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March 10, 2026

The Honorable Jason Smith
Chairman

United States House Committee on Ways & Means
1139 Longworth House Office Building
Washington, DC 20515

The Honorable Richard E. Neal
Ranking Member

United States House Committee on Ways & Means
1139 Longworth House Office Building
Washington, DC 20515

The Honorable Brett Guthrie
Chairman

United States House Committee on Energy & Commerce
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Frank Pallone, Jr.
Ranking Member

United States House Committee on Energy & Commerce
2125 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Smith, Ranking Member Neal, Chairman
Guthrie, and Ranking Member Pallone:

We appreciate your committees' focus on making health care more affordable for American patients, employers, and taxpayers. As you continue your work toward that end this year, we encourage you to modernize the Medicare physician fee schedule, implement policies that enable site-of-care optimization, and reform the federal 340B drug pricing program.

The [American Independent Medical Practice Association](#) represents more than 600 independent medical practices in 46 states and the District of Columbia. AIMPA advocates on behalf of over 12,000 physicians who provide high-quality, affordable health care for approximately 25 million patients each year.

The future of independent physician practice is at risk. Today, large hospitals and health systems employ [roughly half](#) of all physicians, compared to about [one-quarter](#) in 2012. Between 2019 and 2024, hospitals acquired about [7,600](#) physician practices.

Such hospital-driven consolidation reduces competition, drives up costs, and limits patients' choices in where they can seek care. In many communities, consolidation leads to the closure of local clinics, forcing patients to travel farther for care -- or forgo it altogether.

Hospitals have been able to consolidate local markets because they enjoy regulatory advantages that enable them to charge considerably more than independent physician practices for the same tests, scans, and procedures.

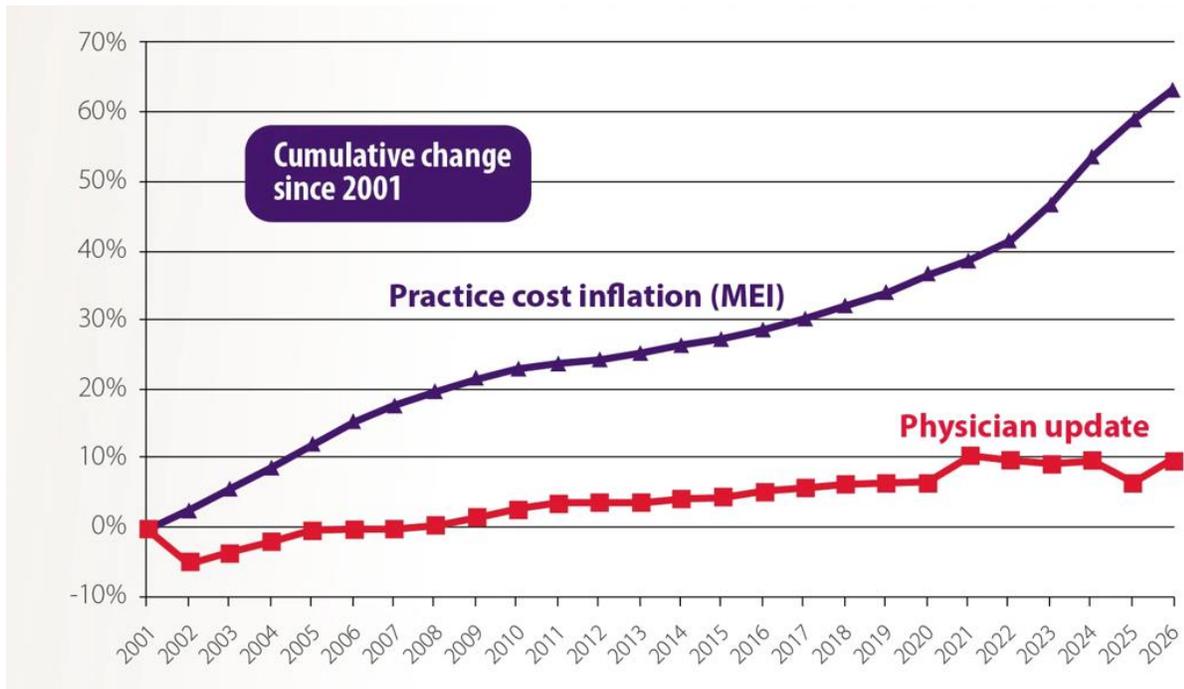
Ensuring that independent physician practices can compete with hospitals on a level playing field would reduce costs for patients, employer-sponsored plans, and federal programs like Medicare. It would also expand patient choice and access to affordable, high-quality care.

Medicare Physician Fee Schedule Reform

One of the structural advantages hospitals enjoy over independent physicians is that Medicare automatically adjusts hospital reimbursement for inflation. It does not do the same for physicians.

In nominal terms, the costs associated with running a physician practice -- staffing, rent, insurance, and other core expenses -- have soared in recent decades. But Medicare physician reimbursement has only increased modestly. After accounting for inflation, Medicare payments to physicians actually *declined* [33%](#) between 2001 and 2026.

