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Before the United States Senate Special Committee on Aging

Hearing: The Doctor Is Out: How Washington's Rules Drove Physicians Out of Medicine.

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I. Introduction and Credentials Chairman, Ranking Member, and Members of the Committee:

My name is Lee S. Gross, MD. I am a family physician and have practiced full time in Southwest Florida for more than twenty years.

I currently serve on the Florida Board of Medicine. This testimony reflects my personal experience and views and does not represent the official position of the Florida Board of Medicine or the State of Florida.

I am the founder of Epiphany Health, one of the earliest Direct Primary Care practices in the United States. I also serve as President of the Docs 4 Patient Care Foundation, a national physician-led organization focused on healthcare policy and workforce sustainability.

Thank you for the opportunity to testify on how Medicare's expanding regulatory framework is accelerating physician burnout, driving consolidation, and worsening access to care for America's seniors, particularly in rural and underserved communities.

II. The Collapse of Independent Medical Practice Independent physician practices have long served as the backbone of American medicine. They deliver continuity, accountability, and relationship-centered care that is especially critical for older adults managing chronic illness.

That foundation is rapidly disappearing.

Across the country, independent practices are closing or being absorbed by hospitals, private equity firms, and large corporate health systems. While many forces influence consolidation, Medicare's regulatory structure has become a dominant and accelerating factor for small and rural practices.

This shift is not being driven primarily by patient preference, quality concerns, or clinical outcomes. It is driven by federal payment structures and regulatory requirements that impose administrative costs unrelated to patient care and largely independent of practice size.

In my own community, my partner and I ultimately became the last remaining independent primary care practice in a rapidly growing city that has expanded to more than 90,000 residents. Every other practice either acquired or closed, overwhelmed not by lack of demand, but by compliance burdens that had little to do with medicine itself.[1]

III. Medicare's Administrative Burden Medicare regulations now permeate nearly every aspect of clinical practice.

Physicians must comply with complex coding systems, documentation rules, multiple quality reporting programs, audit exposure, and continuously evolving compliance requirements. Each program may appear reasonable in isolation. In combination, they consume an extraordinary share of physician time and practice resources.

The consequences are well documented: · Physicians spend hours each day on documentation rather than patient care · Practices must hire staff whose sole role is compliance · Small offices face disproportionate financial strain · Burnout accelerates early retirement and reduced clinical hours

These pressures have intensified in recent years, accelerating early retirement, part-time practice, and physician exit.

For many primary care practices, the administrative cost of participation now exceeds the marginal clinical revenue generated by additional patient visits.

When each additional unit of work produces a net loss, increased volume accelerates failure rather than sustainability.

IV. Mismatch Between Medical Training and Practice Reality Compounding these pressures is a growing mismatch between how physicians are trained and the regulatory environment in which they are expected to practice.

Medical education prepares physicians to diagnose and treat illness, but provides little to no training in practice operations, regulatory compliance, billing systems, human resources management, or administrative risk mitigation.

New physicians enter the workforce clinically competent but structurally unprepared to operate small or rural practices under Medicare's expanding regulatory framework.

As complexity increases, and training costs rise, independent practice becomes not merely unattractive, but functionally inaccessible for early-career physicians. Employment within large health systems becomes the default path, not by preference, but by necessity.

This structural mismatch contributes directly to consolidation and explains why retiring physicians are not being replaced by new independent practices, particularly in rural and underserved communities.[2]

V. Medicare Payment Instability and Workforce Exit Administrative burden alone places enormous strain on independent practices. Payment instability compounds that strain.

During the years governed by the Sustainable Growth Rate formula, Medicare payment policy was characterized by repeated cycles of proposed deep cuts followed by last-minute

congressional intervention. While those cuts were often delayed or reversed, the uncertainty surrounding them created significant operational risk for small physician practices.

In my own practice, these recurring payment cliffs made long-term planning nearly impossible. The uncertainty forced me to take out personal loans simply to ensure payroll continuity while awaiting congressional action. Staff salaries, rent, and operating expenses could not be paused while Washington debated whether scheduled cuts would take effect.

Although many reductions were ultimately averted, the brinksmanship itself imposed financial risk that small offices were poorly positioned to absorb.

