoke of. It is possible to provide someone with insurance, but if that insurance does not pay costs, then you are basically uninsured.

For example, if you put people on Medicaid, I think it is something like 40 percent of all physicians will not accept the Medicaid patient because the reimbursement is so low and I believe my understanding of the ACA is that by 2019, Medicare rates will be around what Medicaid reimbursements are now. So, I think that is a huge issue and a potentially devastating one for access to care for Medicare patients going forward.

Mr. TIPTON. So, effectively, our senior citizens, people who have run the race are walking in the door with their Medicaid card, putting it on the table, it is insurance and they are not able to get a doctor.

Mr. MCINTYRE. I think you could definitely see that problem.

Mr. TIPTON. That is a real challenge.

Mr. Smith.

Mr. SMITH. To add to it, one of the things that my firm does, we do studies on wait times. How long does it take to get to see a physician? An unintended outcome that we discovered was the greatest increase in wait times of any metropolitan market was Boston and the difference between what occurred between our first wait time survey and our second was the implementation of universal health care.

So, a place that I think any of our colleagues would probably have the most physicians, the most training programs, the environment you would not expect to have that issue are having that issue. So, if that is happening in Boston, what is going to happen? I do not think that is a difficult question to ask.

Mr. TIPTON. Right.

Dr. McIntyre, maybe if you would like to, we have got to be able to address some of the accessibility. Every American, I think that we can all agree, we want affordability, accessibility. The president's health care mandate fails on both accounts.

What can we do? What should be done to be able to increase the number of physicians that are going to be able to get into some of these rural areas to be able to provide that access to health care?

Mr. MCINTYRE. In answering a similar question, I thought perhaps injecting a market-based solution to this problem would go a long way to improving quality, decreasing costs, and improving access. I think if the patients have some skin in the game, then they are more likely to seek health care that is of quality to them. If somebody is paying for their health care, especially if it is first dollar coverage, they are less likely to become shoppers, they are less likely to search for quality. They are much more likely to search for volume.

So, I think in the current situation, we have a volume-driven process that is going to be exacerbated by the health care law instead of one where we will be looking for quality.

The health care law does attempt to impose quality on the system through comparative effectiveness research and on other things, but that is sort of a top-down approach.

Mr. TIPTON. Ultimately, and I would just kind of like to get your thoughts on this, original CBO estimates on the president's health

care mandate stated it was going to cost \$900 billion. In the White House, there was dancing in the hallways over that number. I am a small business guy and I know \$1 billion is a lot of money. CBO just rescored this. It is going to be \$1 trillion and \$787 billion. With administrative costs, we are going over \$2 trillion.

Is there a better way to be able to spend \$2 trillion?

Mr. KENNETT. Congressman, if I could, I would like to just comment a little bit on before and then this question, as well, and that is that if we are going to increase access, we have to be able to pay for it. And, so, that is a concern. We have to appropriately pay physicians for the services they perform. So, if we are going to reduce costs within the system, I think if you get any larger number of physicians in a room and talk about how we are going to reduce costs, that you will come to the issue of utilization.

And, so, the American College of Cardiology for years has been working on the perfect use criteria and our registries and I think that we as a profession are going to have to look at the appropriate utilization and cut out the utilization that is inappropriate and that could save possibly as much as one-third of what we are spending right now on health care.

Mr. TIPTON. Would tort reform be a good idea?

Mr. YASSO. Absolutely, and I was going to just mention that. The patient comes in with back pain, let us say, and you may send them for X-rays of their back, let us say low back pain. They come back and they say well, doc, you gave me some medicine, it really did not help, I still have the back pain. And the next thing you know, you are ordering an MRI. Why do you do that? Is it because it is really a necessary test or is it because you are worried about the liability of the situation? Am I missing something? Is there something else going on here that I will pick up with the MRI? And you are thinking about the legality of the situation more than you are—is this really appropriate care for the patient? And medical liability is what is perceived a lot of times and I think that is really true in the ER setting. You wonder how much money is spent needlessly in the emergency room on CTs of the head, stress tests for chest pain, all those kinds of things where they may not necessarily be needed.

Mr. TIPTON. I mean, I thought it was curious that the administration and the 111th Congress, we are in the 112th, would not even consider tort reform because I have actually held meetings with physicians. I just met with about 24 physicians over in Brentwood, Colorado. Tort reform came up as one of the number one cost drivers and it is fear factor that if the patient is not totally forthcoming and you did not catch it, you can be sued. We have got to be able to bring some common sense into that portion of the equation, as well. So, certainly thank our panel for taking the time to be able to be here. We would love to be able to hear more from you. This is about affordability, it is about accessibility, and as I travel through rural Colorado in my district, I am talking senior citizens right now who are frightened about what the consequences are going to be to their health care going forward as we continue to see the president's health care mandate put into place and I think maybe we should have started with you at the very beginning, talk to the physicians before they started writing a 2,000-plus-page bill

that many of them did not read, yet passed, and Minority Leader Pelosi was correct. She said we will find out what is in it once it has passed, and, unfortunately, that discovery is still continuing. We are seeing increased costs, increased control, and reduced access to health care in this country. Thank you for coming in today.

I yield back, Mr. Chairman.

Chairman COFFMAN. Thank you, Mr. Tipton. I have got a few other questions. I want to make sure that we have everything done on record.

Dr. Yasso and Dr. Kennett, in your written testimony, you both mentioned a burden of complying with statutory and regulatory requirements, particularly electronic health records, electronic prescribing, and physician quality of reporting, which will carry significant penalties for non-compliance in future years.

Would you elaborate on how these burdens disproportionately impact a small or solo practice physician's time and revenue?

Mr. YASSO. I have a friend that practices in Kansas City and has a predominately Medicaid practice. She has chosen to date not to implement the electronic health record because of the expense. I mean, she is barely breaking even paying her help, taking a salary, and those types of things and she is a very altruistic person and she wants to take care of her patient population, but she cannot afford—and even though the government says well, we will reimburse you if you put in a system that is compatible or I forget what the terminology is for that, but, anyway, she has made the decision that in 2014, she is going to retire. And the community is going to lose one darn good doctor because of that. And it is those types of things. It is just a heavy burden in situations like that and it takes good people out of the practice of medicine.

Mr. KENNETT. With our group of physicians, there were only 11 at the time, we spent about \$700,000 on electronic health record and you do not recoup very much. On an ongoing basis, you had that expense of maintaining it on a regular basis and the other bad part of that, when you first institute an electronic health record, actually it reduces your productivity pretty dramatically for the first six months or so and then you come back, but you are never going to get back to where you were before.

So, you are going to have to have electronic health record to demonstrate meaningful use, and if you do not, you get penalized for all your Medicare, funds will be cut—you are not participating in meaningful use and you are not e-prescribing, and it goes on and on. So, that is one of the drivers to hospitals is because the hospital can better afford—they still had to lower costs involved, yet they can better afford to absorb those costs in the small physician practices.

Chairman COFFMAN. Mr. Smith, your testimony mentioned the high cost of malpractice insurance. Do you think malpractice reform will help a small practice physician to shoulder the burden and how so?

Mr. SMITH. Well, I think if tort reform would be part of the legislation, you would have seen a much greater acceptance of the physicians of this legislation, of the changes that were coming, but we have seen in states that apply tort reform, that it is a significant cost savings to the physicians and, of course, what I mentioned be-

fore, the cost of defensive medicine, which is an intangible cost that is significant, would be impacted, as well.

Chairman COFFMAN. Dr. McIntyre, some health care mandates, such as the reporting requirements for health information technology and establishing Accountable Care Organizations are first instituting with “incentive payments,” but involved penalties later.

Do you think that the inability to comply with mandates may be contributing to the disappearance of small medical practice?

Mr. MCINTYRE. The short answer is yes. We implemented an electronic medical record in 2002. So, we were early adopters. Totally, we spent \$500,000, which was about \$100,000 per doctor. We initially saw some savings because we were able to get rid of file clerks and paper costs and transcription costs, but going forward with upgrades and having to hire new staff to enter data, those cost savings went away. So, basically, it’s a huge cost for a small business. The HITECH Act leaves physicians \$44,000 over 5 years to implement a record as long as they comply with meaningful use. So, that would not even cover half of our investment per doctor.

In addition, the quality reporting in much of the act is very difficult to comply with because the quality reporting criteria have been developed by National Quality Forum and places like that of the I think it is 44 quality measures, only 3 of them apply to orthopedics at all. So, we were trying to fish around for what we are going to start reporting on to comply with the mandate. Asking people about looking at things sometimes had nothing to do with what they were seeing us for. We have to report those things, even though they are not in the scope of our practice, just because of the reporting regulations.

Chairman COFFMAN. Dr. Kennett.

Mr. KENNETT. Chairman Coffman, I will just give you a quick personal anecdote about tort reforms. Missouri has a tort reform law with a cap on non-income damages of \$350,000. So, my insurance says an interventional cardiologist dropped from \$35,000 to \$14,000.

Chairman COFFMAN. Right, okay.

Mr. Tipton.

Mr. TIPTON. Thank you, Mr. Chairman. I just did have one follow-up question.

Dr. McIntyre, you had brought it to mind and it is not in regards to the electronic medical records, but going back to Medicare, being able to fill out compliance forms to be able to get paid.

Has it been your experience many in all of your professions—I talked to a good family practice doc in my hometown, finally just pretty much quit simply out of frustration from the standpoint that they had moving bars when it came to being able to fill out the forms, make sure they filled in the right dots, and it was constantly changing.

Have you written any analysis in terms of the costs, how much you were spending rather than spending time with patients, you are paying people to be filling out more records when it comes to Medicare?

Mr. MCINTYRE. Well, certainly, our costs in general increased significantly to the point where they were about 80 percent of revenue for our clinical practice. We had other portions of the practice that

had a lower overhead figure but even with those figured in, our total overhead cost was about 63 percent, but that had increased hugely since the earlier part of the 1990s. We never culled out Medicare specifically to analyze the cost just for Medicare patients, but overall, it increased tremendously. When I started, we had one billing person. When I left, we had six. When I started, we had one person to do pre-certifications and things like that. When we sold the practice, we had one person per physician. So, all these things added up over time.

Mr. TIPTON. I am sorry, I apologize for interrupting, but just so that I am clear on that, you did not mean you were seeing more patients, that you were putting out more bills, it was just compliance?

Mr. MCINTYRE. Right, just compliance, correct.

Mr. TIPTON. Just strictly compliance.

Mr. MCINTYRE. We did have to ramp up volume, too, because we could not—

Mr. TIPTON. Pay for it.

Mr. MCINTYRE. Since we were getting a set fee, the only way for—there are two ways for a private practice to increase income in a set-fee market and that is to see more volume or to add ancillary services. You can decrease costs, but the quality of your service suffers to the point where you are not worth going to see.

Chairman COFFMAN. Dr. Kennett.

Mr. KENNETT. Congressman, I would just say that I hope CMS is not listening or the Department of Justice, but if on a regular basis a physician actually read all the documents which you are supposed to sign every day, it would add hours to your day. There is no way. You have reams of documents that you go through every day you sign your signature on, whether it is home health or hospice or Medicare documentation, it is huge; there is just no way you can actually read it all.

Mr. YASSO. When I first started in private practice in 1980, there were three of us, three physicians, and we had four people working for us, two in the front office, two in the back, and that was it and we did just fine. Today, with four providers, three physicians, one nurse practitioner, we have an office manager, four people working in the front office, and four people working in the back office. So, I mean, realizing we have got one more provider than we did 30 years ago, but, still, all this regulation and all the things that we need to do, the precertification of everything, you just have to have more bodies. You cannot get by without them.

Mr. TIPTON. It is no consolation, but in this country, businesses are paying \$1 trillion 750 billion per year on just regulatory compliance. Small businesses are paying \$10,685 per employee in regulatory compliance. We all know there needs to be some regulations, but I think we have certainly seen an overreach in the complexity that is inhibiting the very important work that I know you physicians in particular want to do, and that is to be able to provide quality health care at an affordable price. So, thank you.

Thank you, Mr. Chairman. I yield back.

Chairman COFFMAN. Thank you.

