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OREGON STATE SENATE

Testimony/Presentation Public Hearing for SB 28-1.
Save Primary Care with Basic Fairness Act
Senate Health Care, 4/3/25

Primary Care

Primary care is foundational to our health care system. Access to regular sources of primary and preventive care have long lasting positive effects on overall population health, early detection and treatment of disease, chronic disease management, and health equity.

Independent primary care clinics are integral parts of the healthcare landscape and allow physicians to practice the way they choose, be nimble and pivot when needed, and innovate to take better care of their patients[1]. Independent practices also decrease healthcare spending compared with larger clinics.[2]

It is not a secret that pediatricians and other primary care specialties like Family Medicine are among the lowest paid specialties and that this is exacerbating primary care shortages across the country. Folks are literally leaving this type of practice. We are not immune to this issue in Oregon: it is estimated that Oregon will need a 40% increase in primary care providers in the next 10 years to meet the state's growing needs.[3]

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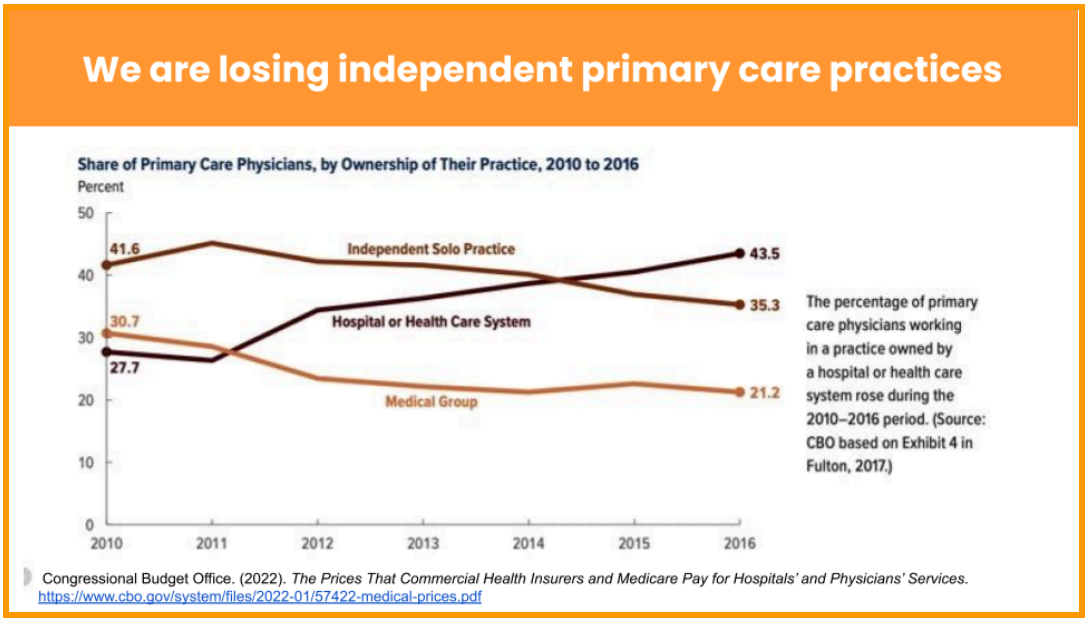
[1] Weinberg, A. (2023). Independent practice is the secret to surviving and thriving in primary care. *Medical Economics Journal*, 100(9), 29-30. https://www.medicaleconomics.com/view/independent-practice-is-the-secret-to-surviving-and-thriving-in-primary-care

[2] Gibbons, J.B., Chang, C.H., Banerjee, M., Meddings, J. Norton, E.C., Chen, L., & Bynum, J.P.W. (2022). Small Practice Participation and Performance in Medicare Accountable Care Organizations. *The American Journal of Primary Care*, 28(3), 117-123. *https://doi.org/10.37765/ajmc.2022.88839*

[3] Hernandez, R. (2024, Nov 26). Oregon providers and advocates share more on primary care physician shortage. *Oregon Public Broadcasting*. https://www.opb.org/article/2024/11/26/think-out-loud-oregon-providers-advocates-physicians-shortage/

