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

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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 61percent.

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 (ACOFP) 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.