U.S. House of Representatives
Committee on Ways and Means
Subcommittee on Health

Hearing:
Modernizing Care Coordination to Prevent and Treat Chronic Disease

November 19, 2025

Statement for the Record
American Academy of Dermatology Association

Chairman Buchanan and Ranking Member Doggett, on behalf of the more than 17,000 U.S. members of the American Academy of Dermatology Association (AADA), we thank you for the opportunity to submit a statement for the record regarding your hearing, *Modernizing Care Coordination to Prevent and Treat Chronic Disease*.

Dermatologists are the frontline of coordination between patients, physicians, and other health professionals in the American healthcare system. Dermatologists frequently coordinate with primary care providers and a range of specialists on over 3,000 conditions affecting the skin, hair, and nails. Collaboration and coordination are only possible with access to other health professionals; however, consistent cuts to Medicare physician payment threaten patient access to care. Every closed practice, every second of delayed care, every unfilled job in a practice, all hampers coordination and threatens the viability of Medicare. Unfortunately, after more than twenty years of cuts to Medicare physician payment, these delays, closures, and unfilled roles are far too common.

Stabilizing Medicare Physician Payment

Stable and predictable Medicare reimbursement will help lead to greater access for patients and increase the bandwidth of health professionals to coordinate care. Medicare physician payment cuts threaten patient access as physician offices close or become consolidated within larger health systems with narrow networks to specialists and subspecialists. This results in reduced accessibility to affordable, high-quality dermatologic care and fewer options for patients to choose their own physician and health insurance that best meets their needs.

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To accomplish this goal, Congress must take action to advance Medicare physician payment reform by:

- Establishing a positive annual inflation adjustment; and
- Increasing the budget neutrality threshold.

In the 2025 Medicare Physician Fee Schedule (MPFS) Rule, the Centers for Medicare & Medicaid Services (CMS) finalized changes that resulted in a 2.8% cut to Medicare physician payment on January 1, 2025. *The AADA urges Congress to pass H.R. 879, the Medicare Patient Access and Practice Stabilization Act of 2025,* which would stop the 2.8% cut to Medicare physician payment, ensure that physicians are made whole for the cuts already in effect in 2025, and provide an overdue positive inflationary adjustment for physician practices for 2025. *The AADA also urges Congress to pass legislation like H.R.6371 – 118th Congress, Provider Reimbursement Stability Act of 2023* which would raise the outdated budget neutrality threshold in the MPFS.

The failure of the MPFS to keep up with inflation is the greatest threat to access to care in physician offices. Stabilizing the MPFS is critical to fortify independent medical practice, combat consolidation and maintain access for patients. On January 16, 2025, the Medicare Payment Advisory Commission (MedPAC) voted to recommend tying Medicare physician payment for CY 2026 to the Medicare Economic Index (MEI) minus 1 percentage point. The MEI, which measures practice cost inflation, is projected to increase by 2.3% in 2026.

The AADA is appreciative of the 2.5% plus-up to Medicare physician payment for calendar year 2026 in *H.R.1, One Big Beautiful Bill Act*. Additionally, the AADA was supportive of the policy included in the House-passed version of H.R. 1 that would have tied the MPFS to inflation by establishing a permanent, annual update based on a portion of MEI. This could have been a building block towards long-term, sustainable reform of predictable annual inflationary adjustments, but unfortunately this policy was not finalized and instead physicians have dealt with a cut for all of this year with looming challenges facing them in 2026 despite the increase passed by Congress.

Since 2001, the cost of operating a medical practice has increased 59%. During this time, Medicare hospital and nursing facility updates resulted in a roughly 70% increase in payments to these entities, significantly outpacing physician reimbursement. Adjusted for inflation in practice costs, Medicare physician reimbursement declined 33% from 2001 to 2025. This out-of-balance payment structure disproportionately threatens the viability of medical practices, especially smaller, independent, physician-owned practices, as well as those serving low-income or historically marginalized patients. Dermatologists are seeing the real effect of cuts. In the past 8 years, private insurance patients for dermatologists have increased by 21% while Medicare patients are down 27%.

