NEW YORK INDEPENDENT PHYSICIAN PRACTICE ASSOCIATION

February 4, 2026

Testimony of New York Independent Physician Practice Association to the Joint Legislative Public Hearing on Health Executive Budget Proposal for Fiscal Year 2026-2027

On behalf of the New York Independent Physician Practice Association ("NYIPPA"), we are writing to strongly urge the Legislature to **reject the inclusion of Part H of the Governor's Health and Mental Hygiene Article VII bill** ("HMH Part H"). NYIPPA represents independent physician practices that provide specialty and primary care to patients from Montauk to Buffalo, serving a variety of patient populations, including those where 25% or more are Medicaid or Medicare beneficiaries.

Our principal concern with HMH Part H is that we believe it would have the unintended consequence of jeopardizing efforts by independent medical groups to remain a viable, cost-effective access point for high-quality care in New York by expanding onerous transaction reporting requirements in an increasingly challenging regulatory environment. Independent medicine is on the decline. Across the country, the share of doctors working in private practice decreased from 60.1% to 42.2% between 2012 and 2024.[1] Furthermore, Optum, a subsidiary of UnitedHealth Group, now employs one in ten physicians.[2] Physicians are leaving private practice because of reimbursement cuts,[3] physician workforce shortages,[4] and ever-climbing costs and compliance requirements. Such economic pressures have created an environment in which independent physician practices must either find a way to grow their way to success and remain independent or concede to acquisition by a health system or insurance company.

One method by which independent physician practices have preserved their independence has been through partnerships with management services organizations ("MSOs"), which provide access to capital and sophisticated business support needed for practices to grow and succeed. According to a recent study by health care consulting firm Avalere, in 2022, these practices and

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[1] *Physician Practice Benchmark Survey*, American Medical Association (May 29, 2025), *available at* https://www.ama-assn.org/about/ama-research/physician-practice-benchmark-survey#toc-2024-benchmark-survey-01 ("The AMA Benchmark Survey").

[2] Bob Herman, *UnitedHealth Group now employs or is affiliated with 10% of all physicians in the U.S.*, STAT (Nov. 29, 2023), *available at* https://www.statnews.com/2023/11/29/unitedhealth-doctors-workforce/.

[3] *Updated Report: Hospital and Corporate Acquisition of Physician Practices and Physician Employment 2019-2023*, Physicians Advocacy Institute, slide 8 (April 2024), *available at* https://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/PAI-Research/PAI-Avalere%20Physician%20Employment%20Trends%20Study%202019-2023%20Final.pdf?ver=uGHF46u1GSeZgYXMKFyYvw%3D%3D.

[4] The AMA Benchmark Survey.

unaffiliated independent practices had fewer inpatient days, emergency department visits, and Medicare expenditures than their hospital and corporate-affiliated peers.[5] These partnerships also represent a small minority of providers, with only 6% of physicians affiliating with MSOs across the five specialties studied. It is these beneficial partnerships that would be chilled through the expanded transaction review process included in HMH Part H.

If this proposal must be considered, we believe it should be done outside of the budget process to give adequate opportunity for debate and review. Indeed, the Legislature has repeatedly recognized the flaws in including this proposal in the budget and acted accordingly. Just last year, the Legislature rightly rejected the very same proposal in Part S of the Governor's Health and Mental Hygiene Article VII bill,[6] and before that rejected substantively similar measures in the budget for 2024.[7] The modest changes reflected in Part H from these past proposals are mere window dressing for the same expansion of the material transaction review process that we believe will undermine the viability of independent medical practices in the State.

As independent practices are absorbed into larger hospital systems, patients increasingly find themselves receiving care in higher-cost settings—a shift that has measurable financial consequences. In a peer-reviewed study examining the differences in the cost of care for Medicare and commercially-insured patients across four specialties, care delivered in hospital outpatient departments was found to cost up to 861% more for Medicare and 1,346% more for commercial insurers than the same care delivered in ambulatory surgery centers and physicians' offices on a reimbursement basis.[8] Furthermore, the same study found that Medicare beneficiaries had just a 37% chance of receiving care in the lowest-cost setting if their physician was affiliated with a hospital, compounding the cost problem created by the significant difference in reimbursement. In recognition of these concerns, DOH has supported moving avoidable institutional care to community and outpatient-based care settings because it leads to better care, better health, and lower costs for patients and the State. Onerous and costly reporting requirements such as those proposed by HMH Part H will slow down progress towards achieving that goal.

HMH Part H should be rejected because it unnecessarily expands DOH's authority by saddling independent practices with even greater compliance costs

HMH Part H amends the Public Health Law regarding the reporting to DOH of "material transactions" by a health care entity. These amendments include requiring additional disclosures; imposing an unreasonable seven-day response requirement for supplemental DOH requests; and creating an annual reporting obligation for a five-year period after the transaction closes. Most

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[5] *Medicare Service Use and Expenditures Across Physician Practice Affiliation Models*, Avalere (September 2024), *available at* https://advisory.avalerehealth.com/insights/medicare-cost-and-utilization-across-physician-affiliation-models.

[6] Part S of the Governor's Health and Mental Hygiene Article VII bill in the FY2026 Executive Budget, *available at* http://www.budget.ny.gov/pubs/archive/fy26/ex/artvii/hmh-bill.pdf.