Dr. Yasso, I have got a question. Do you think small or solo practices may survive, but only if they fill a particular niche such as concierge care?

Mr. YASSO. I think that could be the way that this goes. I have a friend of mine that has started a concierge practice, at least part of what he does. He does not do 100 percent of that yet, although, he may very well move into that direction at some point in time.

It is my understanding that you see a lot of that and Mr. Smith could speak to that, I am sure, on the east and the west coast and I am sure that eventually, that is going to move towards us. It only makes sense from the private practitioner if he wants to stay private that he does something like that because now he controls his income. It is not controlled by the government, it is not controlled by any regulator, he controls his income and that makes sense.

Mr. SMITH. I would like to just simply with that, because concierge medicine, people think of it as the billionaire's medicine, the doctor follows them around, and that does exist, but if you were a primary care provider in solo practice, you are going to have three to four employees, you are going to have 50 to 70 percent overhead costs, and you are questioning what do you do? Do I join a hospital? If you can today become a concierge physician, you can take that panel, which could be as low as 2,500, 4,000 patients and if you had 500 of them agree to pay you \$50 a month and you would see them just in their office and take care of all their needs, you would make about 20 percent more money than you made the other way. So, you can survive, but from a small business perspective, you would trim your staff one or two people. So, very lean and those are good-paying jobs, jobs that we hear talk about our health insurance, a big part of the opportunity, but these are smart individuals, they will find a way to adapt and coming off the grid and doing that is one way.

And the second thing I would keep in mind is what if you are not one of the 2,500 that can afford the \$50 a month? So, we have taken that FTE from a full position down to about 15 to 20 percent of an FTE and in environment we already have a supply challenge.

Chairman COFFMAN. My final question involves seniors, seniors on Medicare, seniors in my district and across the country. And seniors on basic Medicare had a very challenging time, an increasingly difficult time finding physicians that will see them and with the Independent Payment Advisory Board that will be fully online I think in 2015 according to the Affordable Care Act, is that not going to make this situation all that much worse when the new way of controlling spending is to have this 15-member board control spending through restricting reimbursement levels. It seems essential, that is how we are controlling spending in the Medicare system. And, so, I wondered if any of you have any comments on where you see senior care going under Medicare.

Mr. MCINTYRE. In addition, I believe that the IPAB not only is tasked with cutting costs significantly, but also with maintaining access at the same time. So, I do not know how they can do that. And I do not know how central planning is going to be able to affect a fair reduction or program, especially without any input from anyone. I believe there is no input from physicians, there is no input from the Congress, they basically just give Congress a report

and Congress can accept it or not. Currently, at least now, we have some input to our reimbursement via some certain committees of the AMA. That will go away with the IPAB.

Mr. KENNETT. Certainly, the environment we are in where there is uncertainty on Medicare reimbursement, seniors are going to have increasing difficulty getting access, you are exactly right. I think we all here could agree that the IPAB is not a good thing and it is really not a good thing and that the only people that they are going to cut between now and 2019 are providers.

And, so, the good news is I think that the current congressional environment, it seems very unlikely you are going to get 15 people to approve by the Senate to be on the board, so, it is not going to be implemented.

Mr. SMITH. And I would argue that they are regulating and controlling prices for services in large—because they cannot get access.

Chairman COFFMAN. Did anyone have any further comments?

Well, thank you, all, for participating today. I ask unanimous consent that the following articles be admitted to the hearing record. A New York Times article dated March 25, 2012, entitled “More Doctors Giving Up Private Practices,” a CNNMoney article dated July 11, 2012, entitled “The Mind of a Solo Doctor,” a Wall Street op-ed dated July 5, 2012, entitled “Obama Care’s Lost Tribe: Doctors,” a Forbes article dated July 2, 2012, entitled “So Long Marcus Welby: Obama Care, Market Kill the Solo Private Practice.”

Without objection, so ordered. I ask unanimous consent that members submit statements and supporting materials for the record. Without objection, so ordered.

This hearing is now adjourned. Thank you very much for your testimony.

[Whereupon, at 11:33 a.m., the Subcommittee was adjourned.]



**TESTIMONY BEFORE THE UNITED STATES  
HOUSE OF REPRESENTATIVES**

**COMMITTEE ON SMALL BUSINESS**

**SUBCOMMITTEE ON INVESTIGATIONS, OVERSIGHT AND  
REGULATIONS**

***"THE DECLINE OF SOLO AND SMALL MEDICAL PRACTICES"***

Testimony of

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**July 19, 2012**

**INTRODUCTION**

Mr. Chairman and Distinguished Members of the Subcommittee

My name is Mark Smith and I am the President of Merritt Hawkins, the largest physician search and consulting firm in the United States and a company of AMN Healthcare, the nation's largest health care workforce solutions company. In the course of my 22 years with Merritt Hawkins I have consulted with hundreds of physician practices and health care facilities across the country, and my company has produced numerous white papers, surveys, presentations and books concerning physician practice patterns, physician supply and demand trends, physician compensation, physician morale and related topics.

I appreciate the opportunity to address the subcommittee today on the decline of solo and small physician practices.

**The Arc of Physician Practice**

Those who remember the 1970s television show "Marcus Welby, M.D." may still have an image in mind of physicians as small business owners running their own practices, perhaps with the assistance of a younger partner or associate.

This classic model of independent, small physician practice still exists, but it is rapidly becoming an anachronism. Today, physicians are more likely to be hospital or medical group employees than they are to be medical practice owners. This is particularly true of medical residents completing their training. In a 2011 survey of final-year medical residents conducted by Merritt Hawkins, only 1 percent of respondents indicated they would prefer an independent solo practice.<sup>1</sup> By contrast, 60 percent indicated they would prefer to be employed by a hospital, medical group, outpatient clinic or academic facility.

In the 12-month period from April 1, 2011 to March 31, 2012, Merritt Hawkins conducted over two thousand, seven hundred physician search assignments on behalf of hospitals, medical groups and small physician practices nationwide. In only 47 of these assignments – or two percent – were we tasked with finding a physician to start a solo practice or to join a solo practitioner as a partner. By contrast, in 2004, 42 percent of Merritt Hawkins' search assignments featured a solo setting or a small practice partnership.<sup>2</sup>

Furthermore, in the 12 month period alluded to above, 63 percent of Merritt Hawkins' physician search assignments featured hospital employment of the physician, up from 56 percent the previous year and only 11 percent in 2004. If this trend continues, we project that in two years, 75 percent of all newly hired physicians will be hospital employees.

In short, virtually no one wants to be Marcus Welby anymore.

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<sup>1</sup> Survey of Final-Year Medical Residents. Merritt Hawkins, 2011

<sup>2</sup> Review of Physician Recruiting Incentives. Merritt Hawkins, 2012

A study by the national consulting firm Accenture further underlines this trend. It indicates that in 2000, independent physicians owning their own practices comprised 57 percent of all physicians. That number declined to 43 percent in 2009 and is projected to decline to 33% by 2013.<sup>3</sup>

This represents a fundamental transformation in the structure of physician practices, away from the classic private practice model and towards employment and an increasingly diverse number of other practice styles.

#### **Five Reasons**

There are six primary reasons why this transformation is taking place that I will address in order. They include:

1. Flat or declining reimbursement
2. Growing regulatory and administrative paperwork
3. Malpractice insurance costs
4. The implementation of information technology
5. Medical education debt
6. The effects of health reform

#### **Reimbursement**

In the days of Marcus Welby, both Medicare and private insurers typically paid physicians retrospectively for “usual, customary and reasonable charges.” The physician used his or her judgment regarding patient treatment and generally was paid for services invoiced at an amount above the physicians’ cost of doing business.

This system has been repeatedly modified since in an effort to reduce costs and manage care. Physician reimbursement in some cases has been cut or has not kept pace with inflation. The result is that many physicians now see little connection between their own labor and business costs and the amount for which they are reimbursed.

In a national survey of physicians Merritt Hawkins conducted on behalf of the non-profit group The Physicians Foundation in 2008, over 68 percent of physicians indicated that Medicaid pays them less than their cost of doing business, over 43 percent said some HMOs and PPOs pay them less than their costs, and over 36 percent said Medicare pays them less than their costs.<sup>4</sup> In some cases, physicians are not paid at all for their services. Over 53 percent of physicians surveyed said they provide \$35,000 or more each year of uncompensated care.

This is a difficult business model to sustain. Many physicians have responded by seeing more patients (and consequently spending less time per patient) and by excluding certain types of patients from their practices. In the survey cited above, over 33 percent of physicians said they have closed their practices to Medicaid patients, over 30 percent have closed their practices to some HMO and PPO patients, and over 11 percent have closed their practices to Medicare patients. Nevertheless, some small private practices physicians are having trouble keeping their doors open. There have been reports in the media

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<sup>3</sup> Adopting to a New Model of Physician Employment. Accenture, August, 2011

<sup>4</sup> Survey: The Physicians Perspective. The Physicians Foundation, 2008

in recent months about a growing number of private practice physicians going out of business -- an unusual occurrence throughout most of my career.<sup>5</sup>

This trend may reach a culmination on January 1, 2013, when physicians are due for a 30 percent reduction of their Medicare reimbursement rates under Medicare's Sustainable Growth Rate (SGR) formula. Though these cuts have been deferred in the past, it is difficult for small private practices to operate in a climate of uncertainty in which their revenues could be reduced by a devastating margin.

By contrast, employment by a hospital, medical group or other entity provides physicians with the security of a salary and the freedom from the fear that their practices will go under.

#### **Regulatory/Administrative Paperwork**

Virtually all businesses in the United States are subject to regulatory compliance, and physician practices are no different. As small business owners, solo and small practice physicians must abide by equal opportunity employment laws, worker safety laws, local real estate ordinances and many other rules and regulations. On top of this, physicians work in one of the most highly regulated of all professions. It has been reported that the U.S. federal tax code runs to some 75,000 pages, whereas the Medicare regulatory code by which physicians must abide runs to 130,000 pages.

Physicians must spend a significant amount of time on paperwork to ensure that they are compliant with the laws regulating their profession. As third party payer reimbursement policies become more restrictive, physicians also must perform considerable documentation to ensure that they are paid.

In the physician survey referenced above, physicians reported that they spend an average of 15 hours per week on non-clinical paperwork duties, or about 26 percent of their total working hours. These administrative duties, and the general pressures of running a business, can be alien to the mindset and makeup of many physicians, who are essentially scientists by training and caregivers by inclination.

Many physicians perceive that employment will reduce the amount of administrative and regulatory duties to which they are subject and allow them to focus on medicine.

#### **Malpractice**

Among the various costs of doing business, small private practitioners must pay for their own malpractice insurance. Malpractice insurance costs vary by region and by specialty and can be quite substantial. The annual cost for malpractice insurance for an obstetrician/gynecologist in Broward County, Florida, for example, is \$158,157 per year.<sup>6</sup> As malpractice insurance rates remain high, employment becomes an attractive option to physicians because employers typically provide malpractice insurance as part of the employment contract.

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<sup>5</sup> Kavalanz, Parija. Doctors going broke. CNNMoney.com. Jan. 6, 2012

<sup>6</sup> [www.mymedicalpracticeinsurance.com](http://www.mymedicalpracticeinsurance.com)

### **Information Technology**

For a variety of reasons, physicians are obliged to incorporate a growing level of information technology into their practices, particularly in the form of electronic medical records (EMR). Those who not do so face reductions in their Medicare reimbursement in coming years. While the federal government has provided funds for physicians to implement EMR, many still find it difficult to do so due to lack of time or available expertise. Sixty-nine percent of physicians in The Physicians Foundation survey referenced above indicated they have not implemented EMR due to lack of resources or expertise, 68 percent said they do not have the personnel to implement EMR, and 61 percent said they do not have the time. In addition, some physicians are doubtful that EMR will increase their efficiency and others have concerns about EMR and patient confidentiality.

The necessity of implementing information technology is a prominent example of how the resources, expertise and time of small medical practice owners is being taxed in today's increasingly complex and demanding medical practice environment.

A growing number of physicians are embracing employment as a potential refuge from these challenges and concerns.

### **Medical Education Debt**

According to the Association of American Medical Colleges (AAMC), U.S. medical school graduates carry an average of \$156,000 in educational debt. This debt load discourages many newly trained physicians from taking on the risk of starting their own practice or joining an existing practice as a partner.

