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American Independent Medical Practice Association®

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VIA ELECTRONIC MAIL

The Honorable Ron Wyden
Ranking Member
Committee on Finance
United States Senate
Washington, DC 20510

Dear Senator Wyden:

On behalf of the [American Independent Medical Practice Association](#) (AIMPA), thank you for the opportunity to respond to [Health Coverage That Works for Everyone](#), your Request for Information on healthcare reform. AIMPA is a physician-led national advocacy organization representing more than 14,000 physicians in 2,000 independent medical practices that care for more than 40 million patients each year across 48 states and the District of Columbia.

AIMPA supports your goal of expanding access to high-quality, affordable health coverage and medical care. Independent medical practices are essential to achieving that goal. They deliver care in patients' communities, often at substantially lower cost than hospital outpatient departments, and provide an important competitive alternative to hospitals, health systems, and insurer-owned provider groups.

AIMPA brings a distinctive perspective to this discussion. We are the country's first national, multi-specialty advocacy organization representing the voice of physicians in independent practices who care for patients in the fields of primary care and internal medicine, cardiology, dermatology, gastroenterology, medical oncology, nephrology, ophthalmology, orthopedics, otolaryngology, reconstructive surgery, urology, women's health, and other

specialties. Every day, physicians in independent practice experience the rewards of forging personal relationships with their patients, tailoring care to their individual needs, and helping people live healthier lives. They also confront economic, administrative, and structural pressures that have made independent practice increasingly difficult to sustain.

AIMPA focuses its comments on the discussion of private investment and corporate involvement in medicine on pages 72 and 73 of the RFI and the related discussion of vertical integration on pages 74 through 76. Those sections raise a central question. Will policymakers treat all forms of corporate investment and support of healthcare provider entities alike, or will they ensure that independent practices have the ability to obtain critically needed financial and business support to remain a viable access point for high-quality, affordable care in communities across the country and resist further consolidation of care in hospitals, health systems, and vertically integrated insurance companies?

Independent practices are under extraordinary pressure. Medicare physician payment has declined roughly [33%](#) since 2001 after accounting for inflation, even as the costs associated with operating a medical practice have risen.

Independent practices must also compete with hospitals and health systems that enjoy greater negotiating leverage with payers and suppliers, more extensive administrative infrastructure, and higher Medicare reimbursement for many of the same services.

These pressures have reshaped American medicine. The share of physicians working in private practice fell from [60.1% in 2012 to 42.2% in 2024](#) -- representing roughly 80,000 fewer physicians in private practice.

For many physicians, a partnership with a management services organization (MSO) offers a way to remain independent in the face of these structural disadvantages. Independent practices can rely on their MSO partners to help them recruit physicians; open new clinical facilities in underserved communities; adopt technologies that improve care; provide access to cancer treatment, clinical trials, and cutting-edge diagnostic services and procedures closer to patients' homes; and manage administrative work that takes physicians and other clinicians away from patients. And they can obtain this critically needed business support while preserving their physicians' clinical autonomy in caring for their patients. Without protecting these models, even more care will consolidate in

vertically integrated hospitals and insurance companies. That would spell the end of independent practice in our country.

MSO partnerships benefit patients and preserve competition

Recent studies show that Medicare spending declines after practices affiliate with MSOs and that independent practices affiliated with MSOs are more likely to furnish care in lower-cost settings.

A [2024 Avalere analysis](#) of Medicare beneficiaries in five specialties found that, in the first year after physicians moved from unaffiliated private practice to affiliation with a private equity-backed MSO, total Medicare expenditures declined by a weighted average of \$963 per beneficiary per year. By contrast, expenditures increased by \$1,327 per beneficiary per year in the 12 months after physicians moved from an unaffiliated private practice to a hospital-affiliated practice.