Compounding this instability, Medicare physician payments have not kept pace with inflation for more than two decades, steadily eroding the financial viability of independent primary care.[3]

Large health systems could manage this volatility across diversified revenue streams. Independent practices operating on narrow margins could not.

That instability ultimately became the decisive factor in my decision to leave Medicare participation. That decision reflected operational realities, not opposition to Medicare's mission or to caring for Medicare beneficiaries.

That experience marked what we later referred to as our "Epiphany" moment and forced a fundamental reassessment of why primary care is structured the way it is.

Why are we insuring primary care?

Primary care is a low-cost, high-value service, yet it is routed through complex insurance structures designed for catastrophic risk. Layers of billing intermediaries, tens of thousands of procedural codes, and hundreds of thousands of diagnostic codes are imposed on care that is fundamentally relational and longitudinal.

Somehow, we are surprised that it has become expensive, impersonal, and complex.

VI. Regulation as Fixed Overhead and the Structural Driver of Consolidation A critical feature of Medicare regulation is often overlooked. It functions as fixed overhead.

Compliance costs do not scale proportionally with patient volume. Certified electronic records, reporting platforms, billing systems, audit preparation, and administrative staffing impose similar expenses on a two-physician rural practice as on a multi-hundred-provider health system.

Large organizations can distribute these fixed costs across many clinicians and locations. Independent practices cannot.

As regulatory complexity increases, scale itself becomes a survival requirement.

Consolidation accelerates not because it improves care delivery, but because it allows administrative costs to be spread across a larger denominator.[4]

VII. Erosion of the Doctor-Patient Relationship Primary care depends on time, trust, and continuity.

Regulatory overload erodes all three.

As documentation demands expand, clinical encounters are increasingly shaped around billing and reporting requirements rather than patient need. Notes increasingly serve regulatory validation rather than clinical communication.

Older adults experience fragmented care, reduced continuity, and shortened visits.

The result is increased downstream utilization, higher total system spending, and diminished quality of care despite growing administrative investment.[5]

VIII. The Rural Access Crisis and Non-Scalable Compliance Costs The impact of fixed regulatory overhead is most severe in rural and underserved communities.

In these settings, access barriers rarely stem from lack of patient demand. They arise from systems that require administrative scale unrelated to the delivery of clinical care.

Under traditional fee-for-service Medicare participation, rural primary care practices often require patient panels approaching 3,000 individuals to generate sufficient billing volume to sustain certified electronic records, quality reporting programs, coding infrastructure, and compliance staffing.

Even at that scale, many practices remain dependent on supplemental subsidies or hospital support to offset administrative costs rather than clinical expenses.

These requirements bear little relationship to the actual clinical capacity of a primary care physician.

By contrast, when administrative design is simplified, the economics change entirely. In environments not dominated by billing and reporting infrastructure, primary care practices can remain financially viable with patient panels of approximately 300 to 600 individuals.

This contrast demonstrates that rural access failures are not caused by insufficient demand or physician shortages alone. They are driven by regulatory structures that impose fixed overhead costs incompatible with small-community medicine.

Physicians are not leaving rural communities because patients are absent. They are leaving because policy design has made independent practice economically untenable at the scale rural communities can support.[6]

IX. Scale as a Regulatory Artifact A frequent criticism raised in workforce discussions is that alternative practice models cannot "scale."

In Medicare, scale has become a survivability mechanism rather than an indicator of clinical quality or efficiency.

When administrative overhead is reduced, the economic necessity for scale diminishes.

Scale is not an inherent requirement of primary care delivery.

It is an artifact of administrative design.

X. Observational Contrast: Direct Primary Care Direct Primary Care provides a real-world observational contrast demonstrating how primary care functions when administrative design is fundamentally altered.

Under DPC, practices do not bill insurance and are not subject to Medicare documentation, coding, or quality reporting programs. As a result, administrative overhead is dramatically reduced, allowing practices to remain financially viable with smaller patient panels and greater clinical capacity per patient.

This contrast is not presented as model advocacy, nor as a substitute for Medicare coverage. Rather, it illustrates a critical policy insight: when fixed regulatory overhead is removed, the economic necessity for scale diminishes and access can be preserved at the community level.

The relevance of this model is not its payment mechanism, but what it reveals about the underlying cost structure of primary care delivery.