### **Health Reform**

Health reform is a driver of a number of health care trends, including the general decline of small, independent private practice. I include in the term "health reform" not just provisions of the Patient Protection and Affordable Care Act but also market forces taking place apart from the Act. So defined, health reform encourages the consolidation of physician practices and hospitals into larger entities. Larger organizations are required in the post reform era to achieve the economies of scale needed to expand access to care while reducing costs.

In addition, health reform encourages the formation of new delivery models such as Accountable Care Organizations (ACOs) which depend on both hospital/physician alignment and the use of advanced information technology. ACOs are risk bearing entities, and as such require a high level of administrative and business expertise. It is difficult for solo or small practice physicians to participate in these models, which more naturally lend themselves to hospital employment of physicians.

### **Conclusion**

Combined, these factors and others have created conditions in which the small, private medical practice model is increasingly untenable. This model is only likely to persist in any numbers in smaller, rural areas where there are few physicians, and even here physicians will likely need to partner or affiliate with larger entities in some way. The solo, small practice model also may persist among those physicians willing and able to maintain "cash only" or so-called concierge practices in which physicians

directly contract with patients and do not accept third-party payments. Whether the proliferation of this model in wide geographic areas is possible remains to be seen.

Otherwise, physicians are likely to be employed by multi-physician groups or by hospitals, as the era of Marcus Welby rapidly disappears in the rear view mirror.

Thank you for the opportunity to address the Subcommittee and for examining the challenges facing America's solo and small practice physicians.

**About Merritt Hawkins**

Merritt Hawkins is a national physician search and consulting firm and a company of AMN Healthcare (NYSE: AHS), the largest health care staffing and workforce solutions company in the United States. See [www.merritthawkins.com](http://www.merritthawkins.com) and [www.amnhealthcare.com](http://www.amnhealthcare.com) or call 800-876-0500.



Statement

of

Dr. Louis McIntyre

On

“Health Care Realignment and Regulation: The Demise of Small and Solo Practices?”

Committee on Small Business

Subcommittee on Investigations, Oversight and Regulations

US House of Representatives

July 19, 2012

Mr. Chairman and members of the Committee, thank you very much for allowing me to participate in this hearing today.

I joined Westchester Orthopedic Associates in 1994. It was, and still is, the oldest continuous orthopedic specialty practice in Westchester County, New York. When I joined the practice, it resided in a 3000 sq foot office and had 9 employees, including the four orthopedic surgeons that worked there. We wanted to grow our practice and improve the quality of the care we delivered to our patients. In 1995 we moved into a new, centrally located, 6000 sq foot office with better parking and access to interstate highways. We hired additional workers as the clerical demands of managed care insurance plans increased the need for insurance verification and pre-authorizations. We added an additional orthopedic surgeon to take care of patients with neck and back problems that year also. The build out for the new office space cost \$500,000.

The late 1990s brought two challenging trends: decreasing reimbursement and increasing costs of business secondary to the clerical demands of insurance companies and skyrocketing malpractice costs. Where in 1995 we had one employee to verify and authorize treatments for all our patients, we now needed one employee per doctor to perform added administrative tasks and maintain quality service. The cost of malpractice insurance increased from \$40,000 per year in 1994 to \$110,000, for every doctor, in 2010. We attempted to negotiate increased rates of reimbursement with insurance companies to offset the increasing costs but were unsuccessful because of lack of market share. We formed a network of orthopedic surgeons to attempt to improve the economic power of private practices but were unable to affect reimbursement rates because of concerns over antitrust issues.

To address these issues, we embarked on an ambitious plan to increase our scope of practice by adding additional doctors and ancillary services to improve patient access to care. We hired doctors to manage pediatric orthopedic problems and pain management issues. In 2002, we added a Magnetic Resonance Imaging (MRI) machine with an additional 2000 sq feet of office and two employees. We implemented an Electronic Medical Record (EMR) to decrease costs and improve quality. We thus became very early adopters of a technology that is now mandated. Our total cost for the EMR implementation was about \$500,000. This represents about \$100,000 per doctor over the total span of implementation. Initially we saved about \$15,000 per doctor per year starting 4 years after implementation in 2002. Additional costs related to upgrades for computerized physician order entry plus the hiring of EMR scribes to enter data negated this savings starting in 2009.

We also built an ambulatory surgery center adjacent to our office in an 11,000 square foot building at a cost of \$5,000,000. The surgery center employed 25 people and performed over 700 cases per month at its busiest in 2008. In 2005, we acquired an additional 5000 sq feet of office space in our building that had housed an MRI scanner. We updated the scanner and built a state of the art physical therapy (PT) center to standardize the quality of PT delivered to our patients. The build out for the MRI and PT cost \$400,000.

When completely configured, we had just under 50 employees. All had health insurance and a generous profit sharing plan, as well as paid sick and vacation leave. Patients appreciated the

convenience of being able to receive all of their musculoskeletal care needs from evaluation to imaging to physical therapy to surgery in a coordinated and contiguous setting. When I started we were a \$2,000,000 business. We invested over \$6,500,000 to grow and improve this business. The practice generated \$5,400,000 in revenues at its height in 2007.

Unfortunately, the regulatory environment and insurance market worked against us. There was continued negative pressure on reimbursement from both Medicare and private payers. The American Academy of Orthopaedic Surgeons (AAOS) estimates that orthopedic surgeons' Medicare reimbursements revenue decreased 28% in the last decade. In addition, because reimbursement from insurers is based on the Medicare Resource Based Relative Value Scale (RBRVS), private insurers reimbursement had fallen in a similar fashion. Practice costs, however, have continued to rise, especially malpractice insurance rates as illustrated by an almost 300% rise in my rates from 1994 through 2010.

In 2009 and 2010, two laws passed by Congress further complicated the landscape for private practice. The American Recovery and Reinvestment Act (ARRA) mandated the adoption of EMR for all physicians serving Medicare patients. Even though we had implemented an EMR, the Meaningful Use Criteria accompanying the regulations still represented a significant burden for us in terms of data collection and quality reporting rules. Complying with the new rules would further increase our cost with no increase in reimbursement and the \$44,000 per physician available from HITECH to offset the cost of purchasing an EMR would not even cover half our investment in the technology. The Patient Protection and Affordable Care Act (PPACA), enacted in 2010, represents another burden for private practices in terms of decreased reimbursement, mandated quality reporting, and the movement toward risk sharing reimbursement methodologies.

The combination of decreased reimbursement, increased reporting requirements, the need for huge outlays for technology improvements and uncertainty about future earning potential are driving private practice physicians to seek employed positions. Doctors know that they cannot meet all the demands placed upon them in an environment of shrinking revenues and increasing costs and take care of patients at the same time. Indeed, according to the AAOS, the employment of orthopedic surgeons by hospitals has increased 300% in the last 5 years. According to Merritt-Hawkins, a leading physician employment search firm, physician employment search assignments for hospital employed positions went from 11% in 2004 to 56% of all searches in 2011.

For all of the above cited reasons, we decided to forgo private practice and become employees of White Plains Hospital last year. This year the other orthopedic group in our city also decided to become employees of the same hospital and will join our group in October. The hospital has embarked on an ambitious project to employ physicians in the ambulatory setting; the first time it has ever done so. The multispecialty practice next to us, WestMed, employs over 200 physicians. Clearly, the employed model is winning out over private practice in Westchester County.

There are advantages for both physicians and patients with the employed model. Doctors have more financial security knowing exactly what their income will be for a given timeframe. They no longer worry about losing money if they care for uninsured and underinsured patients. They are freed from dealing

with troublesome human resource issues and regulatory burdens, which become the purview of their employer. Information Technology and the costs associated with it are also transferred to the employer.

Employment, however, significantly decreases physician autonomy in affecting the environment in which patient-care takes place. The management philosophy of hospital administrators is usually process driven while physicians are much more goal and outcome oriented. This does change how patients interface with a practice. Physicians are in the position to interact with patients on a daily basis and identify deficiencies in care delivery. Administrators are more removed and may not appreciate patient care issues that arise in the ambulatory setting. Hospitals are also more risk averse, and are less willing to examine new and untested practice projects.

As more physicians, especially those right out of training, seek employed positions there will be a generation of physicians who will have never experienced private practice and the business aspect of medicine. They will be unaware of the costs and management issues of providing health care. There is concern that employed physicians will see less of a need to join and maintain membership in medical societies and specialty organizations that in the past have been oriented toward the private practice of medicine. How these concerns will affect the profession is unknown at this time.

Economically, there is concern that as the negative pressure on reimbursement continues, future contract negotiations between doctors and hospitals will become more contentious and will lead to dissatisfaction. Physicians may then band together and unionize to protect their economic rights. This would be a significant reversal of the profession toward physician, as opposed to patient, advocacy. Indeed, I believe this would herald the end of medicine as a profession and the start of medicine as a trade association.

Lastly, private practice is a significant economic engine employing vast numbers of people and paying taxes to support government services. A study conducted by the Medical Society for the State of New York in 2009 showed that the private practice of medicine was the fifth largest employer in Westchester County, second in business establishments, third in personal income taxes paid, and seventh in corporate sales taxes paid. Westchester Orthopedics paid significant federal and state corporate taxes plus sales taxes. Now, a part of a hospital, Westchester Orthopedics is tax exempt in all those categories. The loss of tax revenue resulting from private practice physicians migrating to hospital employment may be significant and worthy of further study.

There will not be employed positions for all of the doctors of Westchester County or the United States. There is, and will continue to be, an increased need for physicians with the implementation of PPACA starting in 2014. If private practice disappears, patient access to care, local employment and tax revenue will all suffer. We need to strengthen private practice as well as the other models of healthcare delivery to ensure patient access to quality care.

Thank for the opportunity to share my thoughts and experiences with your committee.

**Statement of Joseph M. Yasso, Jr., DO  
American Osteopathic Association**

**Presented to the  
House Small Business Committee  
Subcommittee on Investigations, Oversight and Regulations**

**Hearing on Health Care Realignment and Regulation: The Demise of Small and Solo  
Medical Practices?**

**July 19, 2012**

Chairman Coffman, Ranking Member Schrader, and Members of the Subcommittee, on behalf of the American Osteopathic Association (AOA), thank you for the opportunity to testify today on the impact health care realignments and regulation are having upon small and solo medical practices. My name is Joseph Yasso, I am a board certified osteopathic family physician in Independence, Missouri. I am currently the medical director of Heritage Physicians Group, a small physician practice, which is owned by the Hospital Corporation of America. My practice is comprised of three physicians, including myself and a family nurse practitioner. We provide the full array of family medicine services including pediatrics, adolescent health and women's health. We are located in a suburban area serving a large Medicaid population.

Currently, I sit on the Board of Trustees of the AOA. In my 35 years as an AOA member I have been able to interact and work with my colleagues as the practice of medicine has transformed. I directly witnessed this in my previous capacity as Chair of the AOA's Bureau of State Government Affairs and Bureau of Membership.

In over three decades treating patients after separating from the United States Army as a captain and flight surgeon, I have worked in various settings including small practices, hospitals and academic medicine at the Kansas City University of Medicine and Biosciences (KCUMB). Today, I am pleased to share with you my personal experience of how impactful health care realignment and regulations are upon decisions made by new and established physicians alike. After leaving the Army, I entered a small practice with two other physicians that we ultimately chose to sell in 1992 due to multiple financial and regulatory concerns, similar to those my colleagues in practice are facing today. I will speak to the challenges faced by small and solo practices, trends I see in my colleagues' practice types, and how opportunities exist in this evolution if incentives are appropriately aligned.

**Background on the Osteopathic Profession**

The osteopathic profession has a strong and distinguished history of educating, training and placing physicians in underserved communities. This commitment began in the late 1800's and continues today. Our academic and training model, while not unique to the osteopathic profession, places an emphasis on preparing osteopathic medical students for careers in general physician specialties such

as primary care, obstetrics, general surgery and emergency medicine. Our academic curriculum, along with a community-based training model, is the primary reason that the profession has enjoyed great success in the production of primary care physicians and general surgeons.