A [2025 peer-reviewed study](#) compared where 32 high-volume procedures across four specialties were furnished under four practice-affiliation models. Independent physicians in practices affiliated with private equity-backed MSOs were most likely to furnish 29 of the 32 procedures in the lowest-cost setting, which in every instance was either a physician office or an ambulatory surgery center (ASC). Weighted across the four specialties, beneficiaries attributed to independent physicians whose practices were affiliated with PE-backed MSOs had a 63% risk-adjusted probability of receiving the selected procedure in the lowest-cost setting, compared with only 37% for beneficiaries attributed to hospital-affiliated physicians.

A [Government Accountability Office review](#) published last year found that "physician consolidation with hospital systems can lead to increased spending and prices." The review cited several studies showing "increased Medicare spending due to services being provided in more expensive hospital-based settings and increases to prices paid by commercial insurers following hospital-physician consolidation."

GAO concluded that such consolidation "generally resulted in no changes in the quality of care." But its review of the literature did include two studies that suggested that hospital-physician consolidation can lead to lower-quality care.

Taken together, these findings show why organizational structure matters. Partnering with an MSO can help an independent practice reduce spending and furnish more care in lower-cost settings. Hospital acquisition can increase spending without reliably improving quality. Policymakers should not treat these models alike. For many physician-owned practices, business support from an MSO is a critical lifeline that enables them to resist acquisition by hospitals, health systems, and insurers.

The same distinction is essential when considering the [Senate Budget Committee's bipartisan 2025 report](#) on private equity in healthcare. The RFI observes a growing trend of private equity-backed firms purchasing healthcare facilities. The Committee examined exactly that form of investment -- private equity acquisition and ownership of hospital corporations, including Prospect Medical Holdings and Lifepoint Health. It found that investors earned millions while hospitals experienced understaffing, health and safety violations, reduced quality of care, and closures.

Financial investment in an MSO is fundamentally different. The physician practice remains independently owned by physicians, who retain complete authority over clinical care. The MSO provides nonclinical business support that helps the practice survive and remain independent. Evidence of harm arising from private equity ownership and control of hospitals should not be treated as evidence against independent practice-MSO partnerships that preserve physician ownership, clinical autonomy, and competition.

Expanding access and sustaining care in underserved communities

The benefits that MSO partnerships offer independent physician practices are visible in communities across the country. Consider just a few examples from the independent practices whose physicians AIMPA represents.

One practice in South Bend, Ind., reports that its MSO partnership enabled it to survive rather than close or join one of two large health systems. When the largest local system stopped accepting Medicaid patients through its primary care practices, the independent practice continued to serve them.

In Ohio, MSO support has enabled independent gastroenterology practices to expand community-based infusion services for patients with Crohn's disease and ulcerative colitis, giving more patients a convenient, lower-cost alternative to receiving that care in hospitals. In California, an independent oncology practice

recruited a new provider and opened a clinic in Santa Clarita in less than a year, bringing cancer care closer to patients, including many enrolled in Medi-Cal. In New York, an independent oncology practice reports that support from its MSO partner enables it to accept every insurance plan, making it the only major cancer-care provider in its market to do so.

Providing more care in convenient, lower-cost settings

MSO partnerships help independent practices provide more care in physician offices and ambulatory surgery centers, giving patients convenient, lower-cost alternatives to hospital outpatient departments.

With support from its MSO partner, an independent Connecticut orthopedic practice launched a same-day outpatient total-joint program. In Massachusetts, an independent urology practice introduced prostate artery embolization -- a minimally invasive alternative to surgery with lower costs and a shorter recovery -- and expanded the service to a second community.

Across an MSO-supported network encompassing more than 2,000 independent women's health practices in 26 states, practices perform 59% of eligible procedures in the office -- more than twice the industry average of 27% -- placing substantially more care in convenient, lower-cost settings.

Improving quality and bringing advanced care closer to patients

Independent practices and their MSO partners can build clinical data systems, quality programs, and technological capabilities that would be difficult for a stand-alone practice to develop on its own.

MSO-supported independent gastroenterology practices analyzed data from nearly 3 million patients to develop care-management tools to improve outcomes and reduce avoidable emergency-department visits. Other independent practices, with support from their affiliated MSOs, have deployed AI-assisted polyp detection, advanced genetic testing, and same-day mammography in community settings.