The current Medicare physician payment system has led to increased consolidation and hospital ownership of physician practices resulting in higher expenses and reduced competition to the health care system. In considering the failure of the MPFS to keep up with the rising costs of delivering medical care, it is important to remember that physicians rely on reimbursement to cover a multitude of practice

expenses. These expenses include staff salaries, benefits, federal and state regulatory compliance costs, and expenses associated with insurance mandates, such as step therapy and prior authorization. The impact of these burdens is unsustainable. Many physicians have already had to close their doors, leave their communities, retire early, or leave the practice of medicine. The inability to provide inflationary pay raises to practice employees is contributing to the current health care workforce crisis in which we are seeing increasing burnout rates and a mass exodus of our clinical, administrative, and clerical staff into other industries.

Fewer physicians in our communities means longer waiting times for patients to receive care. Currently, dermatology is only able to meet approximately 37.1% of patient demand in non-metro areas.[i] When those patients do receive care, their only option may be non-physician providers of care with less training, or more expensive care in suboptimal settings including emergency departments and hospital-based practices. Medicare patients will suffer in the end with delayed and second-rate care at a higher cost. Declining reimbursement and increasing administrative burdens will exacerbate this shortage of physicians when offices close their doors.

In its latest report, MedPAC shared its concerns about whether beneficiaries will continue to have adequate access to care in the coming years as growth in physician practice operating costs is expected to exceed growth in Medicare payment rates by a greater amount than it did in the prior two decades. This larger gap could create incentives for physicians to reduce the number of Medicare beneficiaries they treat, stop participating in Medicare entirely, or vertically consolidate with hospitals, which could increase spending for beneficiaries and the Medicare program.

Concerns In the CY 2026 MPFS

In the CY 2026 MPFS, CMS finalized a proposal to apply a 2.5 percent "efficiency adjustment" policy. The AADA is strongly opposed to this policy as it is not supported by valid data, is inconsistent with the Medicare statute, undermines the relativity of resource-based relative value scale (RBRVS), and most importantly, risks harming patient care.

CMS has not explained the rationale for selecting 2.5 percent for the efficiency adjustment beyond citing productivity adjustments in the MEI, which has no meaningful relationship to physician work. Applying an economy-wide productivity factor to physician services is arbitrary and ignores the realities of clinical care. Further, reliance on the MEI is particularly misplaced in this policy because, unlike hospitals and other Medicare payment systems that receive routine inflationary updates, physician services do not benefit from an automatic adjustment for rising costs.

There is no evidence that dermatologists, or physicians in general, are performing procedures more efficiently today than in the past. The time it takes for local anesthesia to become effective or for a patient to stop bleeding has not changed and cannot be made more efficient simply through repetition. In fact, many modern tools require additional physician time, including the use of artificial intelligence. Advanced imaging systems and artificial intelligence tools produce far more data that must be carefully

reviewed, interpreted, and documented. A recent national study of 1.7 million surgical procedures found that operative times have increased over the past five years, while patient complexity has also grown. The authors concluded that there is no evidence to support CMS's assumption that physicians are performing procedures more efficiently today.

Unsupported and meritless policies such as the "efficiency adjustment" destabilize the healthcare system by encouraging consolidation and further exacerbate the failures within Medicare, which reinforces the need for long-term sustainable reform. The AADA stands ready to work with CMS and Congress on an alternative path forward such as linking Medicare physician payment to a positive inflationary adjustment and reforming budget neutrality.

On behalf of the AADA, thank you for your leadership and help ensuring that Medicare meets the needs of Americans. The AADA is committed to excellence in the medical and surgical treatment of skin diseases; advocating for high standards of clinical practice, education, and research in dermatology and dermatopathology; and driving continuous improvement in patient care and outcomes while reducing the burden of disease. The AADA welcomes the opportunity to continue working with Congress to identify opportunities to maintain patient access to care and improve outcomes. Together, we can make a positive difference for patients across the nation.

[i] https://data.hrsa.gov/topics/health-workforce/workforce-projections