Today, 60.5 percent of all osteopathic physicians practice in a primary care specialty. Currently, one in five medical students in the United States is enrolled in a college of osteopathic medicine. We are one of the fastest growing fields in the health care sector.

Currently, there are 26 colleges of osteopathic medicine operating on 34 campuses. We estimate that 2 to 3 new colleges will open in the next few years. Many of our colleges are located in geographic regions with acute physician shortages, such as western Washington, Arizona, and the full span of Appalachia where we have four schools. This commitment to establishing colleges and training opportunities in areas of need is key to meeting the health care needs of underserved communities and is indicative of the profession's commitment to this cause. The nation's colleges of osteopathic medicine currently graduate more than 3,600 osteopathic physicians. In 2013 that number will grow to 4,700 and by 2015 over 5,000 osteopathic physicians will graduate each year. If current trends continue, by 2020 there will be over 100,000 practicing osteopathic physicians in the United States.

#### **Challenges Faced by Small and Solo Practitioners**

The health care delivery system is constantly evolving. Today, physician practices face new demands as required by statute and regulation. These include the adoption of electronic health records and electronic-prescribing systems, preparation for coding under ICD-10, implementation of quality measures, and adjusting to other changes in the health care delivery system. These additional policies and procedures are important and are primarily beneficial to efficiency as well as to providing improved patient care. However, each new requirement can be quite costly to a physician practice operating as a small business. The accumulated cost and subsequent time spent implementing new systems or procedures have an impact on revenue. For instance, making the decision to move forward with an electronic health record (EHR) system requires a considerable amount of time and financial investment for a physician practice. In a February 2012 survey conducted by the National eHealth Collaborative, stakeholders were asked "What are the biggest challenges to achieving widespread health information exchange?" The top response, funding and sustainability, garnered 61 percent.

While physicians in all practice settings face unnecessary and costly administrative hassles, the burden on small practices is particularly disproportionate, detracting from the time available for patient care. A physicians' role in coordinating care and making needed referrals typically involves frequent interaction with managed care organizations and other third-party payers to obtain required approvals, services, and payment, resulting in paperwork and overhead expenses. For example, the new restriction that requires consumers who use their tax advantaged accounts to purchase over-the-counter (OTC) medications to obtain a prescription from their physician is counterintuitive to enhancing access to health care and promoting patient-centered care. This provision of the

Affordable Care Act increases costs to the health care system and places a new administrative burden on already over-burdened physicians. The AOA was pleased to testify on this topic before the House Ways and Means Committee earlier this year.

The AOA has urged the Centers for Medicare and Medicaid Services (CMS) to re-evaluate penalty timelines associated with the value-based modifier, electronic prescribing, the Physician Quality Reporting System (PQRS), electronic health records and ICD-10. The "imminent storm" associated with implementation of these programs creates a burden faced by physicians in complying simultaneously. A March 28 letter sent to CMS by numerous physician organizations stated, "We urge CMS to re-evaluate the penalty timelines associated with these programs and examine the administrative and financial burdens and intersection of these various federal regulatory programs. We also urge CMS to use its discretionary authority provided by Congress under these programs to develop solutions for synchronizing these programs to minimize burdens to physician practices, and propose these solutions in the physician fee schedule proposed rule for calendar year 2013."

The AOA appreciates CMS efforts to align its various programs; however more steps are needed to streamline the requirements, such as the various data submission deadlines involving such programs as PQRS, value-based payment modifier, the EHR incentive program, and e-Prescribing Incentive Program. These deadlines and other reporting requirements must be better aligned to eliminate the administrative burden and confusion caused by the current demands.

An additional overarching and overwhelming challenge faced by all physicians, one especially felt by those in small and solo practices, is the instability of the physician payment system stemming from the flawed sustainable growth rate (SGR) formula which threatens annual cuts to physician payments. This looming concern forces small practices with limited revenues and narrow margins to make difficult decisions about whether to lay off staff, reduce their Medicare patient population, defer investments or opt for early retirement. The AOA supports full repeal of the SGR and replacement with a payment model that appropriately compensates for the services they are providing patients.

#### **Trends in Practice Types**

Today's medical school graduates are faced with difficult decisions after completing their education and training. The average osteopathic medical school graduate has a debt nearing \$200,000. As you can imagine, this makes the prospect of opening a small practice extremely daunting. To reach medical students early in the pipeline, Congress should examine options for targeted scholarship, loan deferment and loan forgiveness programs to encourage medical school graduates to invest in the small primary care practices so many communities are lacking.

In a recent environmental scan conducted by the AOA, a survey was sent to state associations and specialty colleges to collect information on issues and trends confronting the profession. The respondents were asked to report on the three most important medical practice trends. Overwhelmingly, a shift from private practice physicians to employed physicians was noted. In

addition, the collective cost of increasing administrative, financial and licensing burdens on physicians was also a dominant trend.

This spring, the American College of Osteopathic Family Physicians (ACOF) retained Avenue M Group, LLC to conduct a survey of its membership. The survey included questions and findings related to practice types and settings. The survey found that 60 percent of family physicians are "employees with no ownership stake in a practice." The most significant change in practice characteristics from a similar survey conducted in 2010 was the percentage of physicians who consider their primary employment setting to be a public non-profit hospital - 2 percent in 2010 increasing to 12 percent in 2012.

Furthermore, new and established physicians are forced to consider and balance their personal financial debt, administrative and financial burdens resulting from rules and regulations, and their desire to practice in a specific type of setting. Often, the overwhelming collective burdens are cost prohibitive and outweigh desire for a practice setting akin to a small or solo practice. There are also physicians who wholeheartedly embrace the choice of becoming an employed physician. This option can provide physicians with greater security. Nonetheless, physicians should not be forced to enter an employed situation out of pure necessity, and should retain their option to choose their ideal practice type absent undue financial considerations and regulatory burdens.

#### **Opportunities Through Aligned Incentives**

The AOA believes opportunities exist in a patient-centered medical home model (PCMH) and within Accountable Care Organizations (ACOs) for physicians to continue managing patient care while still being able to operate as a small or solo practitioner. Neither model requires a physician to be employed by a hospital or large health system in order to be successful. Both PCMHs and ACOs allow for the sharing of resources such as equipment and facilities that a small or solo practitioner might not normally possess. In an effort to realize these opportunities, we have actively participated in the development of new payment models that support and advance the goals of care coordination and greater integration in delivery systems.

The PCMH provides opportunities for physicians to be paid for coordinating a patient's care, an activity that has not been valued traditionally. The AOA has actively engaged commercial insurers, business organizations, consumer groups and government health care programs on the development and implementation of patient-centered delivery models such as the PCMH. We have pursued this as a means of improving the delivery of health care, and also as a contributing solution to the escalating costs of health care. Numerous studies have demonstrated that greater coordination of health care services reduces overall spending on health care services. The spring 2012 survey found that 48 percent of family physicians currently identify their practice as a medical home or anticipate becoming a recognized medical home within 18 months.

ACOs also incentivize care coordination and allow physicians to benefit from shared savings stemming from a patient's improved health at a lower cost. Twenty-one percent of surveyed family physicians reported being part of an ACO, with 46 percent anticipating becoming a part of one in

the next 18 months. In this regard, the AOA supports the efforts of the Center for Medicare and Medicaid Innovation (CMMI) in developing a shared-savings program that provides numerous options for providers. The Pioneer ACO program was designed for those providers already experienced in comprehensive coordinated care for their patients. In an effort to address initial cost concerns for new participants, the Advance Payment Model was created. This is a positive step toward ensuring all physicians can benefit from a shared-savings model without cost being a prohibitive factor. We believe that Congress should support the continued evolution of ACOs. We strongly support the concept of integrated delivery models as a means of improving the quality and efficiency of health care. We recommend that ACOs be better designed to allow for the virtual versus contractual alignment of physician practices as a means of achieving integration.

Appropriately aligned incentives can serve to foster success as a solo practice, a small practice, a group practice, or as an employed physician. Regulators should be cautious in creating additional financial burdens on physicians that would inhibit their ability to choose the practice setting that is most appropriate. Options should be retained for all practice settings that are not restricted in this regard.

#### **Conclusion**

In closing, the AOA believes that the transformation of the practice of medicine has undoubtedly impacted the ability of physicians to thrive in a small practice or as a solo practitioner. Physicians are faced with new financial and regulatory burdens that contribute to this conundrum. However, physicians are adapting to the changing practice of medicine by becoming patient-centered medical homes and participating in shared savings programs. As we work to improve the health care delivery system for patients, physicians must be provided appropriate payment and incentives to practice effectively in the setting of their choice. Patients deserve this level of access.

I would like to thank you and the members of the committee for affording me the opportunity to share my experiences and the AOA's perspective regarding this important topic affecting osteopathic physicians and our patients. The AOA appreciates the work that you do to promote policies that enable physicians to successfully operate as small businesses absent undue regulatory and financial burdens. We look forward to working with you in the weeks and months ahead to ensure that congressional action fosters, rather than impedes, the physician-patient relationship.



**Statement of**

**Jerry D. Kennett, MD, MACC**

**On behalf of the**

**American College of Cardiology**

**Presented to the**

**HOUSE SMALL BUSINESS COMMITTEE**

**SUBCOMMITTEE ON INVESTIGATIONS, OVERSIGHT AND  
REGULATIONS**

**Health Care Realignment and Regulation: The Demise of Small and Solo  
Practices?**

**July 19, 2012**

Chairman Coffman and members of the Subcommittee, I am Jerry Kennett, Chairman of the American College of Cardiology (ACC) Advocacy Steering Committee. I am a cardiologist with Missouri Cardiovascular Specialists - a seventeen person cardiology and cardiovascular surgery practice in Columbia, Missouri. I also serve in the role of Chief Medical Officer for Boone Hospital Center, a large community hospital in the BJC Healthcare System.

The ACC is a 40,000-member nonprofit medical society serving the needs of both providers and patients in this country and internationally. The College has been a leader in producing guidelines of care, professional and patient education, and operating national registries for assessing process measures and outcomes of cardiovascular procedures and everyday outpatient care.

A little more than a year ago, our group was an independent practice but now we are integrated with Boone Hospital in what is termed a purchased service agreement. According to a 2011 Lewin Group report on the economic impact of office based physician practices, these small businesses, such as mine, account for 4 million jobs across the United States with \$833 billion in wages and benefits. These small businesses generate \$63 billion in state and local tax revenue.

My group was one of those typical office based practices but due to a variety of factors, some of which are discussed (below), chose to become integrated with our hospital. We had grown to over 100 employees. We occupy over 15,000 square feet in an office building attached to our hospital. Our practice included a cardiac diagnostic center where patients had easy access to echocardiograms, stress tests and even an outpatient cardiac catheterization laboratory.

Physician practices are different from almost any other small businesses. The payment for services performed is not controlled by free market dynamics but instead payment is tightly regulated by Medicare and Medicaid and private payers who essentially follow the lead of the government with the recipient of the services or patient often having very little personal cost.

*The ACC estimates that 60-70 percent of our current physician members have integrated with hospitals. Why has this happened?* There are a variety of factors that have contributed to this evolution. The prominent reasons relate to Medicare physician payment not keeping up with actual practice costs (See Appendix A), direct cuts in Medicare physician reimbursement (See Appendix B), and increased administrative and regulatory burdens. All these add up to tremendous uncertainty among physicians as to what the future holds and so many physician practices see hospital integration as their only choice.

#### Congress Must Act To Permanently Repeal the SGR

Every year since 2002, physician practices have been threatened with significant cuts in Medicare reimbursement. In March 2012, Congress stepped in to prevent a 27 percent payment

cut effective until January 2013, marking the 14<sup>th</sup> time Congress has had to intervene with a short term patch in the last 10 years. Congress must act again before the end of the year for the 15<sup>th</sup> time to avoid a nearly 30 percent cut. This process is a vicious cycle that creates uncertainty for physicians and their practices and threatens access to seniors.