Medicare Physician Updates Compared to Inflation in Practice Costs (2001-2026)



Credit: [American Medical Association](#)

These real declines in reimbursement have forced many independent physicians to close their practices or sell to larger entities, including hospitals.

The one-time [2.5% increase](#) in Medicare physician reimbursement that took effect this year was welcome as a response to a comparable decrease in reimbursement for physicians in 2025. But a more durable fix is needed.

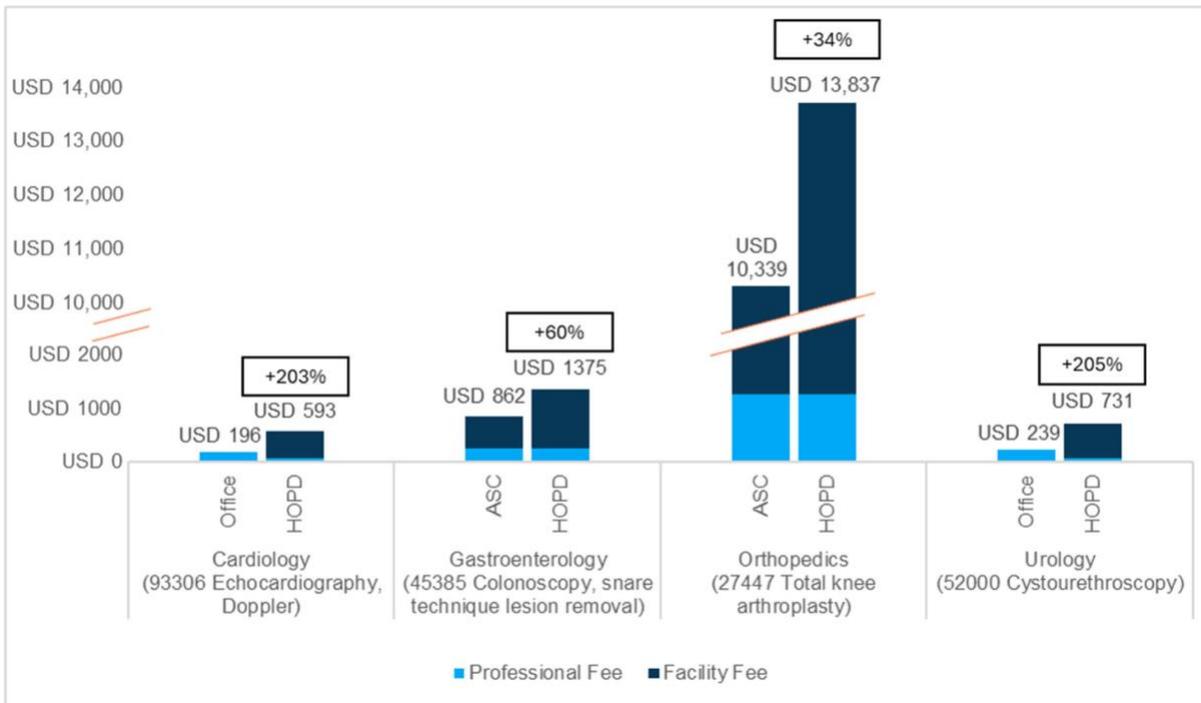
Permanently indexing Medicare physician reimbursement to inflation would offer independent practices a degree of financial certainty that would enable them to invest in their practices, hold off the acquisitive overtures of hospitals, and keep serving their communities.

Lawmakers from both parties have shown interest in addressing this issue. The [Strengthening Medicare for Patients and Providers Act](#), introduced in the House in November 2025 as H.R. 6160, would permanently peg physician reimbursement under the Medicare program to the Medicare Economic Index, a measure of practice cost inflation. That bill deserves to become law.

Site-of-Care Optimization

Medicare has long provided higher reimbursement for identical care delivered in a hospital outpatient department than in a physician office or ambulatory surgery center. For example, research published in the peer-reviewed *Journal of Market Access and Health Policy* in July 2025 found that Medicare reimbursement for a knee replacement is 34% higher in a hospital outpatient department than in an ASC. Medicare reimbursement for other common procedures can be 1.2 to 8.6 times higher in the hospital outpatient setting.

Reimbursement for HOPD vs. lowest-cost site of care (ASC or office) for highest-volume selected procedure per specialty, Medicare (2024)



Credit: *Journal of Market Access and Health Policy*

This disparity is helping to fuel consolidation, as hospitals use their revenue premium to buy up competing independent physician practices -- and force more patients to seek care in the higher-cost settings the hospitals operate.

The disappearance of independent physician practices -- and the concomitant migration of care into hospital settings -- have significant implications for our healthcare system.

The July 2025 *Journal of Market Access and Health Policy* study found that independent physicians were far more likely to deliver care in the lower-cost office or ASC setting than their hospital-affiliated peers were. Similarly, hospital-affiliated physicians were far more likely to perform procedures and services in the higher-cost hospital outpatient department than in the lower-cost office or ASC setting.