MSOs can also provide the personnel, regulatory support, data systems, and sponsor relationships that enable practices to expand access to clinical trials in patients' communities. Thanks to that kind of support, an independent urology practice in Michigan has been able to maintain one of the nation's largest community-based urology research programs and launch certain clinical trials in

roughly 90 days, compared with one to two years at many academic medical centers.

Patients can gain access to promising therapies earlier and closer to home -- including patients whose jobs, transportation needs, or caregiving responsibilities might otherwise prevent them from participating.

Policies that would undermine independent practice

1. The Stop Corporate Takeovers of Physicians Act

Pages 72 and 73 of the RFI seek feedback on limiting corporate and private-equity involvement in healthcare through restrictions similar to those enacted in Oregon. After the RFI was issued, Senators Warren, Wyden, and Merkley introduced the [Stop Corporate Takeovers of Physicians Act of 2026](#), which would translate Oregon's approach into a sweeping federal framework -- and render many of the MSO-practice partnerships on which independent physicians rely unworkable.

AIMPA unequivocally supports the principle that physicians -- not MSOs, investors, hospital corporations, insurers, or other unlicensed actors -- must have the first and last word in clinical care. But the bill extends far beyond protecting clinical autonomy. Its practical effect would be to deny many independent practices the support they need to recruit clinicians, participate in insurance networks, open and staff community clinics, invest in technology, offer cutting-edge therapies, and participate in value-based care arrangements.

Practices deprived of that support would not become more independent. Some would close clinics and ASCs, reduce services, stop accepting lower-paying insurance plans, or leave the market. Others would have little choice but to sell to hospitals or insurers that can offer them the administrative infrastructure and financial resources no longer obtainable through an MSO affiliation.

The consequences would ripple throughout the healthcare system, even to practices without MSO partners. Primary care physicians frequently rely on independent community specialists to provide timely, affordable care close to home. If those specialists close or are absorbed by hospital systems, more patients will be sent to hospital-affiliated providers farther away, often at greater cost and after longer waits. That shift would reduce patient choice, increase spending, and place additional demands on hospital capacity.

The bill would give hospitals a license to consolidate

The legislation's treatment of hospitals makes its approach especially difficult to justify. It exempts hospitals, hospital-affiliated clinics, critical access hospitals, and rural emergency hospitals from its central prohibition on corporate ownership of practices and employment of physicians.

Hospitals are responsible for much of the consolidation that has plagued the healthcare market and attracted concern from policymakers. As of [January 2026](#), hospitals employed nearly six out of ten physicians. Between 2018 and 2026, they acquired approximately 32,800 additional physician practices and added 181,200 employed physicians.

The share of physicians affiliated with private equity-backed MSOs is minuscule by comparison. Among the five specialties examined by [Avalere](#), only 6% of Medicare-billing physicians were affiliated with PE-backed MSOs in 2022. Forty-five percent were affiliated with hospitals.

The bill would allow hospitals to continue purchasing practices while eliminating an important alternative to hospital acquisition -- a one-way ratchet toward further consolidation.

That outcome is not in patients' interests. By employing physicians, hospitals can influence referral patterns and keep services within the facilities they control, even when competing alternatives may be more convenient and more affordable.

A patient's right to care guided by a physician's independent professional judgment should not be contingent upon the setting in which that physician practices. Yet the bill would subject physician-led independent practices to structural restrictions from which hospital-affiliated practices are exempt.

That does not protect clinical autonomy evenly; it creates a competitive preference for hospital ownership.

Congress should preserve state authority over CPOM policy

States have historically regulated the corporate practice of medicine (CPOM) in ways that reflect the unique needs of their residents. The challenges a rural state with persistent provider shortages faces are not identical to those a densely populated state with several competing health systems faces.

The Stop Corporate Takeovers of Physicians Act would nevertheless establish an Oregon-style national floor and displace the judgments of states that have chosen more tailored approaches.