An online survey conducted by the American Medical Association (AMA) in May 2010 received feedback from over 9,000 Medicare physicians about the impact of short-term delays on Medicare physician payment and found the following:

- Physicians looked into opting out of Medicare and treating patients through the private contracting option (60%)
- Delayed payments for supplies, rent and/or other expenses (39%)
- Took out a loan or line of credit in order to continue paying bills (17%)
- Held up paychecks or laid off/furloughed staff (17%)
- Cancelled or postponed scheduled services to Medicare patients (14%)
- Temporarily closed practice to new appointments with Medicare patients (13%)

This is no way to conduct a small business. Our practice just like many others has to consider these options when cash flow is interrupted. How would Members of Congress feel if you didn't know what next month's check would be?

Another major turning point occurred in the 2010 Medicare Physician Fee Schedule in which payment to cardiology practices for some in-office procedures such as echocardiograms, and stress tests were reduced by up to 35 percent. The same test performed at the hospital and interpreted by the same physician was reimbursed to the hospital by as much as three times greater. How many small businesses could survive a 35 percent cut in payment for the exact same service? Our practice, like many others, decided we could not continue to run our diagnostic center without losing large amounts of money and decided our best option was to integrate with the hospital.

The College urges Congress to avert the nearly 30 percent scheduled Medicare reimbursement cuts, repeal the sustainable growth rate (SGR) and provide stable payments for several years to allow the development of new delivery and payment models. Medicare's future uncertainty stifles physician practices from making real investments aimed at improving coordination and reducing the current fragmentation of care and reducing waste. It also hinders badly needed economic activity and growth in our communities. Congress needs to take decisive action to end this continuous cycle that harms physician practices, our patients, and our economy.

Congress Must Act to Limit and Reduce Regulatory and Administrative Burdens to Practices

There are a significant number of regulatory and administrative burdens that contribute to the uncertainty for physician practices and hinder their ability to grow. Here are a few examples:

*Audits*

While physician claims for services are generally subject to contractor medical review, greater scrutiny in recent years has increased costs and uncertainty. Physician claims must comply with National Correct Coding Initiative (NCCI) Edits, Medically Unlikely Edits (MUEs), Comprehensive Error Rate Testing (CERT), and Recovery Audit Contractors (RACs). Other initiatives such as prepayment review demonstrations for certain cardiovascular and orthopedic DRGs have been delayed, but continue to create uncertainty for providers. Each of these programs has different rules and regulations. Physicians struggle at first to determine the program to which they are being subjected, and then attempt to quickly resolve any issues to minimize the impact on the practice's ability to provide high-quality patient care.

*ICD-10*

The Centers for Medicare and Medicaid Services (CMS) has announced the implementation of ICD-10, a diagnostic coding system, to replace ICD-9. Moving to ICD-10 is expected to impact all physicians due to the increased number, complexity and specificity of codes. ICD-9 has 14,315 codes to choose from for a diagnosis, ICD-10 will have more than 87,000. This transition will require significant planning, training, software/system upgrades/replacements, as well as other necessary investments which can cost, for example, a small three physician practice a total of over \$83,000 to implement. These figures are higher than CMS originally estimated and place a heavy financial burden on physician practices.

*Multiple Medicare Penalties*

Starting in 2011, Medicare began to penalize physicians for not meeting the requirements of certain incentive programs. In the coming years, physicians will be penalized for not prescribing electronically, not participating in the meaningful use of an electronic medical record, and not submitting quality data through the Physician Quality Reporting System (PQRS). In addition, beginning in 2015 a value-based purchasing modifier, as yet not specified, has the potential to further penalize physicians. Because CMS will base its assessment of a physician's performance as much as two years in advance of the actual penalty, physician practices must account for the possibility of even further decreased payments in long-term planning.

*Cost and challenges of implementing EHR and achieving meaningful use*

ACC strongly supports the establishment of a nationwide health information technology infrastructure as a critical step in improving the quality of healthcare. The costs and challenges of implementing an electronic health record and taking the steps necessary to qualify for the incentives offered through the electronic health record (EHR) incentive program authorized by Congress under the American Recovery and Reinvestment Act (ARRA), however, can be overwhelming for small and medium sized physician practices. ACC members – even those who were early adopters of EHRs-- have reported significant challenges in meeting the requirements for just the first stage of the meaningful use incentive program.

Small practices can have difficulty making the initial outlays required to implement an EHR. A recent study of EHR implementation in a network of primary care practices estimated direct costs through the first year at \$46,000 per physician, with anticipated annual maintenance costs of \$17,000 per physician in subsequent years.<sup>1</sup> In addition, practices must re-engineer workflow for both physicians and staff to accommodate the additional time needed for electronic documentation. Practices in the early stages of implementation typically experience significant lost revenue due to reduced productivity. The payments offered under the EHR Incentive Program for those who qualify can offset some of these costs, but the challenges of making the upfront investment, retraining staff and physicians, and marshaling the necessary expertise can be too much for an independent practice to manage on its own.

*The Future of Medicare Physician Payment*

Finally, physicians have significant anxiety regarding the future of Medicare payment reform. New payment systems that are being implemented such as accountable care organizations (ACOs) and bundled payments often require specialized staffing just to administer them. Future payment models may be even more complex. Physicians are afraid of being left out or being unable to participate in these new payment systems, further contributing to uncertainty.

Conclusion

The financial pressures associated with declining reimbursements and rising operational costs on private cardiology practices have resulted in rapid migration of practices to hospital affiliation. Continued cuts in Medicare reimbursement, combined with increasing overhead costs, increased

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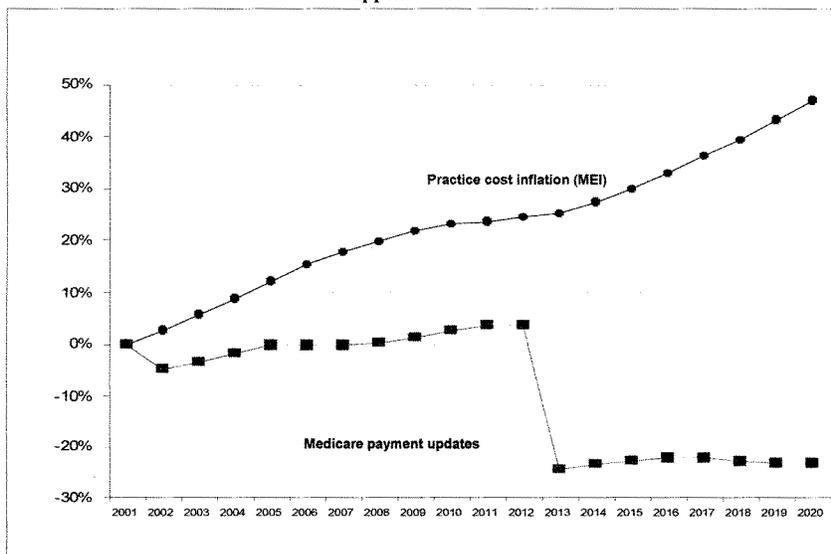
<sup>1</sup> Fleming, et al. The financial and nonfinancial costs of implementing electronic records in primary care practices. *Health Affairs*, 30, no. 3 (2011): 481-489.

regulation, unfunded mandates and an uncertain, cloudy future are making it difficult for practices to remain viable.

We believe that a well-functioning Medicare payment system provides opportunities for physicians to practice both independently or as employees of a hospital. Increased payment should come from increased quality and demonstrated appropriate utilization and physicians should be appropriately paid for the increasing expectations associated with the practice of medicine.

Thank you for the opportunity to share my views with the Committee.

**Appendix A**



Source: 2011 Medicare Trustees Report for all years except 2013, which is derived from CMS letter to Medicare Payment Advisory Commission of March 6, 2012. Prepared by American Medical Association, Economic and Health Policy Research, April 2012.

**Appendix B**

## Timeline of Payment Reductions Impacting Cardiology

## January 2007

- Imaging cuts included in the Deficit Reduction Act of 2006 implemented – capped payment for advanced imaging services paid under the Physician Fee Schedule (PFS) at the lower of the PFS rate or the Hospital Outpatient PPS (HOPPS) rate
- CMS implemented Relative Value Unit (RVU) Cuts (4 year phase-in)

## January 2010

- CMS implemented first year of Physician Practice Information Survey (PPIS) cuts. Survey data resulted in significant reduction in practice expense per hour rates over 4 year phase-in
- CMS increased equipment utilization rate assumption to 90% from 50% for expensive imaging equipment. Increase set to be phased-in over 4 years

## January 2011

- Patient Protection and Affordable Care Act (PPACA) set equipment utilization rate assumption at 75 percent (up from an effective rate of 62.5 percent due to 4 year phase-in of 90 percent assumption)
- Bundled payments for procedures performed together more than 75 percent of the time

## July 2012

- CMS proposes 25 percent reduction of the technical component when one cardiovascular diagnostic service is provided by the same physician practice at the same session

## January 2013

- Physicians who do not e-prescribe are subject to a 1.5 percent Medicare penalty

## January 2015

- Physicians who elect not to participate in PQRS or are found unsuccessful during the 2013 program year, will receive a 1.5% payment penalty in 2015, and 2% thereafter.
- Value-Based Payment Modifier program will begin in 2015 to adjust some physician or group Medicare payments based on 2013 quality and cost measurement data

# Forbes



**Bruce Japsen**, Contributor

I write about health care and policies from the president's hometown

**PHARMA & HEALTHCARE**

*7/02/2012 @ 9:55AM 3,934 views*

## So Long, Marcus Welby: Obamacare, Market Kill The Solo Private Practice



Doctors are less likely to work as solo practitioners according to a new study by physician staffing and recruiting firm Merritt Hawkins. This is due to economic and trends and related to health reform. : Getty Images via @daylife)

When healthcare search firm Merritt Hawkins helped hospitals look for doctors just a few years ago, about one in four clients were looking for a solo practicing physician, often a primary care doctor who would open up shop in a small community.

But these days doctors find safety in numbers by joining larger practices and leaving self-employment to go to work for a hospital or clinic, according to the latest annual physician recruiting incentives survey by AMN Healthcare Company's (AMN) Merritt Hawkins subsidiary.

Just 1 percent of the firm's searches were for solo practitioners, down from 22 percent in 2004, according to data from recruiting assignments from April 2011 to late March of this year. Essentially, that means nobody wants a solo practicing doctor and nobody in the physician workforce wants to be one, Merritt Hawkins said.

“Nobody wants to be Marcus Welby anymore, practicing alone or with a partner and fewer hospitals are seeking solo doctors for their communities,” Merritt Hawkins founder James Merritt says, referring to the annual survey.

Doctors need to be a part of a larger group practice to afford large investments in electronic health record systems and other technology. Meanwhile, most health insurance companies like Aetna Inc. (AET), UnitedHealth Group (UNH), Humana (HUM) and others are moving toward new payment models that want doctors to care for larger groups or “populations” of patients through so-called Accountable Care Organizations (ACOs). Under the Affordable Care Act, larger doctor groups and hospitals are forming ACOs to contract with the Medicare program.

“Physicians today almost have to be part of a larger practice to be employed by hospitals,” Merritt said.

To be sure, three in five, or 63 percent of Merritt Hawkins searches were for hospitals that employed the doctor, compared to about half or 56 percent last year. In 2004, just one in 10 or about 11 percent of Merritt Hawkins searches were for hospitals. “At this rate, within about two years, over 75 percent of newly hired doctors will be hospital employees,” Merritt said.

Though today’s doctors might not be able to make a go of it alone, they are at least getting more money when they start.

The average family practice doctor's base salary that does not include production bonus or benefits jumped more than six percent to an average of \$189,000, compared to \$178,000 in last year's survey.

As the health care system places a greater emphasis on primary care to keep patients out of the hospital and healthy, primary care remains the strongest area of demand. Family medicine, for example, was by far Merritt Hawkins most requested search assignment, the firm said.

**THE WALL STREET JOURNAL.**

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• **WONDER LAND**

• Updated July 5, 2012, 6:24 p.m. ET

## Henninger: ObamaCare's Lost Tribe: Doctors

*The practice of medicine is the Obama health-care law's biggest loser.*

• By DANIEL HENNINGER



Back at the dawn of ObamaCare in June 2009, speaking to the American Medical Association's annual meeting, President Obama said: "No matter how we reform health care, we will keep this promise: If you like your doctor, you will be able to keep your doctor. Period."