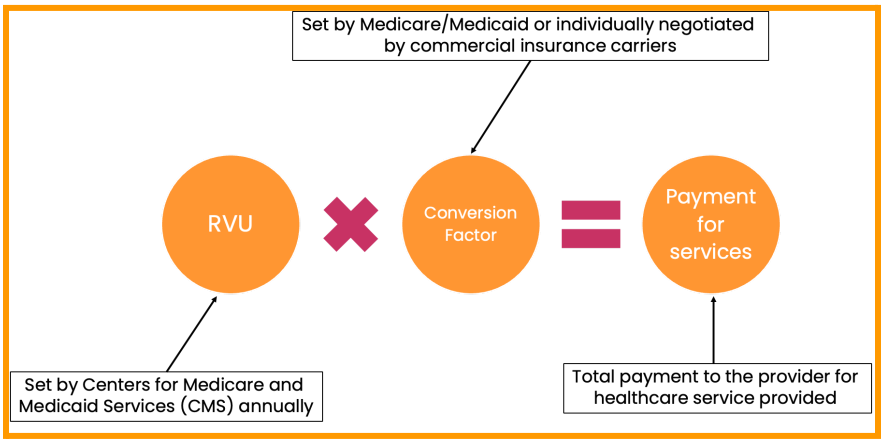


The business of medicine

Within my own practice, I am able to decide how many patients I see in a day, and my physician partners and I make frequent decisions about how we run our clinic so that our patients receive the best care possible.

Of course, we also have to consider how to keep our doors open and our business sustainable and must retain our superb staff, pay a good wage with benefits, and provide a pleasant, safe, and clean clinic for our patients.

Balancing the books is getting more challenging over time with increasing financial pressures and costs to keep the clinic operational. Our reimbursement - our revenue - is not keeping pace. In patients for whom we are paid "fee-for-service" (we see a patient, then bill for the visit), there is a cumbersome system that calculates our payment.



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This complex system, originally designed by the Centers for Medicare and Medicaid Services (CMS), places relative value on a service provided based on (supposedly) how much time and effort a clinician spends, and the resources, staff time, and equipment used in delivering that billable visit/service. The goal in creating this system was to use a standardized way to try to cover the cost of providing the service. However, this system has resulted in procedures and surgeries being assigned higher value and therefore higher payment than primary and preventive health care, even if the time involved is similar. The relative value unit (RVU) is the measure of value assigned to a specific diagnosis code (like "well child visit" or "management of a broken arm"). This is then multiplied by a conversion factor (a dollar amount) to get the amount paid for that visit. [4]

Both public (Medicaid/Medicare) and private (commercial) insurers use this system, but the conversion factor is (mostly) negotiated by CMS for the public plans, and are individually negotiated by single or groups of providers or entire hospital systems for private plans.

In private plans, the **conversion factor is highly variable** depending on where the patient is receiving care. Even for the exact same care. The bigger the practice or system, the greater their negotiating power and the higher the conversion factor (and the more they get paid by insurance carriers).[5]

For example, OHSU, as a large hospital system has negotiated to get paid commercial rates for their Medicaid patients, more than any other system or clinic in Oregon.

Hospital based clinics are able to negotiate a higher CONVERSION factor for the visits in their facilities than my independent group of pediatricians can AND in addition to that, they are also able to charge a facility fee, or surcharge, for using their clinic space within the hospital system.

Independent clinics - such as the one I work at - cannot charge a facility fee, and can only charge the basic fee of RVU x Converstion factor for the doctor to see the patient. This means that charging facility fees, AND getting higher negotiated rates in addition, **makes hospital based clinics able to collect much more revenue than independent practices for the same care** and makes the independent primary care practices more vulnerable to the increasing financial stresses of delivering patient care in this healthcare environment. For primary care providers, this gap can be up to $63,000 per year.[6]

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[4] American Association of Professional Coders. (2023). *What are relative value units*? https://www.aapc.com/resources/what-are-relative-value-units-rvus?srsltid=AfmBOoo8WtqiP5akh6nOtpZvGRenv0_1_zMJg-edosTRXno4J78Kp0nL

[5] Congressional Budget Office. (2022). *The Prices That Commercial Health Insurers and Medicare Pay for Hospitals' and Physicians' Services*. https://www.cbo.gov/system/files/2022-01/57422-medical-prices.pdf

[6] Lagasse, J. (2021). A large pay gap exists between independent and hospital-employed doctors. *Healthcare Finance News*.

Currently, **independent primary care providers** are experiencing increasing financial stressors in the face of poor payment compared to their counterparts in large hospital systems, making it **more difficult to maintain a clinic that is financially solvent and stable.** These payment gaps have an additional effect of increasing healthcare consolidation as more independent practices are being taken over by hospital systems (and private equity). This healthcare consolidation decreases price competition, increases the hospital system's market share and power further, and increases overall healthcare spending.

I am seeking a modest but meaningful, fairly simple, fairness intervention. And it has no fiscal:

REQUIRE that private insurance companies use the hospital based CONVERSION factor to reimburse primary care providers for the same care.

This will increase revenue for independent primary care providers for about 25% of their patient visits.

The good news is that improving parity in payment between hospital systems and independent primary care providers will not cost the state anything and will serve to drastically improve the stability and long term sustainability of independent practices, which is better for the patients and communities they care for.

Thank you

https://www.healthcarefinancenews.com/news/large-pay-gap-exists-between-independent-and-hospital-employed-doctors

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