[California](#) and [Vermont](#) enacted laws in 2025 and 2026 that focused on protecting clinical decision-making while preserving access to nonclinical business support. Oregon-style proposals imposing broader structural restrictions on ownership, governance, and contractual arrangements were introduced in [Washington](#) and [Rhode Island](#). Those measures did not receive a vote on the floor of either chamber of those states' legislatures before their 2026 legislative sessions ended -- and were not enacted.

The varied approaches across the country -- and the continuing debate in states that have considered but not enacted broader restrictions -- underscore why CPOM policy has historically been entrusted to state legislatures, which are best positioned to exercise reasoned judgment in light of local conditions, experience, and healthcare needs. Congress should preserve that authority rather than establish Oregon's unusually restrictive approach as a national rule.

2. Transparency should serve patients and apply equally across the healthcare system

The RFI asks whether healthcare investments made by private equity should be reported to a centralized, publicly available database. AIMPA does not believe that a database limited to private equity transactions would materially help patients. It would duplicate information already submitted to regulators and impose additional costs without necessarily providing useful information about the price, quality, or availability of care.

Transparency requirements should instead focus on information patients can use to make informed decisions. Data on price and quality across various sites of care can help patients compare options and choose the care setting that best meets their needs.

Any new requirements should also apply equally across the healthcare system. Hospitals, health systems, insurers, insurer-owned providers, nonprofit entities, physician groups, MSOs, and other market participants should be subject to comparable standards. Policymakers should not single out one organizational model or source of capital.

Policymakers should make full use of information already submitted to federal and state regulators and avoid duplicative requirements whose costs ultimately fall on practices and patients.

3. Insurer-provider integration threatens patients and independent physicians

Insurer-provider integration presents a distinct and serious threat to patients and competition because it can give a single conglomerate control over both the financing and delivery of care. Vertically integrated insurers can design benefits, determine network participation, adjudicate claims, establish reimbursement, and furnish the care for which they are paying. Those powers create opportunities to steer patients to affiliates, exclude independent practices, favor affiliated providers through reimbursement, and move revenue among related entities in ways that obscure profits or circumvent medical-loss-ratio safeguards.

Those incentives are fundamentally different from the support MSOs provide to physician-owned independent practices. MSOs do not control patients' health benefits, design provider networks, adjudicate claims, or determine what independent competitors will be paid.

Congress should preserve the distinction between insurer-provider conglomerates and MSO-supported independent practices as it considers the Stop Corporate Takeovers of Physicians Act, the Break Up Big Medicine Act, the Patients over Profits Act, and related proposals. Definitions of ownership, affiliation, and control should not reach physician-led practices merely because they receive administrative, technological, financial, or supply-chain support from an MSO. Curtailing those partnerships would weaken one of the few remaining competitive alternatives to hospital and insurer ownership.

Conclusion

AIMPA applauds your focus on expanding access to high-quality, affordable care and building a healthcare system that works better for patients. Achieving those

goals requires policymakers to distinguish consolidation that reduces competition from mechanisms that help physician-led practices remain independent.

For thousands of physicians, an MSO partnership is not a surrender of independence; it is what makes independence possible. These partnerships help medical practices remain open, recruit specialists, bring clinical trials and advanced technologies into local communities, participate in value-based care, and provide more services in convenient, lower-cost settings -- all while physicians retain complete authority over patient care.

AIMPA urges Congress to respect the traditional role of states in regulating CPOM; confront consolidation driven by hospitals and insurers; apply transparency requirements equally across the healthcare system; and protect MSO partnerships that enable physician-led practices to compete. Oregon-style federal restrictions would instead deprive independent practices of an alternative to hospital or insurer acquisition and risk accelerating the consolidation policymakers are seeking to curb.

AIMPA would welcome the opportunity to discuss these issues with you and your staff and to connect you with physicians who can describe how partnerships between their independent practices and MSOs have benefited their patients and communities.

Sincerely,



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