



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.