Direct primary care is not a Medicare benefit and requires direct payment by beneficiaries. Its growth does not reflect a desire to exclude seniors, but a physician workforce adapting to regulatory conditions that have made traditional participation increasingly unsustainable.

Under current law, Medicare beneficiaries cannot freely contract with physicians for covered services without the physician fully withdrawing from Medicare participation. This statutory restriction limits flexibility for both seniors and physicians and represents a policy barrier rather than a clinical or ethical one.[7]

The lesson for policymakers is not that Medicare should be replaced, but that access collapses when administrative design overwhelms care delivery.

Medicare today guarantees coverage, not care. When physicians can no longer sustain participation, beneficiaries lose access regardless of what card they carry. Direct primary care has emerged not as a rejection of Medicare, but as evidence of how regulatory structure determines whether care can be delivered at all.

XI. Addressing the Panel-Size Workforce Concern Smaller patient panels are often viewed as incompatible with population-level access.

In practice, physician exit poses the far greater threat.

A physician who leaves practice provides care to zero patients. A sustainable practice that retains physicians in active clinical work preserves access even with smaller panels.

Reducing burnout and extending clinical careers is therefore central to workforce preservation.

XII. Conclusion Physicians are not leaving medicine because they lack commitment.

They are leaving because regulatory systems have made sustainable practice increasingly impossible.

If Congress wishes to preserve access for older Americans, particularly in rural and underserved communities, administrative simplification must be treated as workforce policy.

Without reform, consolidation will continue and the doctor-patient relationship will remain collateral damage.

Thank you for the opportunity to testify.

Footnotes [1] Kaiser Family Foundation Health News. Doctors Raise Concerns for Small Practices in Medicare's New Payment System. September 6, 2016.

[2] American Medical Association. "Physician Practice Characteristics in 2024: Private Practices Account for Less Than Half of Physicians in Most Specialties" (Policy Research Perspective, released 2025). Only 42.2% of physicians were in private practice in 2024 (down from 60.1% in 2012), with hospital-owned practices rising to 34.5% and private equity involvement increasing to 6.5%; MedPAC. March 2025 Report to the Congress: Medicare Payment Policy (March 13, 2025, Chapter 4 on physician services and workforce implications); MedPAC. June 2025 Report to the Congress: Medicare and the Health Care Delivery System (June 12, 2025, including recommendations for PFS reform to address sustainability and relative value accuracy).

[3] When adjusted for inflation in practice costs, Medicare physician payment has declined approximately 33 percent from 2001 to 2025, despite a temporary one-time 2.5% statutory increase for calendar year 2026 (plus small MACRA updates, yielding overall conversion factor increases of approximately 3.77% for qualifying APM participants to $33.57 and 3.26% for non-qualifying APM participants to $33.40). This relief expires after 2026, with MedPAC and AMA emphasizing ongoing inadequacy, the need for permanent inflation-linked updates (e.g., a portion of the Medicare Economic Index), and projected cuts returning in 2027 absent structural reform. American Medical Association. "2025 Medicare updates compared to inflation chart" (updated January 2025, confirming 33% decline through 2025); Centers for Medicare & Medicaid Services. Calendar Year (CY) 2026 Medicare Physician Fee Schedule Final Rule (CMS-1832-F), October 31, 2025 (Federal Register, November 5, 2025); MedPAC. March 2025

Report to the Congress: Medicare Payment Policy (March 13, 2025); MedPAC. June 2025 Report to the Congress: Medicare and the Health Care Delivery System (June 12, 2025, recommending long-term PFS updates based on a portion of MEI growth); MedPAC vote (January 15, 2026) recommending +0.5 percentage points above current law for 2027.

[4] Congressional Budget Office. Budgetary Effects of Aligning Payments for Services Provided in Hospital Outpatient Departments and Physician Offices. 2025–2034 projections.

[5] Sinsky CA et al. Health Care Expenditures Attributable to Physician Burnout. Mayo Clinic Proceedings. 2022.

[6] Health Resources and Services Administration. Health Professional Shortage Area data; MedPAC reports on access in rural America. 2025.

[7] Social Security Act §1802(b)(1); 42 CFR Part 405 Subpart D.