But will your doctor be able to keep you? Or will your doctor even want to keep you, rather than quit medicine?

For the longest time now, since day one of the Affordable Care Act, we have been having arguments over the mandate to purchase health-care insurance, requirements that insurance companies accept policyholders regardless of health, and price discrimination in insurance policies.



Corbis

And of course this past week, the Supreme Court—or something resembling the Supreme Court—outputted a decision on the tax status of the insurance-purchase mandate, the states' obligation to pay for Medicaid and as a bonus, the Commerce Clause.

Have you noticed what got lost in this historic rumble? Doctors. Remember them?

ObamaCare has been a war over the processing of insurance claims. It has been fought by institutional interests representing insurance, hospital and pharmaceutical firms. The doctor-patient relationship, or what used to be called "the practice of medicine," has sunk beneath these waves.

Barack Obama, a savvy pol, understood from the start that rationalizing payments claims through the maw of these private and public bureaucracies was not what the average person thinks of as "health care." To any normal person, health care means that when you or yours get really sick, the doctors and nurses who attend to you will push all else aside to give you medical help.

Thus, the constant Obama chorus that you can "keep your own doctor." No one knows better than Barack Obama that his law sends the nation's doctors on a voyage into an uncharted health-care world in which they are just along for the ride with their patients.

A Wall Street Journal story the day after the Supreme Court ruling examined in detail its impact across the "health sector." The words "doctor," "physician" and "nurse" appeared nowhere in this report. The piece, however, did cite the view of one CEO who runs a chain of hospitals, explaining how they'd deal with the law's expected \$155 billion in compensation cuts. "We will make it up in volume," he said.

Volume? Would that be another word for human beings? It is now. At Obama Memorial, docs won't be treating patients. They'll be processing "volume." And then, with what time and energy remains in the day, they'll be inputting medical data to comply with the law's new Physician Quality Reporting System (PQRS), lodged in the Centers for Medicare and Medicaid.

Here's the Centers' own description of what PQRS does: "The program provides an incentive payment to practices with eligible professionals (identified on claims by their individual National Provider Identifier [NPI] and Tax Identification Number [TIN]) who satisfactorily report data on quality measures for covered Physician Fee Schedule (PFS) services furnished to Medicare Part B Fee-for-Service (FFS)."

We're all pressed for thinking time these days, but the one group we should make sure has time to focus on what's in front of them is doctors treating patients. Instead, they'll also be doing mandated data dumps for far-off panels of experts.

Doubts, even among believers, have begun to emerge about what ObamaCare could do to the practice of medicine. A remarkable and important piece by Drs. Christine K. Cassel and Sachin H. Jain in the June 27 *Journal of the American Medical Association* directly asks: "Does Measurement Suppress Motivation?"

The question raised by the article is whether imposing pay-for-performance measurements on individual physicians does more harm than good: "[C]lose attention must be given to whether and how these initiatives motivate physicians and not turn physicians into pawns working only toward specific measurable outcomes, losing the complex problem-solving and diagnostic capabilities essential to their role in quality of patient care, and diminish their sense of professional responsibility by making it a market commodity."

This is an important piece, because Dr. Cassel is part of the intellectual foundation for the measured-directives movement. The saying that comes to mind reading these misgivings is that it's better late than never to notice that the core relationship between doctor and patient is being eroded. Except that in the wake of Chief Justice Roberts's upholding of the Affordable Care Act, it's too late and we're beyond never.

Mitt Romney needs a way to talk about health care in America. This isn't just a fight over insurance companies. It's about the people at the center of *health care*—doctors. The Affordable Care Act will damage that most crucial of all life relationships, that between an ill person and his physician. Barack Obama's assertion that we all can keep our doctors is false. You could line up practicing physicians from here to Boston to explain to Mr. Romney why that is so.

Write to [henninger@wsj.com](mailto:henninger@wsj.com)

*A version of this article appeared July 5, 2012, on page A9 in the U.S. edition of The Wall Street Journal, with the headline: ObamaCare's Lost Tribe: Doctors.*

**The New York Times**

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TRUE STORY

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March 25, 2010

## More Doctors Giving Up Private Practices

By GARDINER HARRIS

WASHINGTON — A quiet revolution is transforming how medical care is delivered in this country, and it has very little to do with the sweeping health care legislation that President Obama just signed into law.

But it could have a big impact on that law's chances for success.

Traditionally, American medicine has been largely a cottage industry. Most doctors cared for patients in small, privately owned clinics — sometimes in rooms adjoining their homes.

But an increasing share of young physicians, burdened by medical school debts and seeking regular hours, are deciding against opening private practices. Instead, they are accepting salaries at hospitals and health systems. And a growing number of older doctors — facing rising costs and fearing they will not

be able to recruit junior partners — are selling their practices and moving into salaried jobs, too.

As recently as 2005, more than two-thirds of medical practices were physician-owned — a share that had been relatively constant for many years, the Medical Group Management Association says. But within three years, that share dropped below 50 percent, and analysts say the slide has continued.

For patients, the transformation in medicine is a mixed blessing. Ideally, bigger health care organizations can provide better, more coordinated care. But the intimacy of longstanding doctor-patient relationships may be going the way of the house call.

And for all the vaunted efficiencies of health care organizations, there are signs that the trend toward them is actually a big factor in the rising cost of private health insurance. In much of the country, health systems are known by another name: monopolies.

With these systems, private insurers often have little negotiating power in setting rates — and the Congressional health care legislation makes little provision for altering this dynamic. If anything, the legislation contains provisions — including efforts to combine payments for certain kinds of medical care — that may further speed the decline of the private-practice doctor and the growth of Big Medicine.

The trend away from small private practices is driven by growing concerns over medical errors and changes in government payments to doctors. But an even bigger push may be coming from electronic health records. The computerized systems are expensive and time-consuming for doctors, and their substantial benefits to patient safety, quality of care and system efficiency accrue almost

entirely to large organizations, not small ones. The economic stimulus plan Congress passed early last year included \$20 billion to spur the introduction of electronic health records.

For older doctors, the change away from private practice can be wrenching, and they are often puzzled by younger doctors' embrace of salaried positions.

"When I was young, you didn't blink an eye at being on call all the time, going to the hospital, being up all night," said Dr. Gordon Hughes, chairman of the board of trustees for the Indiana State Medical Association. "But the young people coming out of training now don't want to do much call and don't want the risk of buying into a practice, but they still want a good lifestyle and a big salary. You can't have it both ways."

In many ways, patients benefit from higher quality and better coordinated care, as doctors from various fields join a single organization. In such systems, patient records can pass seamlessly from doctor to specialist to hospital, helping avoid the kind of dangerous slip-ups that cost the lives of an estimated 100,000 people in this country each year.

And yet, the decline of private practices may put an end to the kind of enduring and intimate relationships between patients and doctors that have long defined medicine. A patient who chooses a doctor in private practice is more likely to see that same doctor during each office visit than a patient who chooses a doctor employed by a health system.

The changes have increasingly put the public and private provision of health care at odds. In the Medicare and Medicaid program, the government sets most prices related to hospitalization and doctor visits. And so organized health

systems are seen as a way to increase quality and lower costs, in part because salaried doctors may order fewer procedures than those in private practice.

But in the private-insurance setting, where big hospitals and health care chains have more clout in setting rates, the push for quality may put health insurance out of reach for much of the middle class.

There are political consequences, too. As doctors move from being employers to employees, their politics often take a leftward turn. This helps explain why the American Medical Association — long opposed to health care reforms — gave at least a tepid endorsement to Mr. Obama's overhaul effort.

Gordon H. Smith, executive vice president of the Maine Medical Association, said that his organization had changed from being like a chamber of commerce to being like a union.

Dr. Michael Mirro of Fort Wayne, Ind., is among those caught in the tide. A 61-year-old cardiologist, he began his career like so many of his peers in a small private practice with two other cardiologists. They gradually added doctors until, by last year, they had 22 cardiologists, making theirs one of the largest private heart clinics in Indiana.

But in December, Dr. Mirro and his partners sold everything to Parkview Health, a growing health system that owns the hospital across the street from their building. "We had to hire more and more people to contact insurers and advocate for people to get the care they needed," Dr. Mirro said. "That's expensive." As insurance rates rose and coverage weakened, patients were forced to pay out of their own pockets an increasing portion of Dr. Mirro's bills. When the economy soured, many stopped trying.

“In the last year, the share of our patients from whom we could not hope to collect any money rose to about 30 percent,” Dr. Mirro said. Dr. Mirro and his partners had been thinking of selling for years. But they made the decision after the Centers for Medicare and Medicaid Services decided last year to cut reimbursements to cardiologists by 27 to 40 percent, depending on the type of practice. The Medicare savings in cardiology are to be used to pay more to primary care doctors, widely seen as under great financial strain.

In the wake of the government decision, cardiology practices across the country began selling out to health systems or hospitals. Dr. Jack Lewin, chief executive of the American College of Cardiology, estimated that the share of cardiologists working in private practice had dropped by half in the past year.

“And the remainder of those left are looking to move in that direction,” Dr. Lewin said. “This is all happening with or without reform passing.”

The process feeds on itself because doctors who remain in private practice worry that as their peers sell out, their own options become more limited and the prices for their own practices fall.

Although Dr. Mirro saw his decision as life-changing, many of his patients noticed little difference. Parkview let the doctors remain in their building and allowed them to continue to hire their own staff.

Mimi Strong, an 89-year-old heart failure patient, said everything was the same when she visited recently. Told in an interview that her care may now be more coordinated, Mrs. Strong expressed little interest.

But it matters to Dr. Mirro. “We wouldn’t go back,” he said, “now that we’ve seen the value of improved patient care and improved communication with primary care physicians.”

Michael Packnett, the president of Parkview and Dr. Mirro’s new boss, said that his organization was growing rapidly, while the number of independent hospital and doctor practices in northeast Indiana shrank. A key reason, Mr. Packnett said, is that many doctors have decided that the challenges of running their own businesses are simply too great.

“Now they get to refocus on practicing medicine,” Mr. Packnett said.

The outlook for private practice, in any specialty, has dimmed. Says ACOG's Lucia Diverere: *"Median expenses for private practices have been steadily rising in relationship to revenues—from 53% in 1990 to 71% in 2002—making it difficult for practices to remain solvent."*

**The view from  
private practice:  
2 ObGyns speak**  
pages 44, 52

PHOTO: STEVE FOR OBG MANAGEMENT

## Is private ObGyn practice on its way out?

🗣️ Last year's Patient Protection and Affordable Care Act was designed to nudge you out of private practice. The law isn't the only pressure on ObGyns to change the way you practice, however, as Lucia DiVenere, ACOG's Senior Director of Government Affairs, makes clear.



Lucia DiVenere with OBG MANAGEMENT Senior Editor Janelle Yates

In the 18 months since the Patient Protection and Affordable Care Act—otherwise known as ACA, or health-care reform—was signed into law by President Barack Obama, the outlook for private practice, in any specialty, has dimmed. As a recent report on the ramifications of the ACA put it:

The imperative to care for more patients, to provide higher perceived quality, at less cost, with increased reporting and tracking demands, in an environment of high potential liability and problematic reimbursement, will put additional stress on physicians, particularly those in private practice.<sup>1</sup>

To explore the impact of these stresses on ObGyns specifically, the editors of OBG MANAGEMENT invited Lucia DiVenere, Senior Director of Government Affairs for the American Congress of Obstetricians and Gynecologists (ACOG), to talk about the outlook for private practice in the coming years. In the exchange, Ms. DiVenere discusses the short- and long-term effects of the ACA, the ways in which ObGyn practice is (or is not) evolving, the challenge of making the switch to electronic health records (EHRs), the rea-

sons ACOG opposed the ACA, and other issues related to the current practice environment. In addition, two ObGyns in private practice describe the many challenges they face (**THE VIEW FROM PRIVATE PRACTICE**, pages 44 and 52).

### What nonlegislative forces have affected private practice?

**OBG MANAGEMENT:** A recent report on the ramifications of the ACA argues that formal reform was inevitable. It also asserts that private practice was subject to many negative pressures long before health-care reform was passed.<sup>1</sup> Do you agree?