As hospitals grow to dominate local healthcare markets, overall costs for patients and payers increase not just because of decreased competition but because hospital-affiliated physicians tend to deliver care in higher-cost environments.

Adopting site-neutral payments -- that is, paying hospitals and independent practices the same amount for the same care -- will reduce the perverse financial incentive for hospitals to acquire independent practices and help stop this vicious cycle of shifting care into settings that cost patients and taxpayers more.

Site-neutral payment enables "site-of-care optimization" -- delivering healthcare services in the lowest-cost setting that can safely and effectively provide them.

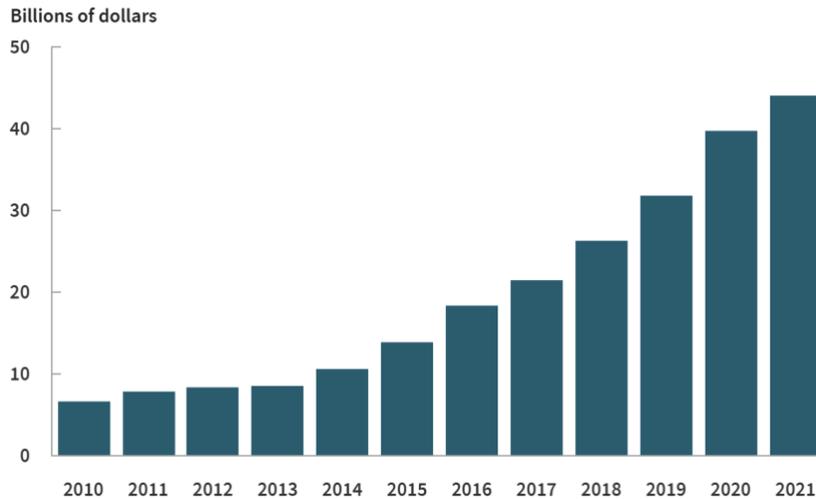
The Centers for Medicare and Medicaid Services have been steadily working to equalize payments for certain services across sites of care. Congress should codify those changes -- and ensure that Medicare pays the same for procedures and services regardless of where they're performed.

340B Reform

The 340B drug pricing program allows thousands of hospitals to purchase drugs at steep discounts, bill insurers for them at marked up prices, and pocket the spread as profit. This gives hospitals a significant competitive advantage over independent physician practices, which don't qualify for 340B.

When Congress created the 340B program in 1992, lawmakers never intended, or envisioned, that most currently-enrolled hospitals would qualify. In fact, Congress initially expected only about 90 hospitals to participate in 340B. But over 2,600 hospitals are currently enrolled. As a result of this exponential growth in enrollment, 340B drug purchases increased from approximately \$6.6 billion in 2010 to nearly \$44 billion by 2021, according to a recent Congressional Budget Office report.

Spending on Drugs Purchased Through the 340B Program, 2010 to 2021



Credit: [Congressional Budget Office](#)

Discounted purchases through 340B have continued to grow exponentially, exceeding [\\$81 billion in 2024](#).

Lawmakers assumed that hospitals would use their 340B proceeds to subsidize care for low-income or underserved patients. Instead, many hospitals are using those proceeds to line their own pockets and finance strategic expansion. That growth frequently involves acquiring independent physician practices and converting them into outpatient departments or subsidiary sites that qualify for 340B pricing.

The result is fewer independent practices and choices for patients -- and higher overall costs for Medicare, private insurers, and families.

Meaningful 340B reform is needed to curb these incentives. Current program rules do not require hospitals to use 340B revenue for charity care and maintain loose eligibility standards that allow large, well-resourced hospitals to qualify for the program. Reforming both of these provisions -- as legislation like [H.R. 5256](#), the [340B ACCESS Act](#) seeks to do -- could help curtail spending and protect independent physician practices.

Indeed, savings from reform of 340B as well as the enactment of site-neutral payment in Medicare could help fund a permanent inflation adjustment for the Medicare physician fee schedule.

We thank you for your attention to these crucial reforms, and we welcome the opportunity to serve as a resource and answer any questions you may have.

Sincerely,



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Chair, Federal Health Policy
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CC: The Honorable Mike Johnson, Speaker of the U.S. House of Representatives
The Honorable Hakeem Jeffries, Minority Leader, U.S. House of Representatives
The Honorable John Thune, Majority Leader, U.S. Senate
The Honorable Charles E. Schumer, Minority Leader, U.S. Senate
The Honorable Mike Crapo, Chairman, U.S. Senate Committee on Finance
The Honorable Ron Wyden, Ranking Member, U.S. Senate Committee on Finance
The Honorable Bill Cassidy, Chairman, U.S. Senate Committee on Health, Education, Labor & Pensions
The Honorable Bernie Sanders, Ranking Member, U.S. Senate Committee on Health, Education, Labor & Pensions