April 5, 2025

Chair Wiklund and committee members,

I am a family physician who trained in Minnesota and practiced here for 30 years. I worked in a variety of medical settings, including non-profit sliding scale community clinics, a physician-owned private practice, a trade union clinic, and an investor-owned practice.

I write in **support** of the **Minnesota Health Care Accountability Act, SF 2939**. This is about my experience in an investor-owned clinic.

It was a new practice, a start-up, providing outpatient primary care for seniors. When I was recruited, I was assured that we would have ongoing training, as none of us hired there were specialized geriatricians. (There is a dire shortage of geriatricians.) We would have continuing medical education, expert chart reviews and routine case consults. We would have the option of longer visits for more complex patients.

However, as the months went on, the focus shifted. The number of patients we were scheduled to see each day increased. The time to spend with each one got shorter. And time in the schedule for education and learning and collaboration was eliminated. Leadership became less interested in supporting our clinical care and more interested in improving our coding of the important diagnoses that would increase billing revenue.

Most of our training from leadership was about entering diagnostic codes for high-priority (highly-reimbursed) diagnoses. Here are examples, taken from my notes from a staff training:
- a cognitive assessment can be its own visit. Can code a non-face-to-face encounter as part of a diagnostic assessment (3d prior or 7d after). If total interaction is >99 minutes, code 6212 (extra time).
- 3 kinds of Medicare preventive visits. Initial Preventive Physical exam, IPPE G0402, once in first 12 months. Annual Wellness Visit, Initial 12 mo *after* they get part B or 12 mo after IPPE, code G0438. AWV subsequent, 12 months later, G0439.
- You can bill for a cognitive assessment every 180 days (2x/yr).
- You can bill for smoking cessation counseling – different code for 3-10 minutes, or >10 minutes.

Is this what you want your doctor studying??

The organization hired more and more employees to deal with billing, technology, and administration, but not for patient care. Support staff would review outside charts before the patient's first visit to draw out important diagnostic codes, highlighting those most important for billing purposes. These staff increase healthcare costs, but do not improve patient outcomes, or actual care.

Clinicians became demoralized. In order to see more patients per day, lunch time was changed to unpaid, the work day was lengthened, and visit time with each patient was shortened. Some days I worked 14 hours. The start-up business had to satisfy investors by reaching various targets. To that end, growth was more of a priority than solid clinical practice - by which I mean quality patient care.

This is the reason I retired a year sooner than I intended to.

MN has a significant and growing shortage of primary care physicians. This kind of experience, where the business and profit concerns run the practice more than the medical care of the patient, is a major reason that physicians are retiring early and leaving practice.

Please pass the Health Care Accountability Act so that Minnesota can monitor and mitigate the effects of private equity and other investors in health care. Doctors want to focus not on finances but on taking care of patients.

Sincerely,

Amy Gilbert, MD, MPH
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