**Ms. DiVenere:** Our nation's health-care system is always evolving, and over the past decade, we've seen a clear trend toward system integration—that is, larger, physician-led group practices and hospital employment of physicians.

Looking at physicians as a whole, the percentage who practice solo or in two-physician practices fell from 40.7% in 1996–97 to 32.5% by 2004–05, according to a 2007 survey.<sup>2</sup> And the American Medical Association (AMA) reported that the percentage of physicians "with an ownership stake in their practice declined

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### ON THE WEB

Ms. DiVenere talks about a fundamental shift in the way you'll work, at [obgmanagement.com](http://obgmanagement.com)

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**The view from private practice; Take #1**


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**"I still love what I do"**

I've been in solo ObGyn practice for 10 years. Before that, I worked 10 years for two medical groups—that makes 20 years of medical practice. I entered medicine late after teaching school for 10 years.

Most of my patients used to have union jobs and were employed by the steel mills in south Chicago and Northwest Indiana or in construction or manufacturing. One of the benefits of a union job was good insurance. As the economy began to sour, those mills changed hands and are now owned largely by foreign companies. Wages were cut dramatically, and insurance benefits are now "bare bones." I continue to see my patients regardless of their circumstances.

Most maternity benefits require a hefty out-of-pocket expense. Around here, the doctor gets stuck with the deductible and, consequently, ends up doing lots of free deliveries. I haven't figured it out yet, but I'm willing to bet that I lose money on OB.

Most patients realize that it's tough to run a business on a declining revenue stream and are grateful that I take care of them. I've treated many of their family members, delivered their babies, provided primary care, done prolapse repairs on mom and grandmom. I know everybody by name—that's the school teacher in me. I still feel honored to do what I do, but it isn't easy. The other docs who cover for me on my rare days off, for CME, tell me I have "a nice practice." That's why I do it, for the good, salt-of-the-earth folks who would like to pay their bills if times were better.

Medicine is changing quickly. It has taken time to learn the electronic health record (EHR) at the local hospital. Every documentation takes longer. I now spend more time at the computer desk than with patients on hospital rounds. I have read about accountable care organizations and being "enabled," but the next round of payment cuts will likely kill private practice.

I have Indiana University medical students come and rotate with me, and I try to be as upbeat as I can. The students tell me that my office is the one everyone wants to rotate through. I used to hope that someone might come back and join me here—but maybe the young people have it right. They won't live with a pager all the time. They won't do call. To them, medicine will be a job. They will be "providers."

I may not have practiced in the golden age of medicine, but at least I feel that I had an impact on the lives of the families I have been honored to serve. I still love what I do—it's just getting harder to justify doing it.

—Mary Vanko, MD  
Munster, Ind.

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from 61.6% to 54.4% as more physicians opted for employment. Both the trends away from solo and two-physician practices and toward employment were more pronounced for specialists and older physicians.<sup>72</sup>

**OBG MANAGEMENT:** What has the trend been for ObGyns, specifically?

**Ms. DiVenere:** The ObGyn specialty employs the group practice model—health care delivered by three or more physicians—more frequently than other specialties do, largely because of the support it provides for 24-7 OB call schedules.

As for private practice, ObGyns have been moving away from it for 10 years or longer. Data from a 1991 ACOG survey shows that 77% of respondents were in private practice; by 2003, that percentage had fallen to 70%.<sup>3</sup> In 2003, ObGyns in private practice tended to be older (median age: 47 years) than their salaried colleagues (median: 42 years) and were more likely to be male (87% vs 77%).<sup>3</sup> The demographic change toward women ObGyns may add to this trend line.

**OBG MANAGEMENT:** What economic forces have shaped practice paradigms in ObGyn?

**Ms. DiVenere:** Median expenses for private practices have been steadily rising in relation to revenues—from 52% in 1990 to 71% in 2002—making it difficult for practices to remain solvent.<sup>4</sup> In addition, a 2011 survey from Medscape reveals that ObGyns in solo practice earn \$15,000 to \$25,000 less annually than their employed colleagues.<sup>5</sup>

ObGyns who have made the switch from private to hospital practice, or who have become ObGyn hospitalists, often point to the difficulties of maintaining a solvent private practice, especially given the push toward electronic health records (EHRs) and increasing regulatory and administrative burdens. These and other issues contribute to rising practice costs and increasing demands on an ObGyn's time and attention.

**What are the short-term effects of formal reform?**

**OBG MANAGEMENT:** What effect has health-care reform had so far?

**Ms. DiVenere:** In 2010, twice as many physician practices were bought by hospitals and health systems as in 2009. We can't conclude that the 2010 law is responsible for these changes, but we know that the architects of health reform were aware of this trend, believed it was beneficial, and looked for ways to

encourage it, including through development of accountable care organizations (ACOs), which give hospitals a new and potentially lucrative reason to purchase private practices.

**OBG MANAGEMENT:** What exactly is an ACO?

**Ms. DiVenere:** An ACO consists of aligned providers—most likely, large multispecialty groups, often affiliated with the same hospital—who agree to manage patients for a set fee, sharing the risk and potential profit. ACOs are required to have shared governance, which gives them the authority to impose standards for practice, reporting, and compensation—including rewards and penalties—across a group of physicians.

Each ACO must sign a 3-year contract with the US Department of Health and Human Services (HHS) and include a sufficient number of primary care professionals to care for at least 5,000 beneficiaries. ACOs will be evaluated by quality-performance measures to be determined by the Secretary of HHS.

#### What aspects of ACA will have the biggest impact?

**OBG MANAGEMENT:** What provision of the new law will have the most direct impact on ObGyns in private practice?

**Ms. DiVenere:** All ObGyns may benefit from the guarantee of insurance coverage for our patients for maternity and preventive care. And all ObGyns should join ACOG's fight to repeal the Independent Payment Advisory Board, which may hold enormous power to cut physician reimbursement.

Here's the quote all ObGyns—especially those in private practice—should read, from an article written by President Obama's health-reform deputies:

To realize the full benefits of the Affordable Care Act, physicians will need to embrace rather than resist change. The economic forces put in motion by the Act are likely to lead to vertical organization of providers and accelerate physician employment by hospitals and aggregation into larger physician groups. The most successful

physicians will be those who most effectively collaborate with other providers to improve outcomes, care productivity, and patient experience.<sup>6</sup>

**OBG MANAGEMENT:** Do these health-reform deputies offer any concrete vision of how this change will be achieved?

**Ms. DiVenere:** They detail what physicians need to do, and how they should change the way they practice, under the Act. For example, to meet the increasing demand for health care, they recommend that practices:

- "Redesign care to include a team of nonphysician providers, such as nurse practitioners, physician assistants, care coordinators, and dietitians"
- "Develop approaches to engage and monitor patients outside of the office."<sup>6</sup>

And to meet the requirements for payment reform, information transparency, and quality, they suggest that practices:

- "Focus care around exceptional patient experience and shared clinical outcome goals"
- "Engage in shared decision-making discussions regarding treatment goals and approaches"
- "Proactively manage preventive care"
- "Establish teams to take part in bundled payments and incentive programs"
- "Expand use of electronic health records"
- "Collaborate with hospitals to dramatically reduce readmissions and hospital-acquired infections"
- "Incorporate patient-centered outcomes research to tailor care."<sup>6</sup>

To capture value, the authors recommend that practices "redesign medical office processes to capture savings from administrative simplification."<sup>6</sup>

**OBG MANAGEMENT:** Do they propose any method for implementing these changes?

**Ms. DiVenere:** The White House is hoping that ACOs can lead. Medicare ACOs will attempt to accomplish these changes by managing hospital and physician services, prompting physicians and hospitals to change how they are both clinically organized and paid for services—this change,

#### FAST TRACK

Accountable Care Organizations are required to have shared governance, which gives them the authority to impose standards for practice, reporting, and compensation across a group of physicians

CONTINUED ON PAGE 49

in particular, is considered by some to be essential to improving the quality and efficiency of health care.

The new Centers for Medicaid and Medicare Services (CMS) Innovation Center, created by the ACA, is given broad authority to test, evaluate, and adopt systems that foster patient-centered care, improve quality, and contain the costs of Medicare, Medicaid, and the Children's Health Insurance Program (CHIP). **The law specifically guides the Innovation Center to look for ways to encourage physicians to transition from fee-for-service to salary-based payment.**

We can safely assume that the experts behind these provisions believe that large, hospital-centered systems or large, physician-led groups can better serve the needs of patients and our health-care system in general than can small private practices. Today, 24% of ObGyns run solo practices, and 27% are in single-specialty practices. Health-care reform can mean big changes for them.

#### Is the EHR a realistic goal for private practices?

**OBG MANAGEMENT:** How does the push for EHRs affect physicians in private practice?

**Ms. DiVenere:** Very profoundly. From the point of view of an ObGyn in private practice, EHRs offer a number of benefits. They can:

- help make sense of our increasingly fragmented health-care system
- improve patient safety
- increase efficiency
- reduce paperwork.

In addition, insurers may save by reducing unnecessary tests, and patients can certainly benefit from better coordination and documentation of care. These advantages don't necessarily translate into savings or revenue for physician practices, however. Many ObGyns—especially those in solo or small practices—don't feel confident making such a large capital investment. In fact, only about one third of ObGyn practices have an EHR.

**OBG MANAGEMENT:** Is it primarily cost that deters ObGyns from adopting EHRs?

**Ms. DiVenere:** That, and the fact that EHR

systems are not yet fully interoperable across small practices, insurers, and government agencies. The initial cost of purchasing an EHR system for a small practice is about \$50,000 per physician, and there are ongoing costs in staff training and hardware and software updates. A steep learning curve means fewer patients can be seen in an hour. It can take a practice months—even years—for physicians to return to their previous level of productivity. That's a lot to ask a busy practicing physician to take on.

**OBG MANAGEMENT:** Is there any way around the push for EHRs?

**Ms. DiVenere:** Congress wants to move us to full adoption of health information technology (HIT). Under health-care reform, beginning in 2013, all health insurance plans must comply with a uniform standard for electronic transactions, including eligibility verification and health claim status.

In 2014, uniform standards must:

- allow automatic reconciliation of electronic funds transfers and HIPAA payment and remittance
- use standardized and consistent methods of health plan enrollment and editing of claims
- use unique health plan identifiers to simplify and improve routing of health-care transactions
- use standardized claims attachments
- improve practice data collection and evaluation.

Uniformity and standardization can help address one of the major roadblocks to physician adoption of HIT. Still, it's little wonder that median expenses for private practices have been steadily rising in relation to revenues.

#### Is there a physician shortage in ObGyn?

**OBG MANAGEMENT:** There has been a lot of attention focused on the shortage of physicians in this country. How severe is the shortage likely to be in the specialty of ObGyn?

**Ms. DiVenere:** William F. Rayburn, MD, MBA, from the University of New Mexico



**24% of ObGyns run solo practices, and 27% are in single-specialty practices**

Health Sciences Center and School of Medicine in Albuquerque, has provided ACOG with important work on this topic. Dr. Rayburn is Randolph V. Seligman Professor and Chair in the Department of Obstetrics and Gynecology at that institution. His report<sup>7</sup> shows that the gap between the supply of ObGyns and the demand for women's health care is widening.

Data from this report point to a shortage of 9,000 to 14,000 ObGyns in 20 years. After 2030, the ObGyn shortage may be even more pronounced, as the population of women is projected to increase 36% by 2050, while the number of ObGyns remains constant.

**OBG MANAGEMENT:** Would the incorporation of more midlevel providers—that is, nurse midwives, physician assistants, and others—ease some of the strains on the ObGyn workforce in general and on private practice specifically?

**Ms. DiVenere:** That's very possible and is one of the reasons ACOG encourages greater use of collaborative care. It's certainly true that the ObGyn specialty is historically comfortable with collaboration.

In 2008, the average ObGyn practice employed 2.6 nonphysician clinicians, certified nurse midwives (CNMs), physician assistants, or nurse practitioners. ACOG strongly supports collaborative practice between ObGyns and qualified midwives (CNMs, certified midwives) and other nonphysician clinicians.