[7] Section 5 of Part M of the Governor's Health and Mental Hygiene Article VII bill in the FY2024 Executive Budget, *available at* https://www.budget.ny.gov/pubs/archive/fy24/ex/artvii/hmh-bill.pdf.

[8] Deepak Kapoor, et al., *Physician Practice Affiliation Drives Site of Care Cost Differentials: An Opportunity to Reduce Healthcare Expenditures*, Journal of Market Access and Health Policy (2025), available at https://www.mdpi.com/2001-6689/13/3/36 (examining the cost of care for physicians practicing in the specialties of cardiology, gastroenterology, orthopedics, and urology).

concerningly, after a 30-day preliminary review, DOH would have the discretion to require a cost and market impact review ("CMIR"), which would create significant transaction costs and further delay the transaction from closing by an additional 180 days. Through indefinite delays of the preliminary review process, the threat of being placed into a CMIR effectively grants DOH the power to halt transactions from proceeding.

In an attempt to make the CMIR process appear more reasonable than prior proposals, Part H grants DOH the discretion to conduct CMIRs for transactions valued at greater than 100 million dollars. However, this purported threshold is illusory. DOH is afforded the same discretion to review transactions below the threshold if DOH "*reasonably* believes that [the transaction] *may* negatively impact" cost, quality, access, or competition. Effectively, DOH is being given the authority to place any "material transaction" into a CMIR process. The 100-million-dollar threshold masks what HMH Part H intends to accomplish—broad expansion of DOH's discretionary authority to decide whether health care transactions can proceed. We are concerned that many parties will forgo or abandon transactions to avoid incurring delays as well as ballooning legal and consulting fees that make the transaction too costly to complete, limiting the options available for independent practices to grow and preserve their independence.

Conducting comprehensive CMIRs, reviewing annual reports, and establishing the infrastructure to expand DOH's oversight will be resource intensive for the State. While we share DOH's concerns about health care consolidation, the mere 22 material transactions posted on DOH's website since the first report was posted in 2023 do not suggest there is a rapid evolution occurring into which the agency lacks line of sight. Furthermore, last May, DOH transformed what historically was a modest notice requirement into a 15-page information request that bears little resemblance to the scope of the reporting obligation created by the legislature in 2023.[9] Without the benefit of public input through the statutorily-required notice process, the form also compels parties to produce documents that are not contemplated by statute.[10] Such unchecked administrative power and the absence of data to suggest that New York's health care market suddenly requires these reforms further demonstrates that the Legislature should not expand DOH's authority as part of the budget.

Investments in independent practices accrue to the benefit of patients and their communities that should be promoted, not prevented.

HMH Part H threatens transactions that support the long-term viability of independent practices and would limit many of the benefits conferred to patients in New York by these transactions. Several of NYIPPA's member practices that have partnered with MSOs have seen first-hand the benefits of such investments:

> "My independent practice, with the support of our MSO partner, accepts all insurance, including a Medicaid managed care plan. Our local hospital, by contrast,

[9] Material Transaction Reporting Form (May 2, 2025), *available at* https://surveygizmolibrary.s3.amazonaws.com/library/4429/MTFormv5_2_25.pdf.

[10] NY Pub. Health L. § 4552(1) (2024) ("a health care entity shall submit to the department written notice, with supporting documentation as described below *and further defined in regulation by the department*, […] in the form and manner prescribed by the department") (emphasis added).

announced it would not accept the Medicaid managed care plan or patients with Humana."
– Justin Maroney, M.D., Cardiologist, New York

"My independent practice, New York Cancer & Blood Specialists, is the sole major cancer care service provider in the New York metropolitan area that accepts all insurance plans. We've been able to do so because of the support of our MSO partner."
– David Eagle, M.D., Oncologist, New York

"The financial support provided by my independent practice's MSO partner enabled us to invest in a multimillion-dollar linear accelerator, which delivers precise radiation therapy to successfully treat prostate cancer in far fewer treatments than older technology — and far less invasively than surgery."
– Angelo DeRosalia, M.D., Urologist, New York

"With the support of our MSO partner, we continue to proudly accept all insurance plans, including Medicaid managed care, and have had access to the capital and business support necessary to reduce wait times, enhance surgical efficiency at our ambulatory surgical center, and improve benefits for our employees."
– William Colman, M.D., Orthopedic Surgeon, New York

These examples demonstrate the value of these partnerships to our patients, communities, and the system of health care delivery in New York. Without these partnerships, independent practices would lack the capital and administrative resources to compete with large hospital systems. By imposing a more burdensome review process in HMH Part H, independent practices would have fewer opportunities to participate in these types of partnerships—jeopardizing our survival.

To ensure that independent providers can continue delivering essential care to their communities, we respectfully request that the Legislature reject HMH Part H. This provision disproportionately impacts independent physician practices, putting them at risk of closure and furthering the consolidation of hospital and health systems at the expense of patient choice.

Please contact John Cordo (jcordo@cordolaw.com), Adam Richardson (arichardson@cordolaw.com) or Ali Rimkunas (arimkunas@cordolaw.com) if NYIPPA can be of further assistance in connection with this critically important health policy issue.

Sincerely,

David Eagle, M.D.
Board Chair & President, NYIPPA