In a recent issue of *Obstetrics & Gynecology*, ACOG's Immediate Past President Richard N. Waldman, MD, and Holly Powell Kennedy, CNM, PhD, president of the American College of Nurse-Midwives, wrote about the importance of collaborative practice, which can "increase efficiency, improve clinical outcomes, and enhance provider satisfaction."<sup>8</sup> The September 2011 issue of *Obstetrics & Gynecology* highlights four real-life stories of successful collaborative practice.

Because of our commitment to the benefits of collaborative practice, ACOG supported a provision in the ACA that increases payment for CNMs. Beginning this year, the Medicare program will reimburse CNMs at 100% of the physician payment rate for the

same services. Before this law, CNMs were paid at 65% of a physician's rate for the same services. ACOG's leadership believes that better reimbursement for CNMs will help ObGyn practices and improve care.

Although ACOG supported that provision in the law, we did not support passage of the ACA. ACOG's Executive Board carefully considered all elements of the bill and decided that, although it included many provisions that are helpful to our patients, it also included many harmful provisions for our members. We felt that the promise of the women's health provisions could be realized only if the legislation worked for practicing physicians, too.

#### Why wasn't the SGR formula abolished?

**OBG MANAGEMENT:** What is the effect, for physicians in general and ObGyns in private practice specifically, of the failure to fix the sustainable growth rate (SGR) formula and implement liability reform in the ACA?

**Ms. DiVenere:** The fact that we have no fix for SGR and no medical liability reform is a disgrace. And the absence of solutions to these two issues is one of the main reasons ACOG decided not to support passage of the ACA. Our Executive Board was very clear in telling Congress that **we can't build a reformed health-care system on broken payment and liability systems**—it just won't work.

ObGyns themselves are the first to point out this fact. ObGyns listed medical liability (65.3%) and financial viability of their practice (44.3%) as their top two professional concerns in a 2008 ACOG survey.<sup>9</sup>

For all ObGyns, these two continuing problems make practice more difficult every day—problems felt most acutely by ObGyns in private practice. Employed physicians often come under a hospital's or health system's liability policy and often don't pay their own premiums. Employed physicians usually are on salary, sheltering them from the vagaries of Congressional action, or inaction, on looming double-digit Medicare physician payment cuts under the SGR.



In 2008, the average ObGyn practice employed 2.6 non-physician clinicians

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Some legislators, and some ObGyns, think Medicare doesn't apply to us. But today, 92% of ObGyns participate in the Medicare program and 63% accept all Medicare patients. This fact reflects ObGyn training and commitment to serve as lifelong principal-care physicians for women, includ-

ing women who have disabilities. Fifty-six percent of all Medicare beneficiaries are women. With the Baby Boomer generation transitioning to Medicare, and with shortages in primary care physicians, it is likely that ObGyns will become more involved in delivering health care for this population.

Medicare physician payments matter to ObGyns beyond the Medicare program, too, as Tricare and private payers often follow Medicare payment and coverage policies. As a specialty, we have much at stake in ensuring a stable Medicare system for years to come, starting with an improved physician payment system. [Editor's note: See Dr. Robert L. Barbieri's editorial on the subject on page 8 of this issue.]

**OBG MANAGEMENT:** What is ACOG doing to improve this system?

**Ms. DiVenere:** ACOG is urging the US Congress to ensure that a better system adheres to the following principles:

- **Medicare payments should fairly and accurately reflect the cost of care.** In the final 2011 Medicare physician fee schedule, CMS is proposing to reduce the physician work value for ObGyn care to women by 11% below what is paid to other physicians for similar men's services—exactly the opposite of what should be done to encourage good care coordination, and in direct contradiction to recommendations by the Resource-Based Relative Value Scale Update Committee (RUC). Medicare payments to obstetricians are already well below the cost of maternity care; no further cuts should be allowed for this care.

- **A new payment system should be as simple, coordinated, and transparent as possible and recognize that there is no one-size-fits-all model.** A new Medicare system should coordinate closely with other governmental and nongovernmental programs to ensure that information technology is interoperable, that quality measurement relies on high-quality, risk-adjusted data, and to guard against new and special systems that apply to only one program or may only be workable for one type of specialty or only certain types

CONTINUED ON PAGE 54

## The view from private practice; Take #2

### So far, the cons outweigh the pros of EHRs

My private practice made the transition to electronic health records (EHRs) about 4 months ago. We have discovered that EHRs do have a number of positive characteristics:

- Prescriptions are completely legible and can be sent directly to the pharmacy
- The staff no longer needs to search for charts
- If test results have been downloaded, they can be quickly accessed.

However, EHRs also require a lot of time to learn how to use them properly. And the problems don't end there. For example, instead of looking at a patient's face when taking a history, we now look at the monitor.

In addition, the templates have many data fields that auto-populate as "normal." There is an illusion that a thorough history and physical were performed—so it requires a lot of time meticulously reviewing each chart to make sure that it is accurate. One must always be aware of the potential for insurance fraud and the medicolegal risk of documenting something as normal when it isn't.

Ordering labs is cumbersome because each test must be handled separately, and the terminology does not always match the options at our contracted laboratories. We spend a lot of time searching for each lab that is ordered.

To achieve "meaningful use" of the EHR, certain parameters must be met at every single visit. The medication list must be reviewed (even if the patient takes no medications), and there must be a notation that cervical and breast cancer screening have been ordered, even though recent Pap smear and mammogram results are included in the chart. Regardless of the patient's age or situation, the issues of contraception, sexually transmitted disease, tobacco use, and domestic violence must be addressed.

So when a 65-year-old woman presents with postmenopausal bleeding, I have to comment on these issues or delete them from the report. I have to provide the same documentation when she returns the next week for a biopsy and the week after that when she returns for the results.

It has become impossible to see patients in the time frame I have used for the past 24 years, and my patients and staff remain frustrated. I am always behind schedule, and I fear that the computer gets more attention than my patients do during the office visit.

—Mark A. Firestone, MD  
Aventura, Fla



Health reform is intended to 1) cover the uninsured, 2) tilt our health-care system toward primary care and use of nonphysician providers, and 3) push practices toward integration with hospitals, health systems, and other paths to physician employment

of diseases and conditions. ObGyns often see relatively few Medicare patients, and unique Medicare requirements can pose significant administrative challenges and inefficiencies to ObGyn participation.

- **Congress should encourage, and remove barriers to, ObGyn and physician development of ACOs, medical homes for women, and other innovative models.** Proposed rules on the Medicare Shared Savings Program allowing for expedited antitrust review should be extended to ACOs and other physician-led models of care that do not participate in the Medicare Shared Savings Program. These models should also recognize the dual role ObGyns may play, as both primary and specialty care providers.
- **Congress should repeal the Independent Medicare Payment Advisory Board.** Leaving Medicare payment decisions in the hands of an unelected, unaccountable body with minimal congressional oversight is bad for all physicians and for our patients.

#### Is private practice doomed?

**OBG MANAGEMENT:** In your opinion, over the long term, is health reform a positive or a negative for ObGyns in private practice?

**Ms. DiVenere:** On balance, I believe that the health reform law is a positive for our patients, and that fact may lead to an eventual positive for its Fellows, ACOG hopes. What it may mean for ObGyns in private practice, though, is more troubling.

The law has many intended purposes: 1) cover the uninsured, 2) tilt our health-care system toward primary care and use of nonphysician providers, and 3) push practices toward integration with hospitals and health systems and other paths to physician employment. Support for continuation or growth in any type of physician private practice is hard to find in the ACA.

**OBG MANAGEMENT:** What changes are in the pipeline?

**Ms. DiVenere:** Under the ACA, by 2013, the Secretary of HHS, with input from

stakeholders, will set up a Physician Compare Web site, modeled after the program that exists for hospitals, using data from the Physician Quality Reporting Initiative (PQRI). Data on this site would be made public on January 1, 2013, comparing physicians in terms of quality of care and patient experience.

By law, these data are intended to be statistically valid and risk-adjusted; each physician must have time to review his or her information before it becomes publicly available; data must ensure appropriate attribution of care when multiple providers are involved; and the Secretary of HHS must give physicians timely performance feedback.

Data elements—to the extent that scientifically sound measures exist—will include:

- quality, patient satisfaction, and health outcomes information on Medicare physicians
- physician care coordination and risk-adjusted resource use
- safety, effectiveness, and timeliness of care.

Physicians who successfully interact with this program will likely be those who have a robust EHR system.

If this and other elements of the Affordable Care Act become real, however, we'll likely see a fundamental shift in the kinds of settings in which ObGyns and other physicians opt to practice. ☹

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## Demise of the solo doctor

By Parija Kavilanz @CNMoney July 11, 2012: 11:45 AM ET

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Independent doctors are closing up shop or going to work at hospitals or bigger group practices where they aren't directly responsible for overhead costs.

**NEW YORK (CNMoney) --** The solo doctor is a vanishing breed.

Squeezed by high costs and shrinking insurance reimbursements, independent doctors are closing up shop or going to work at hospitals or bigger group practices where they aren't directly responsible for overhead costs.

Fresh insight on the trend came this week in a report from one of the country's largest physician recruiting firms.

The finding: By 2014, two-thirds of the nation's nearly 1 million doctors will be employed by hospitals.

As hospitals staff up, they are plucking off physicians who once ran independent practices but couldn't afford to stay in business, said Travis Singleton, senior vice president with Merritt Hawkins, a physician recruiting and consulting firm that did the survey.

"Our projection reaffirms the trend that fewer and fewer doctors are going into solo practice or staying in solo practice," said Singleton.

Merritt Hawkins conducts about 3,000 searches annually on behalf of hospitals, group practices, small independent practices and community health centers.

**Related: Doctors in America are going broke**

In 2011, Singleton said just 1% of all searches it conducted for its clients were for solo physicians, down from 22% in 2004.

"This is the lowest level in the 28-year history of our firm," said Singleton.

"It shows that no one wants to hire a solo doctor, no one wants to be a solo doctor. This is a dying breed of physician that is quickly disappearing from the American landscape," he said.

This is not a new trend. More than half of practicing physicians are employed by hospitals, a figure that has doubled over the last decade, according to Dr. Robert Kocher, who wrote an article on the issue last year in the *New England Journal of Medicine*.

"Hiring of physicians by hospitals definitely accelerated since 2008 as the economy weakened, reimbursements to doctors were shrinking and health reform passed," said Kocher, a partner with venture capital firm Venrock and a former Obama administration health care official.

The Merritt Hawkins' survey also showed that 63% of all of Merritt Hawkins' searches in 2011 were for hospitals looking to hire more doctors, up from 56% in 2010 and compared to a much lower 11% in 2004.

If this pattern continues, the firm also estimates that more than 75% of newly hired physicians will be employed by hospitals within two years.

How a "solo" doctor practices today is dramatically different from 20 or 30 years ago.

"Back then, the solo doctor was truly independent," explained Singleton.

"They had the financial means to pick a place, set up their office, hire their staff and get going."

But the economics of delivering health care have changed considerably over the years, making it much more expensive for doctors to run an independent office.

"These doctors have to pay their employees, pay for the infrastructure, legal compliance and new IT requirements that the government has mandated," Singleton said.

And as their business costs keep going up, doctors aren't seeing more money coming in. "Their reimbursements from insurers are either going down or staying steady," he said.

**Related: Doctors explain why they can't stay afloat**

The closing of independent practices hurts rural **communities** outside the reach of large hospitals particularly hard.

What's more, young doctors joining the profession aren't enthusiastic about solo practice either, said Singleton.

"This new generation wants to have a quality of life instead of money problems and a large caseload of patients," he said. ■

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## A Small Business Plan All Can Agree On, Right? by Chairman Sam Graves



As the nation debates solutions to our stagnant economy and continuing unemployment crisis, more elected leaders now agree that small-business growth plays a crucial role in job creation. An estimated 27 million small businesses employ more than half the country's private-sector workforce, creating 60 percent to 70 percent of all new jobs.

Congress has been debating various proposals aimed at helping small business — lower taxes, fewer regulations, greater access to credit.

But one issue offers a sure way to provide more opportunities: government contracting.

The federal government spends a half-trillion dollars on contracted goods and services. This offers small companies an extremely large market to provide services and products. With the federal government as a customer, small firms can grow and create jobs. When a large company wins a federal contract, it usually has the resources to do the work.